July 31, 2009

Dr. Laurence Raine
Department of Homeland Security
1120 Vermont Avenue, NW
Washington, DC 20005

RE: Contract No. SP0700-00-D-3180, Delivery Order 557, Task 704

Dear Dr. Raine,

Enclosed is the technical report for CBRNIAC Contract No. SP0700-00-D-3180, Delivery Order 557, Task 704, titled *High-Level Analysis of Grant Funding for Medical and Public Health Preparedness.* Conducted as part of the Clearinghouse of Medical and Public Health Preparedness Allocations Skill Development, and Standards (CoMPASS) project, this historical grants analysis captures historical trends in medical and public health grant funding. The findings provide a basis for informed national discussion and the recommendations prioritize the need for future collaborative efforts across the government to support the National Priorities and National Preparedness Guidelines. Please call Dan Bird at 410-306-8562 should you have questions.

Sincerely,

Jim Beddard, MS, MPH, FACHE
Director
Medical Readiness and Response

KAN

Enclosure

cc:
CBRNIAC, w/enclosure CBIAC_deliverable@battelle.org
Dhiraj. G. Parekh, COTR, w/enclosure dhirajlal.parekh@us.army.mil
Jim Adase, DTIC-I, w/o enclosure jadase@dtic.mil
Alvin Butler, PCO, w/o enclosure 55.cons.dtic@offutt.af.mil
Enrique de Alderete, ACO, w/o enclosure Enrique.dealderete@dcma.mil

Contract No. SP0-700-00-D-3180

CBRNIAC Task No. 704, Delivery Order No. 557

REPORT

HIGH-LEVEL ANALYSIS OF GRANT FUNDING FOR MEDICAL AND PUBLIC HEALTH PREPAREDNESS

Technical Report

Department of Homeland Security
1120 Vermont Avenue, NW
Washington, DC 20005

July 2009

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Battelle Eastern Science & Technology Center
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Conducted as part of the Clearinghouse of Medical and Public Health Preparedness Allocations Skill Development, and Standards (CoMPASS) project, this historical grants analysis captures historical trends in medical and public health grant funding The findings provide a basis for informed national discussion and the recommendations prioritize the need for future collaborative efforts across the government to support the National Priorities and National Preparedness Guidelines.

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On

High-level Analysis of Grant Funding for Medical and Public Health Preparedness

Prepared for:

Department of Homeland Security
1120 Vermont Avenue, NW
Washington DC 20005

July 31, 2009

Prepared by:

Melody Graves Allen
(703) 875-2117

Battelle
1204 Technology Drive
Aberdeen, MD 21001

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Executive Summary

Clearinghouse of Medical and Public Health Preparedness Allocations Skill Development, and Standards (CoMPASS) is a multi-phase project funded by the Department of Homeland Security's (DHS) Office of Health Affairs (OHA) to address the need for a central data repository of medical and public health preparedness and response training courses, grant opportunities, and standards for the first responder community. In parallel to inventorying relevant grant opportunities, the CoMPASS project team conducted an analysis of historical Federal grant program funding support of medical and public health preparedness. Through this analysis, the CoMPASS project team seeks to capture grant program historical trends; to understand how they have shaped the evolution of medical and public health preparedness; provide a basis for informed national discussion; and prioritize the need for future collaborative efforts across the government to support the National Priorities and National Preparedness Guidelines.

In the first post-September 11 budget, President George W. Bush's proposed Fiscal Year (FY) 2003 Budget directed $37.7 billion (up from $19.5 billion in 2002) to homeland security efforts, including support for first responders, bioterrorism prevention efforts, border security, and technology, reflecting an increased focus on homeland security.[1] In October 2007, the White House released Homeland Security Presidential Directive (HSPD)-21, which established, "…a National Strategy for Public Health and Medical Preparedness" and, "…transformed our national approach to protecting the health of the American people against all disasters." HSPD-21 Section 36 mandates the Department of Homeland Security (DHS) and Department of Health and Human Services (HHS) to, "…develop and thereafter maintain processes for coordinating Federal grant programs for public health and medical preparedness using grant application guidance, investment justifications, reporting, program performance measures, and accountability for future funding…"[2]

The scope of the analysis presented in this *High-Level Analysis of Grant Funding for Medical and Public Health Preparedness Report* includes medical and public health preparedness DHS and HHS grant program funding available to the first responder community from the six-year period (FY03 through FY08) since this heightened focus on preparedness activities began. Based on the results of the grant guidance analysis, five high-level findings and recommendations were developed to address the following questions regarding grant program availability, integration and accessibility:

- **Availability:** What historical funding opportunities were made available to support medical and public health preparedness activities?
- **Integration:** How do funding opportunities work in support of one another to provide funding to medical and public health communities?
- **Accessibility:** How efficiently was this funding disbursed to State/local entities?

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[1] http://www.dhs.gov/xlibrary/assets/brief_documentary_history_of_dhs_2001_2008.pdf (accessed July 27, 2009)

[2] Bush, G.W. (2007, Oct 18). *Homeland Security Presidential Directive-21*. Washington, D.C.: U.S. Department of Homeland Security.

Availability

Finding #1: ***DHS and HHS funding available to the medical and public health preparedness community have decreased during the six-year period reviewed, even though the number of grant programs supporting this community increased. Smaller funding pools may lead to development of medical and public health capabilities receiving a lower priority than other capabilities.***

Recommendation #1

Conduct an analysis of DHS and HHS grantee data to determine how the measured decline in Federal preparedness funding has affected prioritizing expenditures for medical and public health preparedness target capabilities over this six-year period. There is awareness in the medical and public health community that grantees are not prioritizing Emergency Medical Services (EMS) when spending Federal funding. Various resources, including congressional reports, EMS articles, and an EMS funding survey, focus on the lack of funding given to the EMS community. None of these reports however, contains an analysis that reveals what these preparedness funds ultimately do support. A letter written by the National EMS Management Association to President Obama made the following recommendation, "The Administration should require HHS and DHS to evaluate the distribution of all Federal grant funds across disciplines. This evaluation should be compiled and reported to Congress."[3] The project team concurs and proposes including target capability analysis in this evaluation.

Integration

Finding #2: ***The number of DHS grant programs that support a target capability is not representative of funding amounts allocated to that capability. The government may overestimate the percentage of available funding dedicated to medical and public health preparedness because of the preponderance of medical and public health preparedness grant programs.***

Recommendation #2

Investigate factors determining why so many grant programs support medical and public health target capabilities, but actual funding is minimal. Conduct an analysis of the programmatic data of seven DHS and twelve HHS programs, investigating the correlation between expenditures for medical and public health target capability development and the number of programs that support them. The results may highlight a need for increased coordination between DHS and HHS in administering funds for the subset of thirteen medical and public health target capabilities. In effect, the Federal government may need to reorganize or consolidate current grant programs to direct funding to these critical areas.

---

[3]National Emergency Medical Services Management Association. (2009, January). *Letter to President-Elect Barack Obama and Secretary-Designate Tom Daschle*. San Diego, CA

Finding #3: ***DHS programmatic data show that development of medical and public health target capabilities were not well supported by DHS program spending, including capabilities not supported by HHS programs. For example, although DHS has primary responsibility for the mass care capability under ESF #6, DHS funding did not support development of this capability. Further, while HHS plays a supporting role in ESF #6, no HHS grants supported this target capability. This indicates a likely preparedness gap and the medical and public health communities may lack resources to address a catastrophic health event.***

Recommendation #3

Conduct an investigative process to determine if States are finding other funding avenues to fill these preparedness gaps. Other Federal departments, DHS, and HHS agencies have a role in supporting State and local capability development; therefore, the Federal government should expand this analysis to capture a complete picture of funding shortfalls. Making the best grant policy decisions requires full knowledge of the medical and public health preparedness landscape; otherwise, achieving and maintaining medical and public health preparedness levels will be challenging and may leave the nation vulnerable to future catastrophic health events.

Finding #4: ***Lesser-funded grant programs are more prevalent now than in years past. Grantees may have to apply to multiple grant programs to sufficiently fund medical and public health target capabilities, which leads to grant writing and reporting burdens.***

Recommendation #4

Implement minimally funded programs judiciously, as in the event of a short-term critical need grant like Emergency Communications Network or an audience-specific grant like the Assistance to Firefighters Grant (AFG). The analysis suggested in the previous recommendation—along with conducting a needs assessment for the medical and public health communities—will assist Federal agencies in determining whether a need for a discipline-specific grant program such as EMS exists.

Accessibility

Finding #5: ***Disbursement of funding is a complicated and inefficient process across departments. Grantees may have to interface with multiple program representatives across all levels of government and meet various reporting requirements.***

Recommendation #5

Continue attempts to streamline reporting processes and/or ensure the reporting format/content is mutually beneficial to the recipient. While many initiatives have been undertaken to reduce grant-reporting burdens across agencies and departments, reporting requirements remain cumbersome. This is especially true if the content of program reports vary from one grant program to another or if deliverable dates are uncoordinated.

1 INTRODUCTION

In October 2007, the White House released Homeland Security Presidential Directive (HSPD) -21, which established "...a National Strategy for Public Health and Medical Preparedness" and "...transformed our national approach to protecting the health of the American people against all disasters." Accordingly, "...it is the policy of the United States to plan and enable provision for the public health and medical needs of the American people in the case of a catastrophic health event through continual and timely flow of information during such an event and rapid public health and medical response that marshals all available national capabilities and capacities in a rapid and coordinated manner." This strategy identifies the four most critical antecedent components of medical and public health preparedness and directs implementation actions. In particular, HSPD-21 Section 36 mandates the Department of Homeland Security (DHS) and Department of Health and Human Services (HHS) to "...develop and thereafter maintain processes for coordinating Federal grant programs for public health and medical preparedness using grant application guidance, investment justifications, reporting, program performance measures, and accountability for future funding…"[4]

This directive acknowledges the need for DHS and HHS grant programs to work in concert to provide effective funding mechanisms for medical and public health sectors and accountability for future funding, and to promote cross-sector and capability-based coordination consistent with the National Preparedness Guidelines developed pursuant to HSPD-8. "The Target Capabilities List (TCL) supports the National Preparedness Guidelines by providing guidance on specific capabilities and levels of capability that Federal, State, local, tribal, and non-governmental entities shall develop and maintain in order to ensure readiness for all-hazards."[5]

The project team conducted this study to provide further insight on the cross-sector, capability-based collaborative needs among grant awarding agencies by addressing the following questions:

Availability	What historical (FY03 through FY08) funding opportunities were available to support medical and public health preparedness activities?
Integration	How have funding opportunities worked in support of one another to ensure adequate funding is provided to medical and public health communities?
Accessibility	How efficiently was this funding disbursed to State/local entities?

[4] Bush, G.W. (2007, Oct 18). *Homeland Security Presidential Directive-21*. Washington, D.C.: U.S. Department of Homeland Security.

[5] U.S. Department of Homeland Security Federal Emergency Management Agency (2009, February) *Target Capability List User Guide.* Washington, DC.

In order to make informed policy decisions, grantors need to understand the full landscape of medical and public health preparedness funding for State and local governments and entities that is *available* from the Federal government. Understanding and learning from historical patterns of earlier grant programs facilitates the grant-issuing agency's ability to take the best course of action for future decisions and most favorably shape how grantees achieve and sustain preparedness goals.

Federal agencies also need to *integrate* grant programs to ensure sufficient and efficient funding for the medical and public health communities. While researching medical and public health preparedness and response funding, project team members found a large sample of articles recognizing Emergency Medical Services (EMS) as a profoundly underfunded component within the medical and public health first responder community. A 2005 Center for Catastrophe Preparedness and Response report echoes this former sentiment stating that EMS has received only 4% of DHS funding, even though it represents roughly one-third of traditional first responders. While the authors of this report recognize that the EMS system does not represent the totality of medical and public health preparedness, this result emphasizes the need for grant programs to work together in order to provide increased funding to the EMS community. For example, DHS' Homeland Security Grant Program (HSGP) 2006 grant guidance directs grantees "...to engage the EMS community in preparedness efforts" and promises to question those States that do not allocate 10% of its funding to EMS.

Finally, grantees need to have quick and uncomplicated *access* to grant funding which supports their preparedness needs. A 2003 Government Accounting Office (GAO) report highlights that:

> *"Federal grant recipients must still navigate through a myriad of Federal grant programs in order to find the appropriate source of funds to finance projects that meet local needs and address local issues. In many cases, numerous grants from several different agencies support similar purposes and activities, giving rise to the potential for fragmentation in service delivery."*

Streamlining the process by which Federal agencies award grant funds across departments leads to greater efficiency in grant funding.

1.1 Purpose and Scope

In the first post-September 11 budget, President George W. Bush's proposed Fiscal Year (FY) 2003 Budget directed $37.7 billion (up from $19.5 billion in 2002) to homeland security efforts, including support for first responders, bioterrorism prevention efforts, border security, and technology, reflecting an increased focus on homeland security[6]. The scope of this analysis includes the medical and public health preparedness grant program funding available to the first responder community from the six-year period (FY03 through FY08)

[6] http://www.dhs.gov/xlibrary/assets/brief_documentary_history_of_dhs_2001_2008.pdf (accessed July 27, 2009)

since this heightened focus on preparedness activities began. Grant program evolution since FY03 includes the number of available grant programs, fluctuating funding amounts, target capabilities supported, and allowable costs.

Although relevant funding opportunities within other departments (e.g., United States Department of Agriculture [USDA] and the Department of Transportation [DOT]) exist, due to time and data access constraints the CoMPASS project team narrowed the scope of this analysis to the departments identified in HSPD-21: DHS and HHS.

The CoMPASS project team narrowed the scope of this analysis to the departments identified in HSPD-21: DHS and HHS.

This *High-Level Analysis of Grant Funding for Medical and Public Health Preparedness (Grant Analysis Report)*, presents the analysis of the allowable expenditures—as identified in grant guidance documents and other open source material—relating to DHS and HHS medical and public health preparedness grants from FY03–FY08. Through this analysis, the Clearinghouse of Medical and Public Health Preparedness Allocations (CoMPASS) project team seeks to:

- Capture historical grant programs trends
- Understand how they have shaped the evolution of medical and public health preparedness
- Provide a basis for informed national discussion
- Prioritize the need for future collaborative efforts across the government to support the National Priorities and National Preparedness Guidelines

Provided in this report is the working definition of "medical and public health preparedness," grant selection methodology, an introduction to the open source documents used in the analysis, and the methodology and results of the medical and public health preparedness funding analysis. The CoMPASS project team also presents findings and recommendations that support increased coordination across Federal departments and agencies and proposes future collaborative analyses of programmatic and financial grantee data.

1.2 About CoMPASS

DHS' Office of Health Affairs (OHA) developed the concept of CoMPASS in response to HSPD-21[7], which directs the Secretary of HHS to coordinate with DHS and other Federal agencies to develop:

[7] Homeland Security Presidential Directive-21 directs HHS to coordinate health and medical disaster preparedness and response efforts with the following agencies: DHS, DoD, DOT, and VA.

- Processes for coordinating Federal grant programs for medical and public health preparedness
- A mechanism to coordinate medical and public health disaster preparedness and response core curricula and training across Federal departments and agencies

Substantial resources from multiple Federal agencies exist to support the achievement of National Preparedness Guidelines but, in the absence of a coordination mechanism, the medical and public health community must seek out this information from fragmented sources. This results in inefficient and cumbersome exploration of training, standards, and/or funding, and users may never reach the specific resource that best addresses their needs. CoMPASS will synergize existing medical and public health preparedness efforts by providing a consolidated resource with targeted search functionality to applicable opportunities. The CoMPASS project goal is to provide direction for the enhancement of medical and public health preparedness by exploiting existing inter/intra-agency resources; consolidating them into a user-friendly single point Web application aligned by target capability and agency-specific preparedness missions.

The CoMPASS project goal is to provide direction for the enhancement of medical and public health preparedness by exploiting existing inter/intra-agency resources; consolidating them into a user-friendly, single point Web application aligned by target capability and agency-specific preparedness missions.

In addition to developing a clearinghouse portal that will benefit the medical and public health community, a parallel CoMPASS objective is to conduct a historical analysis of relevant grant program funding opportunities in order to gain a better understanding of DHS and HHS' support of State and local level medical and public health preparedness efforts. The findings of the analysis will assist Federal agencies in making informed policy decisions, reducing duplicative funding streams, and increasing funding opportunities in any gaps identified.

2 METHODOLOGY

In this section, the CoMPASS team details the four-step process that was followed to conduct this analysis.

2.1 Step 1. Define Medical and Public Health Preparedness

HSPD-21 defines 'public health and medical preparedness' as:

> "…the existence of plans, procedures, policies, training, and equipment necessary to maximize the ability to prevent, respond to, and recover from major events, including efforts that result in the capability to render an appropriate medical and public health response that will mitigate the effects of illness and injury, limit morbidity and

mortality to the maximum extent possible, and sustain societal, economic, and political infrastructure."

Team members expounded upon this definition in order to ensure that the subset of grants directly supporting medical and public health preparedness and response activities were included in the analysis. In accordance with the HSPD-21 directive to promote capability-based coordination, the CoMPASS team determined the TCL 2.0 would serve as the most appropriate and objective basis for defining 'medical and public health preparedness'. Developed by DHS' National Preparedness Directorate (NPD)—with the active participation of stakeholders representing all levels of government, non-governmental organizations, and the private sector—the TCL serves as a guide to address the eight National Priorities and achieve the National Preparedness Guidelines. It identifies 37 capabilities that may be needed in the event of terrorist attacks, natural disasters, health emergencies, and other major events. For this study, 'support' of a medical and public health target capability indicates an allowable cost based on grant guidance; it does reflect an actual expenditure.

Because no formal guidance presently exists identifying which of the TCL 2.0 target capabilities are applicable to medical and public health preparedness, team members conducted research and sought input from Subject Matter Experts (SMEs). The CoMPASS team collected input from the eight source types described in Table 1. For a more vetted approach recommended by the CoMPASS project team, see the methodology described in Appendix A.

Table 1. Input Sources: Medical and Public Health Target Capabilities

Source	Description
1. OHA Representative	Federal entity representative
2. Responder Knowledge Base (RKB)	First responder website
3. Policy document (TCL 2.0)	Target Capabilities linked to Emergency Support Function (ESF) #8 (HHS)
4. Policy document (TCL 2.0)	Target Capabilities linked to ESF #6 (DHS)
5. State of Mississippi ESF #8 After Action Report (AAR)	State and local first responder entity
6. First Responder Briefing (United States Public Health Service [USPHS])	State and local first responder entity
7. Public Health Preparedness SMEs	Medical and public health institutional knowledge
8. Target Capability SME	Target capability institutional knowledge

Representatives and SMEs (sources 1, 7, and 8 in Table 1) have institutional knowledge of the inner workings of medical and public health preparedness and response, target capabilities, or both. Representatives are those who *currently work directly for* the Federal entity, while SMEs have extensively *worked with* Federal entities on a variety of preparedness projects. Please note; SME input is not representative of the opinion of any Federal entity, but of the individual expert only.

Source 2, RKB.gov, is a first responder website[8] linking relevant target capabilities (from TCL 2.0 document) to the DHS Authorized Equipment List.[9] To determine which target capabilities were within the scope of their website, RKB.gov searched for the key terms 'medical' and 'health' in the TCL 2.0 document.

Sources 3 and 4 directly reference the section the TCL 2.0 policy document that links the 37 target capabilities to applicable ESFs. The project team included target capabilities associated with ESF #8—led by HHS—because it covers medical and public health services, and ESF #6—led by DHS—that covers mass care, housing, and human services.

Sources 5 and 6 represent State and local first responder entities, respectively. Source 5 is an AAR prepared by North Carolina (NC) for the State of Mississippi. In this report "NC staff with expertise in Emergency Support Function (ESF) 8, public health and medical services, reviewed each capability and identified those with general relevance to ESF 8…All capability areas, with the exception of recovery capabilities, were included in the data collection framework."[10] Source 6 is a First Responder Briefing prepared by an officer of the United States Public Health Service (USPHS).[11] This presentation contained a slide entitled "ESF-8 Target Capabilities List" which was referenced for this study.

Discussions with SMEs and research of policy documents and websites heavily emphasized thirteen target capabilities as medical and public health target related (those above the red line in Figure 1) including:

1. Epidemiological Surveillance and Investigation
2. Environmental Health
3. Emergency Triage and Pre-Hospital Treatment

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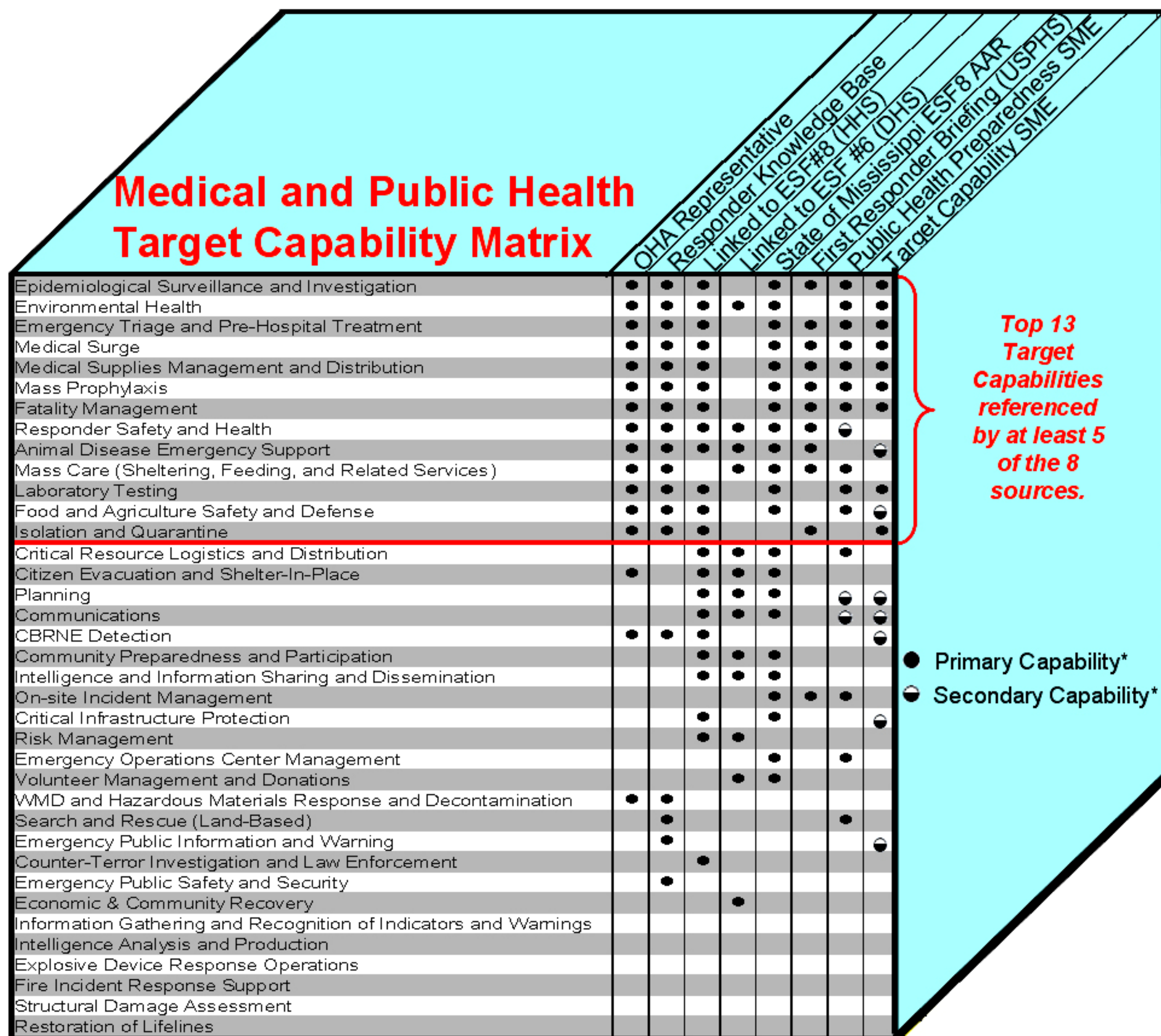
[8] https://www.rkb.us/hspd8.cfm (Accessed February 9, 2009).

[9] The Authorized Equipment List is produced by the FEMA Grant Programs Directorate, Department of Homeland Security. It is the generic list of equipment items allowable under several DHS grant programs, including HSGP.

[10] North Carolina Department of Health & Human Services. (2006). *Hurricane Katrina after action report and recommendations.* Retrieved May 1, 2009 from http://www.msdh.state.ms.us/msdhsite/_static/resources/1676.pdf

[11] U.S. Public Health Service (2006). *Joint medical operations: Challenges in leadership [Presentation]*. Retrieved May 1, 2009 from http://usphs-ppac.org/COA2006Lectures/06_COA_French.pdf

4. Medical Surge
5. Medical Supplies Management and Distribution
6. Mass Prophylaxis
7. Fatality Management
8. Responder Safety and Health
9. Animal Disease Emergency Support
10. Mass Care (Sheltering, Feeding, and Related Services)
11. Laboratory Testing
12. Food and Agriculture Safety and Defense
13. Isolation and Quarantine



Target Capability	OHA Representative	Responder Knowledge Base	Linked to ESF#8 (HHS)	Linked to ESF #6 (DHS)	State of Mississippi ESF8 AAR	First Responder Briefing (USPHS)	Public Health Preparedness SME	Target Capability SME
Epidemiological Surveillance and Investigation	●	●	●		●	●	●	●
Environmental Health	●	●	●	●	●		●	●
Emergency Triage and Pre-Hospital Treatment	●	●	●		●	●	●	●
Medical Surge	●	●	●		●	●	●	●
Medical Supplies Management and Distribution	●	●	●		●	●	●	●
Mass Prophylaxis	●	●	●		●	●	●	●
Fatality Management	●	●	●		●	●	●	●
Responder Safety and Health	●	●	●	●	●	●	◒	
Animal Disease Emergency Support	●	●	●	●	●	●		◒
Mass Care (Sheltering, Feeding, and Related Services)	●	●		●	●	●	●	
Laboratory Testing	●	●	●		●		●	●
Food and Agriculture Safety and Defense	●	●	●		●		●	◒
Isolation and Quarantine	●	●	●			●		●
Critical Resource Logistics and Distribution			●	●	●		●	
Citizen Evacuation and Shelter-In-Place	●		●	●	●			
Planning			●	●	●		◒	◒
Communications			●	●	●		◒	◒
CBRNE Detection	●	●	●					◒
Community Preparedness and Participation			●	●	●			
Intelligence and Information Sharing and Dissemination			●	●	●			
On-site Incident Management					●	●	●	
Critical Infrastructure Protection			●		●			◒
Risk Management			●	●				
Emergency Operations Center Management					●		●	
Volunteer Management and Donations				●	●			
WMD and Hazardous Materials Response and Decontamination	●	●						
Search and Rescue (Land-Based)		●					●	
Emergency Public Information and Warning		●						◒
Counter-Terror Investigation and Law Enforcement			●					
Emergency Public Safety and Security		●						
Economic & Community Recovery				●				
Information Gathering and Recognition of Indicators and Warnings								
Intelligence Analysis and Production								
Explosive Device Response Operations								
Fire Incident Response Support								
Structural Damage Assessment								
Restoration of Lifelines								

Figure 1. Medical and Public Health Target Capability Matrix

Note *– Scoring System Used to Identify Top Thirteen Target Capabilities: Public health and medical response target capability designation as 'primary' (those that directly support medical and public health preparedness and response activities) or 'secondary' (those that indirectly support medical and public health activities) was requested and factored in where possible (e.g., SME and Representative input). If not possible from the source to distinguish, target capabilities were considered 'primary'.*

2.2 Step 2. Data Collection

The CoMPASS project team compiled a comprehensive list of FY03 through FY08 DHS and HHS grant programs using two primary sources: GRANTS.GOV and CFDA.GOV.

2.2.1 GRANTS.GOV

"GRANTS.GOV is a website developed by the federal government to be the single portal for submitting all grant applications to the 26 federal grant-making agencies."[12] Grantors log in to GRANTS.GOV in order to input information regarding grant opportunities. Users (typically grant applicants) can search and apply for grant opportunities that are currently available—as well as search for closed and archived opportunities—through an advanced search feature on the website. Potential applicants can conduct a basic search for a grant by keywords, a funding opportunity number, or Catalog of Federal Domestic Assistance (CFDA) number. While searching the website, team members captured data on all grants that were open, closed, or archived, and associated with DHS or HHS agencies.

2.2.2 CFDA.GOV

"The Catalog of Federal Domestic Assistance [CFDA] is a government-wide compendium of Federal programs, projects, services, and activities that provide assistance or benefits to the American public. It contains financial and nonfinancial assistance programs administered by departments and establishments of the Federal government."[13] Programs listed in the CFDA are categorized by the type of assistance they provide. For the purpose of this analysis, team members included only those grants classified as formula grants, project grants, and cooperative agreements. Definitions of these types of assistance are as follows.

- Formula Grants – Allocations of money to States or their subdivisions in accordance with distribution formulas prescribed by law or administrative regulation, for activities of a continuing nature not confined to a specific project.
- Project Grants – The funding, for fixed or known periods, of specific projects. Project grants can include fellowships, scholarships, research grants, training grants, traineeships, experimental and demonstration grants, evaluation grants, planning grants, technical assistance grants, survey grants, and construction grants.[14]
- Cooperative agreement – An assistance mechanism like a grant, that is used when there is substantial Federal staff involvement (more than in a grant), but not to the point of having the Federal government play a dominant role in the conduct of the project (as in a contract).[15]

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[12] http://www.ospa.umn.edu/GrantGov/Whatisgrantsgov.html (accessed March 20, 2009).

[13] https://www.cfda.gov/downloads/Intro_CFDA_Overview.pdf (accessed July 31, 2009).

[14] Ibid.

[15] http://www1.od.nih.gov/oir/sourcebook/ethic-conduct/coop-agr.htm (accessed June 25, 2009).

Analyzing these data sources, the project team determined which grants met the initial grant selection then researched each of these grants' guidance documentation (see Section 2.3.2) to develop the final list of public health and medical preparedness and response grants analyzed in this study.

2.2.3 Grant Guidance Documentation

When grant funding is available, grant-issuing agencies release guidance documents to help applicants to understand the purpose, scope, and requirements for that grant. Although the structure and language can vary by Federal agency—and in some cases by grant programs within the same agency—guidance documents generally contain the following information:

- Overview of the grant program
- Available funding
- Eligible applicants
- Funding priorities
- Allowable costs
- Application instructions
- Updates/changes to the grant program from the last iteration
- Reporting requirements
- Other requirements (pass-through funds, matching, etc.)
- Application evaluation scoring and/or methodology
- Close-out procedures
- Grant point of contact information

Most grant guidance documents were available from Federal agency websites or other open source websites; the project team made direct requests to Federal agencies for documentation not located through open source avenues.

2.3 Step 3. Grant Selection Process

This section explains the objective criteria team members developed to define the scope of grant programs included in the analysis.

2.3.1 Grant Selection Criteria

In accordance with the mission of integrating emergency management and medical response capabilities, OHA designed CoMPASS as a single resource of medical and public health preparedness grants, training, and standards for the first responder community. Therefore, the CoMPASS team targeted those preparedness grant programs that would directly assist the medical and public health community in preparing for,

protecting against, and responding to natural and/or manmade disasters. During the analysis, team members encountered a plethora of funding opportunities, which indirectly contribute to public health and medical preparedness by funding activities such as Research and Development (R&D), concept and design, construction, routine testing, and technical assistance. However, only those activities directly affecting medical and public health preparedness are within the current scope of CoMPASS.

With these caveats in mind, the CoMPASS team developed the following funding selection criteria:

1. Available to State and local governments and entities; this includes fire departments, law enforcement agencies, and EMS
2. Available to health-related entities at the State, regional, and local levels including primary care associations, regional laboratories, volunteer medical corps, and public health/healthcare facilities
3. Not used for R&D projects
4. Not used to develop and deliver (facilitate) training programs, however, funds can be used to enroll in training programs
5. Not used to provide technical assistance
6. Grant or Cooperative Agreements designation (as designated by CFDA)
7. Awarded within FY 2003-2008
8. Not used for preparedness/readiness activities other than construction/relocation of buildings or other pre-disaster mitigation activities
9. Supports at least one medical and public health target capability

2.3.2 Grant Selection Methodology

The project team analyzed each grant program identified in GRANTS.GOV in accordance with the selection criteria illustrated in Figure 2. This website categorizes each grant by many descriptive fields; team members collected data from the following fields to implement steps 1-6 of the criteria selection process (Section 2.3.1) on each individual record:

- Agency
- Eligible Applicants
- Categories of Funding Activity
- Description
- Title
- CFDA Number

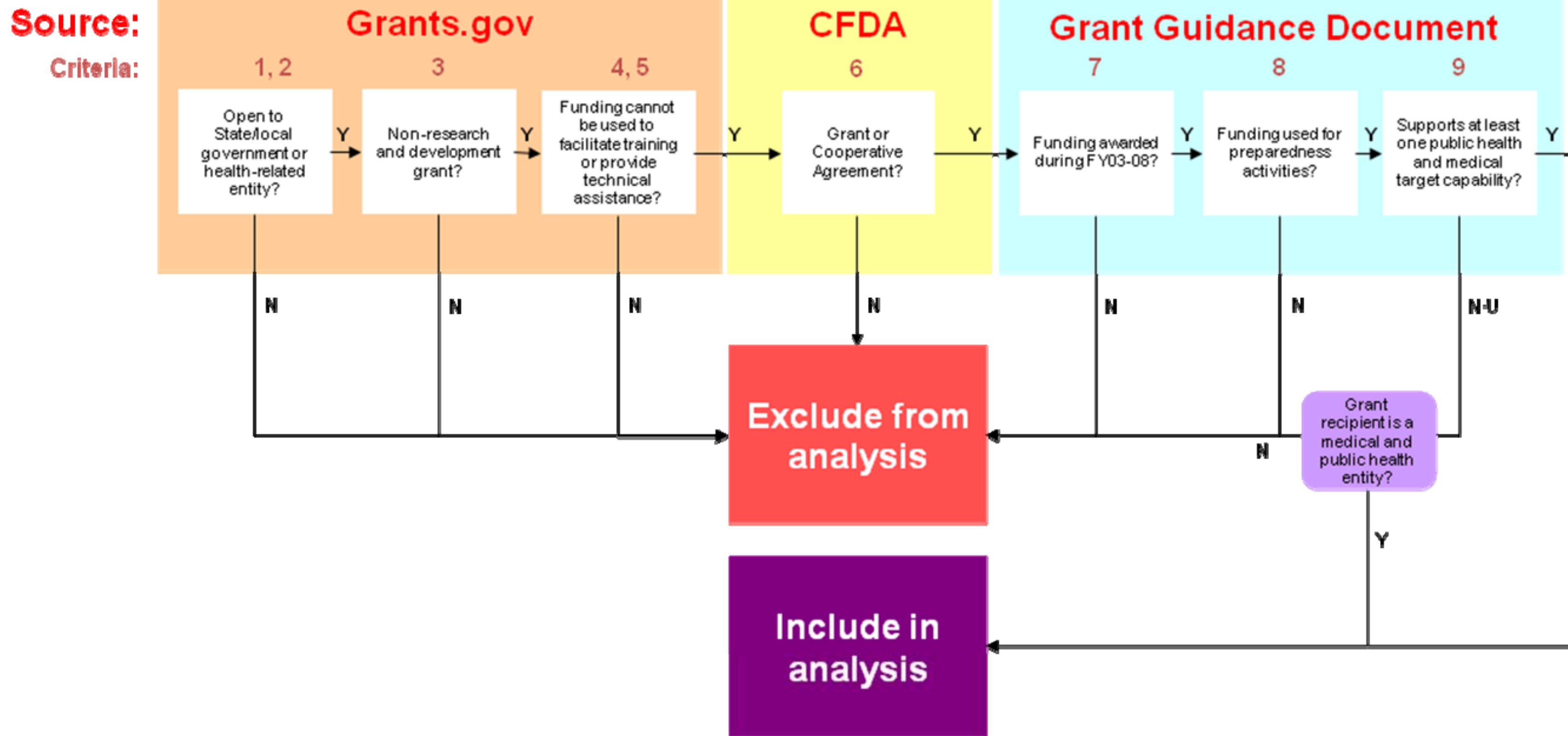

Figure 2. Grant Selection Methodology Process Flow Diagram

The CoMPASS project team analyzed over 2,000 FY03–FY08 grant programs with a DHS or HHS designation in the **Agency** field of the GRANTS.GOV data record.

Criteria 1 and 2. The project team confirmed the eligibility of each of these DHS and HHS programs by using the **Eligible Applicants** field. Grant programs with an eligible applicant designation of 'State, local, and tribal governments/entities' met the criteria. Those designated as 'Other' were included if the eligible applicant described was a health-related entity.

Criteria 3, 4, and 5. The next step required analyzing each grant's **Categories of Funding**, **Description** and **Title** data fields from GRANTS.GOV. Aside from eliminating grants based on a classification of 'Science and Technology and other Research Development' (see next paragraph), the **Categories of Funding** field was determined to be too subjective for significant use in the grant selection criteria. Different grantor end users input data into GRANTS.GOV and each interprets these broad categories differently. Grantor assignments differed widely by granting agency, which would not lead to sound analysis.

Based on the **Title** and **Description** fields, the project team excluded grants funding indirect preparedness activities including R&D, development of training classes, or provision of technical assistance. If, due to the ambiguity of the description and title, more information was required, team members utilized open source websites and grant guidance documents to ascertain relevance.

Criteria 6. The project team used the **CFDA number** to determine whether the grantor categorized the grant opportunity as a formula grant, project grant, or cooperative agreement—the accepted CFDA assistance categories for this analysis.

Criteria 7, 8, and 9. Finally, by reviewing grant guidance documentation, team members were able to determine if a grant program existed during the historical timeframe, funded preparedness activities, and supported at least one of the designated thirteen medical and public health preparedness target capabilities. In cases where ambiguity remained after reading guidance documentation, team members contacted the agency's grants office to inquire about the intent of the grant program.

Two grant programs did not definitively support any of the thirteen target capabilities but were included in the analysis because they supported medical and public health entities. The purple box in Figure 2 demonstrates where the project team made an exception for these grants.

2.4 Step 4. Data Collection and Analysis

Team members collected the following information for nineteen grant programs from their respective grant guidance documentation:

- Funding amounts

- Target capabilities supported
- Award distribution

The project team analyzed the data found within the areas defined above to determine the following:

- Trends in numbers of relevant grant programs and total amount of grant program funding for each
- Target capabilities supported (allowable) by grant programs
- The process by which funding is distributed to State/local agencies

Additionally, the project team analyzed available DHS grantee programmatic data to determine actual funding spent on the development of each target capability. Only partial data was available for the time covered in this analysis. During the study period, the project team received FY06–FY08 DHS programmatic data for five of the seven programs being analyzed including; the State Homeland Security Program (SHSP), Urban Area Security Initiative (UASI), Metropolitan Medical Response System (MMRS), Citizen Corps Program (CCP), and Emergency Management Performance Grant (EMPG) programs only.

3 RESULTS

This section presents the final list of medical and public health preparedness and response related grant programs and results of their analysis.

3.1 List of Medical and Public Health Preparedness Related Grant Programs

Following the grant selection methodology described in Section 2.3.2, the project team identified nineteen DHS and HHS grant programs supporting public health and medical preparedness target capability development from FY03 through FY08. Hereafter, the terminology 'HHS grant programs' and 'DHS grant programs' refer to this subset of medical and public health preparedness grants presented in Table 2. Additional grant programs met criteria 1–6 but because grant guidance documentation could not be located, the project team could not verify criteria 7–9. Therefore, these nineteen grant programs may not represent the entire set of relevant programs.

Table 2. DHS and HHS Medical and Public Health Preparedness Grant Programs (FY 03–FY08)

Department	Agency/Sub-agency	Grant Program Name
Department of Homeland Security (DHS)	Federal Emergency Management Agency (FEMA) / Grant Programs Directorate (GPD)	Assistance to Firefighters Grant Program
		Citizen Corps Program
		Emergency Management Performance Grant Program
		Metropolitan Medical Response System[16]
		Regional Catastrophic Preparedness Grant Program
		State Homeland Security Grant Program
		Urban Areas Security Initiative
Department of Health and Human Services (HHS)	Assistant Secretary for Preparedness and Response (ASPR)	Healthcare Facilities Emergency Care Partnership Program
		Healthcare Facilities Partnership Program[17]
		Hospital Preparedness Program
	Centers for Disease Control Prevention (CDC)	Pandemic Influenza Supplemental
		Public Health Emergency Preparedness
	Food and Drug Administration (FDA)	Food Protection Rapid Response Team and Program Infrastructure Improvement Prototype Project
		Food Safety and Security Monitoring Project-Chemical
		Food Safety & Security Monitoring Project-Radiological Health
		Ruminant Feed Ban Support Project
	Health Resources and Services Administration (HRSA)	Emergency Communication Networks
		Rural Emergency Medical Service Training and Equipment Assistance Program
	Office of Surgeon General (OSG)	Cooperative Agreement Demonstration Project for the Medical Reserve Corps

Of the nineteen grant programs, only eight awarded funding consistently across the FY03–FY08 period (see Appendix B). Caveats include:

- DHS funded the Regional Catastrophic Preparedness Grant Program (RCPGP) in FY07 and FY08 only

[16] Transferred from HHS to DHS in 2004.

[17] Formerly HRSA's National Bioterrorism Hospital Preparedness Program from FY03-06.

- The MMRS was under HHS authority in 2003 and transferred to DHS in 2004 where it remained active through FY08. Therefore, team members assigned MMRS to DHS for this analysis.
- The SHSP and UASI grants had two separate awards during FY03, which team members combined into one award for the purposes of this report
- Additionally, team members were unable to access FY03 and/or FY04 grant guidance documents for the CCP, EMPG, and MMRS grant programs. Therefore, the project team could not include those grant's years in the analysis. (See Appendix B)
- HHS had two six-year legacy programs, CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement, and ASPR's Hospital Preparedness Program (HPP). Before HPP transferred to ASPR in FY07, HRSA managed it under the name National Bioterrorism Hospital Preparedness Program (NBHPP) during FY03–FY06. Team members credited NBHPP to ASPR (for number of grant programs) to eliminate double counting in the analysis.

3.2 Grant Program Availability

Grant Program **availability** refers to the grant programs offered to grantees in previous years to fund medical and public health preparedness needs.

3.2.1 Overview of Grant Program Funding

From FY03–FY08 DHS and HHS allocated a total of $23.9 billion[18] through the nineteen grant programs supporting medical and public health preparedness target capability development. The departments' dispersed this funding to States, territories, tribal and local governments, and other entities to prepare for, prevent, respond to, and recover from natural and manmade disasters. Figure 3 presents trends in total grant program funding and the number of programs for each department over the six-year period analyzed. On the primary axis (left), the project team presents the total department-funding amount for these grants. The secondary axis (right) displays the number of department grant programs for a given year.

[18] The CoMPASS project team collected funding information from grant guidance documents for all HHS programs and a subset of DHS programs. When not provided in grant guidance; the project team used the funding information provided in DHS' National Funding History 2002-08 spreadsheet.

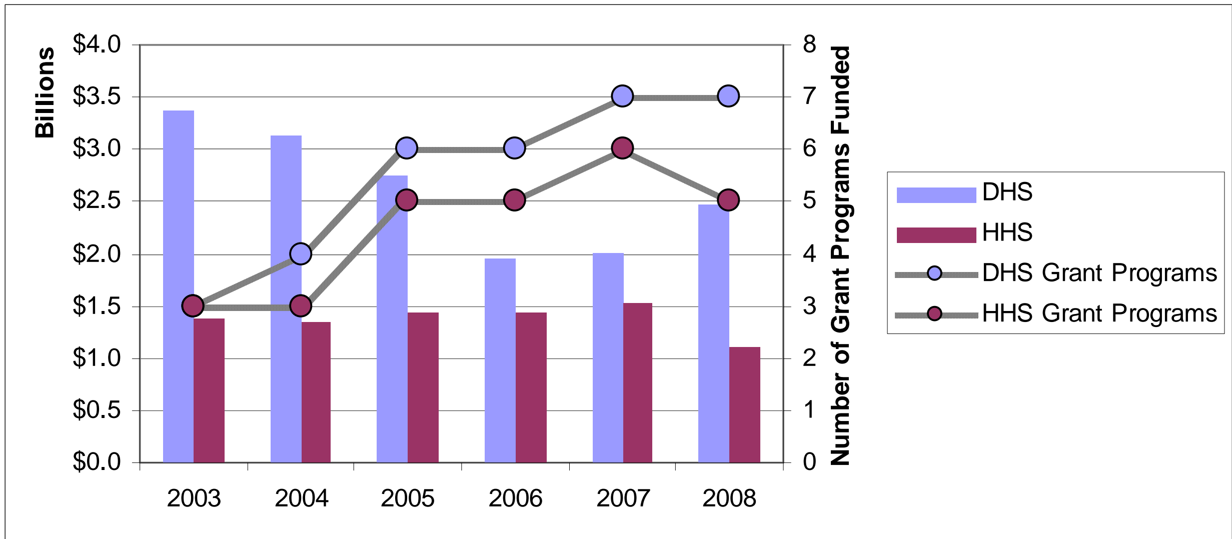

Figure 3. Medical and Public Health Preparedness and Response Related Grant Programs – Total Number and Funding Amount by FY

DHS steadily decreased grant program funding from FY03 to FY05, followed by a sharp decline in FY06. The *numbe*r of DHS grant programs however, remained constant between FY05 and FY06—though three of the six experienced a decline in funding during that time. The State Homeland Security Grant Program (SHSGP)—which encompasses SHSP, UASI, CCP, and MMRS—had funding cut most significantly, from approximately $1 billion (FY05) to $500 million (FY06). Funding increased slightly from FY06 to FY07, as FEMA introduced an additional grant program, RCPGP. By FY08, funding levels had reached almost $2.5 billion when nearly every FEMA[19] grant program received an increase in funding over previous years.

By and large, both DHS and HHS funding available to the medical and public health communities has decreased over the six-year period, even though the number of grant programs has increased.

Annual funding amounts for HHS programs remained stable from FY03 to FY06, fluctuating between $1 billion and $1.5 billion. Funding exceeded that threshold slightly in FY07 but experienced a sharp decline in FY08 when HHS removed two ASPR grants (one FDA grant, and

[19] At the time of this report, AFG FY07 funding was greater than FY08 funding. Team members retrieved AFG funding amounts for FY08 from award spreadsheets located on www.firegrantsupport.com. AFG updates funding information as they grant awards in rounds until they disburse all monies; therefore, FY08 funding numbers are not final.

one CDC grant totaling $215.8 million). FDA also added a grant in FY08, but with a total funding amount of only $6.1 million. Adding to this decline, all HHS grant programs that existed during FY07 and FY08 underwent a reduction in funding.

Table 3 presents medical and public health grant program funding as a percentage of the total grant portfolio funding available by Federal agency between FY03–FY08. Financial contributions from both the FDA and OSG grant-funding portfolios to medical and public health preparedness were negligible. Although FDA had four related grant programs, their average funding level was only $1.6 million. In comparison, the average funding level for FEMA grants was $475 million. Two programs, SHSP and UASI, accounted for almost three-quarters (71%) of the funding from FEMA grants, and the PHEP cooperative agreement accounted for 90.8% of the $5 million awarded by CDC. HRSA total grant funding included the money awarded by the FY03–FY06 NBHPP cooperative agreement (see discussion Section 3.1).

Results of a comparison of FY03–FY08 HHS medical and public health preparedness grant funding to the overall HHS grant portfolio funding[20] show that 16% of HHS portfolio funds went toward the twelve HHS medical and public health preparedness grant programs (Figure 4). ASPR directed the highest percentage (82%) of HHS portfolio funds to grants supporting medical and public health preparedness target capability development. HHS established ASPR through the Pandemic and All-Hazards Preparedness Act[21] (PAHPA) of 2006 to address bioterrorism and other public health emergencies. Approximately 20.2 % of CDC funding went to its two medical and public health preparedness grants, PHEP and Pandemic Influenza Supplemental. FDA, HRSA, and OSG medical and public health preparedness and response related grants received less than 10% of total portfolio funding.

DHS had a larger percentage of grant portfolio funding dedicated to medical and preparedness related grant programs (Figure 4). FEMA GPD funding amounts for FY 2003–08 totaled $22.3 billion;[22] 65.6% of this funding ($15.7 billion) was awarded through the seven FEMA grant programs included in this analysis. Only 15.9% of HHS' total grant funding portfolio funding was allocated to medical and public health preparedness grant programs.

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[20] U.S. Department of Health and Human Services. (2008). *TAGGS 2003-2008 annual report [Word Document]*. Retrieved May 1, 2009, from http://taggs.hhs.gov/AnnualReports.cfm.

[21] http://www.hhs.gov/aspr/conference/pahpa/2007/pahpa-progress-report-102907.pdf.

[22] National Funding History Spreadsheet (9/5/08).

Table 3. Medical and Public Health Grant Program Funding as a Percentage of Total Grant Portfolio Funding by Federal Agency (FY03–FY08)

Dept-Agency/Sub-agency	Total Medical and Public Health Grant Dollars	Medical and Public Health Grant Funding (% of Total Portfolio)	Total Grant Portfolio** Dollars
DHS-FEMA/GPD	$15,683,578,659	65.6%	$22,310,658,677
HHS-ASPR	$853,127,000	3.6%	$970,567,913
HHS-CDC	$5,450,416,943	22.8%	$26,964,700,037
HHS-FDA	$11,450,000	<1.0%	$120,891,450
HHS-HRSA*	$1,921,521,032	82.4%	$23,325,166,397
HHS-OSG	$6,000,000	<1.0%	$401,804,688
Grand Total	**$23,926,093,634**	**46.2%**	**$51,783,130,485**

*Includes FY03-06 National Bioterrorism Hospital Preparedness Program funding
**Portfolio refers to all grant dollars awarded by the department/agency

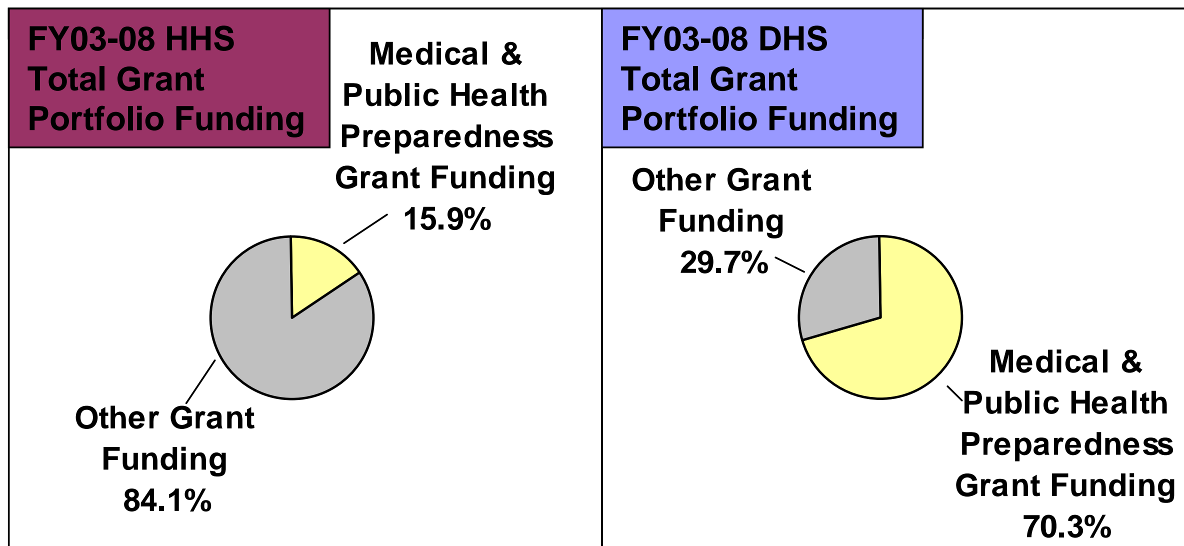

Figure 4. Department Grant Portfolio Funding for FY03-FY08 by Grant Funding Type

3.2.2 Historical Evolution of Grant Program Funding Amounts

Team members reviewed how the number of grant programs and associated funding levels has shifted during FY03–FY08; the results are presented in this section. Figure 5 illustrates the shift from larger funding amounts (right) to smaller funding amounts (left) as the number of grant programs increased through the years. Highlights include:

DHS

- FY03–FY05 were the only years in which a grant program totaled over $1 billion (far right bin): DHS' SHSP program.
- The grant program in the smallest bin ($0-$250 million) during FY04 represents the addition of the CCP.[23]
- DHS introduced two additional programs in the smallest funding bin in FY05: EMPG and MMRS.[24] UASI moved to a higher funding bin ($750 million–$1,000 million) during that same year.
- The sharp drop in funding during 2006 resulted in AFG and UASI program shifting left by one bin and SHSP shifting by two. RCPGP was implemented in FY07; hence, another grant program represented in the smallest funding bin.
- By FY08, EMPG received increased funding and joined AFG in the $250 million–$500 million funding range. SHSP and UASI moved to the right by one funding bin.

HHS

- During FY03–FY07, HHS consistently had one grant program (PHEP) in the $750 million–$1 billion range and another in the $500million–$750 million range (HPP).
- HHS funded each newly added program (FDA & OSG programs, HRSA's Emergency Communications Network and Rural EMS Equipment and Training Assistance grant programs, CDC's Pandemic Influenza Supplemental, and ASPR's Healthcare Facilities Partnership Program and Healthcare Facilities Emergency Care Program) at levels lower than $250 million, as shown in the far left bin.
- In 2008, HHS decreased funding for its highest funded grant, PHEP causing a shift to the left by one funding bin while DHS appeared to reverse the trend of funding smaller grant programs and began to swing to the right again.

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[23] CCP existed in FY03, but team members could not access FY03 grant guidance, therefore, the project team did not analyze it for the corresponding year. See Appendix C.

[24] Both EMPG and MMRS existed in FY03–04, but team members could not access FY03 & FY04 grant guidance, therefore the project team did not analyze it for the corresponding years. See Appendix C.

DHS had three grants (AFG, SHSP, and UASI) with sustained funding levels above $250 million while HHS had only two (PHEP and HPP). For FY08 alone, the six grant programs that were in the smallest funding bin (three programs each for DHS and HHS) represented only 0.7% of the total funding available for that year.

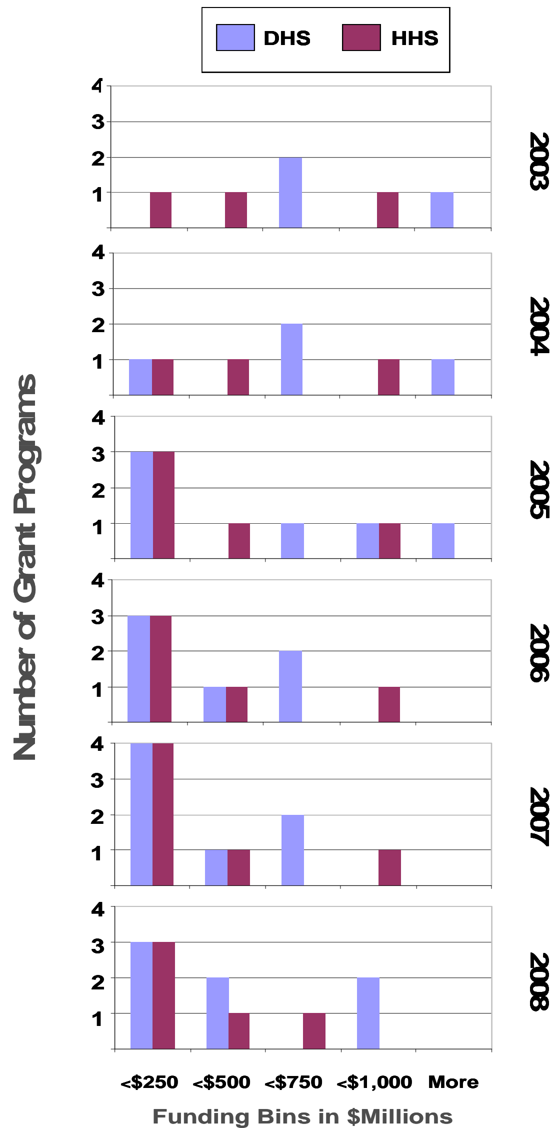

Figure 5. Grant Program Funding Bins by FY

3.3 Grant Program Integration

This section presents an examination of how the combination of available grant programs financially support the thirteen medical and public health target capabilities to provide sufficient coverage for State and local entities.

The nineteen grant programs included in the scope of this analysis support the development of at least one of the thirteen medical and public health target capabilities, but may also support any combination of other target capabilities. Therefore, the project team conducted analysis to determine the number of target capabilities supported by this subset of grant programs. This data will support the examination of how the combination of available grant programs work in concert to provide sufficient coverage for first responder community preparedness support.

Table 4 presents the findings for the subset of thirteen medical and public health target capabilities only; Table 5 presents the subset of (the complete list of 37) target capabilities that were funded by the highest number of DHS and HHS grant programs.

Table 4. Medical and Public Health Preparedness and Response Target Capabilities Supported by DHS and HHS Grant Programs

Medical and Public Health Target Capabilities	DHS Grants (7)	HHS Grants (12)	Total (19)
Medical Surge	7	5	12
Laboratory Testing	3	7	10
Responder Safety and Health	5	5	10
Food and Agriculture Safety and Defense	3	6	9
Epidemiological Surveillance & Investigation	3	5	8
Mass Prophylaxis	4	4	8
Fatality Management	5	2	7
Isolation and Quarantine	4	3	7
Medical Supplies Management and Distribution	4	3	7
Emergency Triage and Pre-Hospital Treatment	4	2	6
Environmental Health	3	3	6
Mass Care (Sheltering, Feeding, and Related Services)	6	0	6
Animal Disease Emergency Support	2	1	3

Table 5. Target Capabilities Supported by the Largest Number of DHS and HHS Grant Programs

Target Capability (37 total)	Number of Grant Programs Supporting this Capability
DHS	***7 total grant programs***
Medical Surge	7
On-Site Incident Management	7
Planning	7
Citizen Evacuation and Shelter-in-Place	6
Community Preparedness and Participation	6
Mass Care (Sheltering, Feeding, and Related Services)	6
Search and Rescue (Land-based)	6
Volunteer Management and Donations	6
HHS	***12 total grant programs***
Emergency Public Information and Warning	7
Laboratory Testing	7
Planning	7
Food and Agriculture Safety and Defense	6
Volunteer Management and Donations	6
Epidemiological Surveillance & Investigation	5
Medical Surge	5
Responder Safety and Health	5
Risk Management	5

***Note** – Yellow highlight indicates medical and public health target capability*

Intuitively, the number of grant programs supporting a target capability should be representative of the overall funding a target capability receives however, after analyzing available DHS grantee programmatic data [25](FY06–FY08 SHSP, UASI, MMRS, CCP, and EMPG grant programs) for funding allocated to the 37 target capabilities team members found that this was not the case (Figure 6). In fact, Medical Surge, supported by all seven DHS grant programs, received only 2% of the total DHS funding analyzed. Similarly, six of the seven DHS grant

> The results demonstrate that the number of grant programs that support a target capability does not necessarily correlate with the actual funding spent on developing that capability.

[25] DHS GPD Grants Reporting Tool (GRT) data.

programs supported Volunteer Donations and Management but this capability received less than 1% of the funding. These results demonstrate that the number of grant programs that support a target capability does not necessarily correlate with actual funding spent on developing that capability. In essence, a target capability can be supported by multiple grant programs and still receive minimal funding.

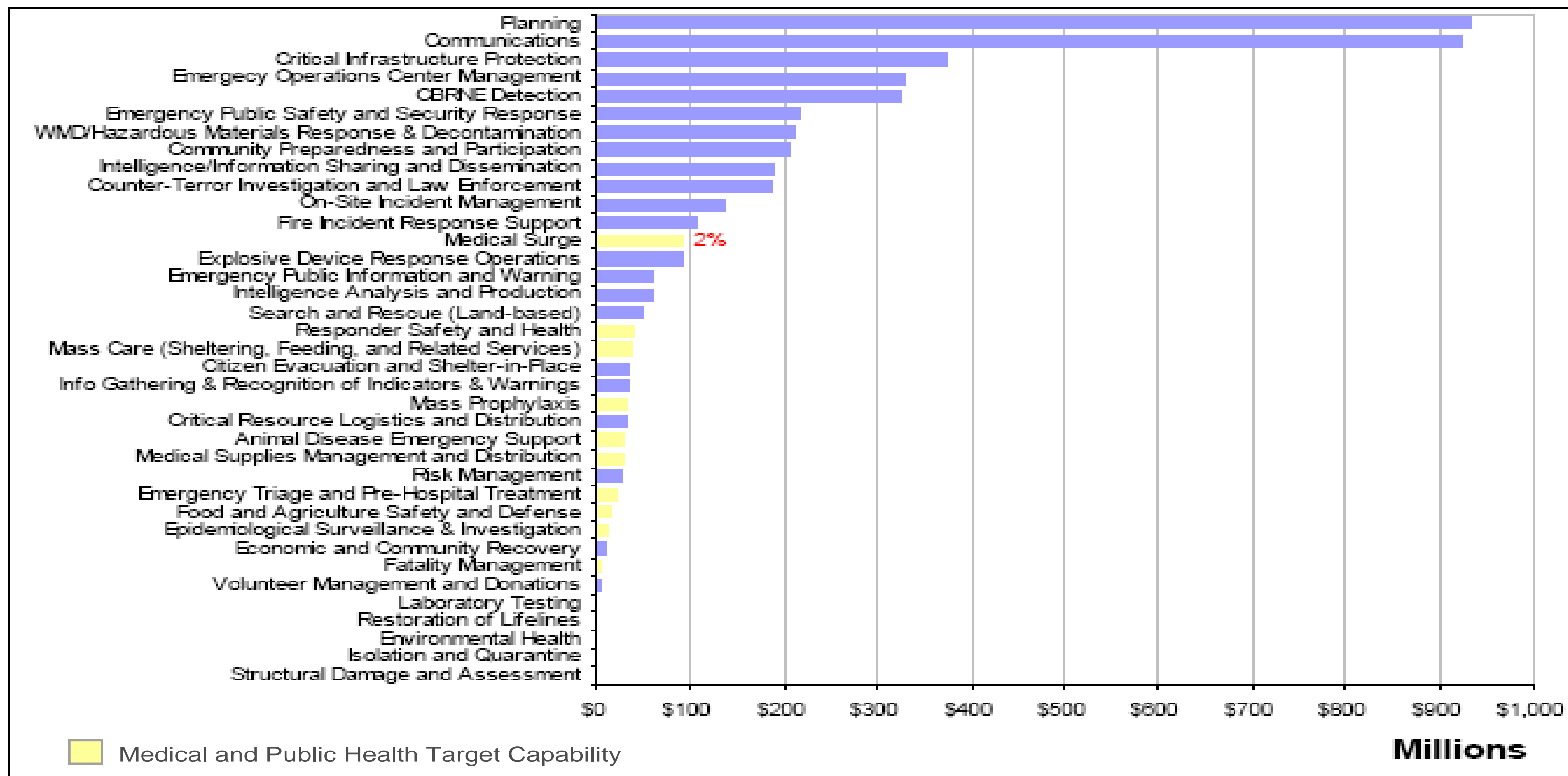

Figure 6. DHS FY06-08 Funding Allocations for SHSP, UASI, MMRS, CCP, and MMPG by Target Capability ($4.9 billion)

3.4 Grant Program Accessibility

This section presents the results of an investigation of the grant disbursement process and a discussion of the efficiency by which agencies award grant funds across departments to State and local beneficiaries.

The project team researched the disbursement of grant funding from DHS and HHS agencies to State and local entities. This required analyzing the most current (through FY08) grant guidance documentation to track the matriculation of awarded funding released from the Federal government down to the State/local government entity or beneficiary. Team members identified Federal and State entities, grantees, and sub-grantees involved in the disbursement process from sections addressing eligible applicants and the award administration process. In some cases, team members took the funding disbursement information from recent articles on grant administration (including an HHS grant policy document) and interviews with those familiar with the agency's awarding process.

Figure 7 provides a mapping of the award administration process for the nineteen DHS and HHS grants, illustrating the multiple paths that award funding takes before reaching the beneficiary. Each box in the figure depicts an entity that participates in the disbursement process. However, a box may represent multiple Points of Contact (POC) as they can vary by State and grant program. For example, within the State Administrative Agency (SAA) box, team members have identified multiple POCs that the governor can designate as the POC for a specific grant. Dashed arrows depict possible funding paths.

Each Federal agency has grants management personnel that release funding to one or more recipients at the State or local level. There is a Grants Management Office (GMO) within each HHS agency that assigns Grant Management Specialists (GMS) to one or more programs. The GMO administers grant funding; however, the GMS' serve as the primary POC for recipients on grant-related issues[26] and have the authority to act on behalf of the GMO. Alternatively, DHS programs are under one agency and one directorate, GPD, which in effect acts as a centralized GMO. This office also assigns individual GMS' to different grant programs administered by GPD; however, this singular office allows for a more centralized funding distribution process (see Figure 7).

Grant liaisons varied at the State level and within each State office or department by grant program. According to HHS grant policy, each State entity has an authorized representative that acts on its behalf in matters related to award and administration of grants[27]. For example, a recent article on ASPR grant funding administration reported

[26] Office of Grants. (2007, January). *HHS grants policy statement*. Washington, D.C.: U.S. Department of Health and Human Services.

[27] Ibid.

that, "Because each State administers ASPR funds, the way hospitals receive these dollars differ from State to State." The article discusses how the various participants can be involved in the process of determining how States spend funds, including the State's Department of Health or a State-appointed ASPR grant administrator.[28] For certain DHS grant programs, each governor is required to identify an SAA to serve as the fiduciary agent. Depending on the State, the SAA may be a State Homeland Security Agency (SHSA), Emergency Management Agency (EMA), Public Safety Department (PSD), or other government entity. For the EMPG program, if the governor chooses an agency other than the EMA to serve as the SAA, the SAA still must pass funds through the EMA before disbursing to recipients.

The disbursement process was also complex at the local level for both HHS and DHS grants. Some local entities (i.e., local regulatory agencies, labs, and local law enforcement agencies) interfaced with a single State or Federal agency within *either* DHS or HHS in order to receive medical and public health related funding. However, grant funding must flow through multiple offices prior to receipt. The process becomes even more complicated if the local grantee must interact with more than one POC within each State or Federal entity. For instance, fire departments or non-affiliated EMS organizations must interface directly with two Federal entities (FEMA GMS and HRSA GMO/GMS), as well as two State entities (SAA and the State Health Department) for certain funding streams. These local recipients also have to meet the multiple reporting requirements of each awarding entity, which may result in a diversion of funds from other efforts—such as capability development—to support these additional administrative requirements.

Further, local recipients may receive only a percentage of grant funding that is passed through a State entity. For example, FY08 HSGP funding—encompassing four medical and public health preparedness grant programs—was disbursed as follows:

- Two programs, SHSP and UASI, required the State to pass through 80% of the funding to local entities; designated State agencies retained the remaining 20%
- Recipients typically passed CCP program funding through the SAA to local recipients. However, if State and local entities agreed, they disbursed some of the funding to State Citizen Corps Councils.
- State recipients passed 100% of MMRS program funding from the SAA to local recipients

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[28] National Association of Public Hospitals and Health Systems. (2008, May). *Recent changes to emergency preparedness mandates and funding [Research Brief]*. Washington, D.C.

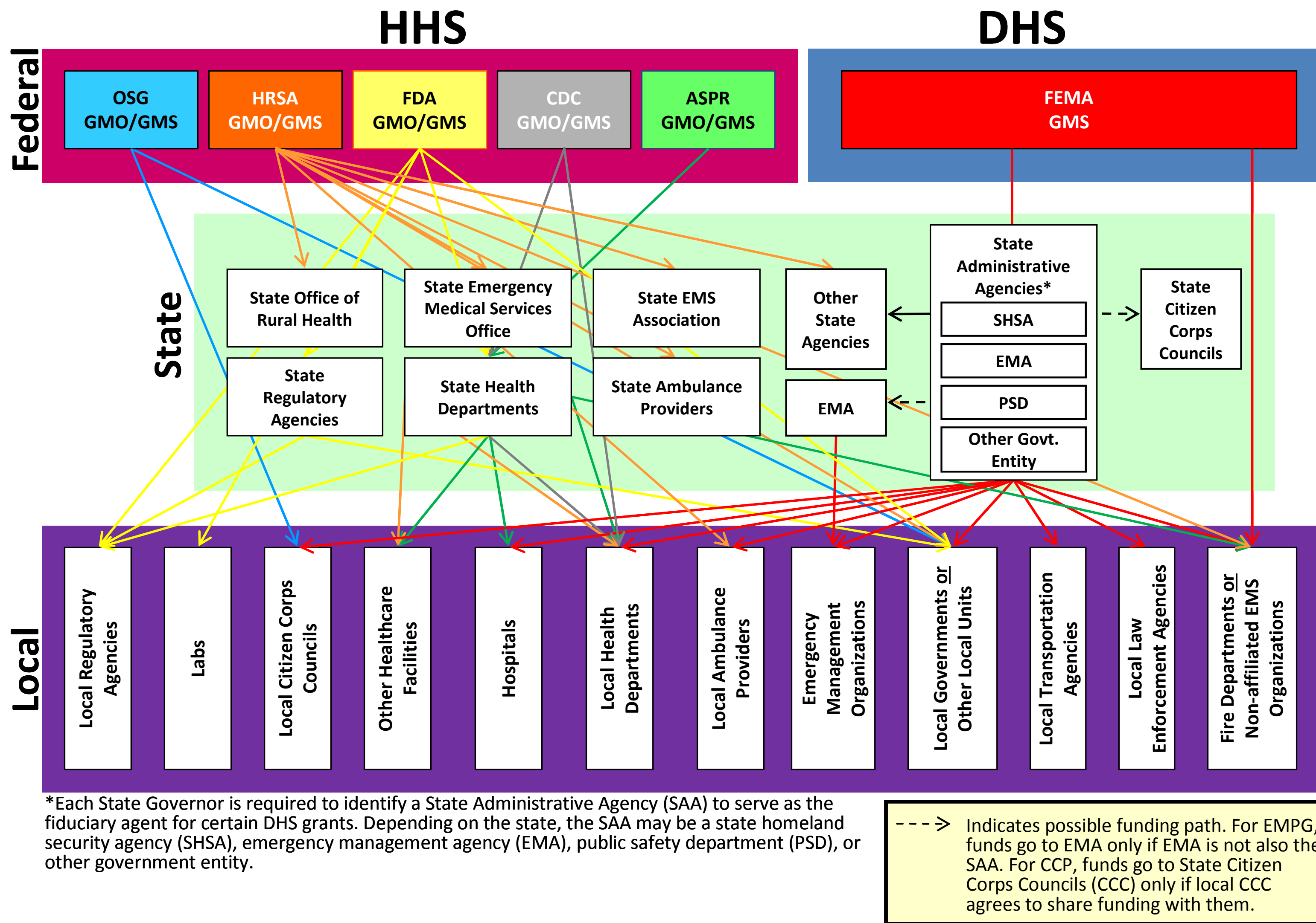

Figure 7. Funding Streams for Medical and Public Health and Preparedness Grant Programs

4 FINDINGS AND RECOMMENDATIONS

From the results of the grant guidance analysis, five high-level findings and recommendations were developed to address the following questions regarding availability, integration and accessibility:

- **Availability:** What historical funding opportunities were made available to support medical and public health preparedness activities?
- **Integration:** How do funding opportunities work in support of one another to provide funding to medical and public health communities?
- **Accessibility:** How efficiently was this funding disbursed to State/local entities?

Definitions of the terminology are as follows:

- **Availability** addressed grant programs offered to grantees in previous years to fund medical and public health preparedness needs.
- An examination of how the combination of available grant programs financially support the thirteen medical and public health target capabilities to provide sufficient coverage for State and local entities is reviewed to address **integration**.
- **Accessibility** refers to the efficiency by which agencies award grant funds across Departments to the local beneficiaries.

Availability

Finding #1: ***DHS and HHS funding available to the medical and public health preparedness community have decreased during the six-year period reviewed, even though the number of grant programs supporting this community increased. Smaller funding pools may lead to the development of medical and public health capabilities receiving a lower priority than other capabilities.***

Discussion #1

The combined funding amounts for both departments decreased by 24.5% from FY2003 to FY2008. This downward trend occurred even though the total number of grant programs doubled over the same period. Even without knowing how the medical and public health preparedness grant programs dollars were distributed across the 37 capabilities, it can be acknowledged that there was less funding available to all communities, including medical and public health, from these grant programs. Although 65.6% of DHS' total funding portfolio supported medical and public health and target capability development, most DHS actual funding was geared toward wide-ranging preparedness and response activities instead of targeting medical and public health capabilities, as illustrated in Figure 7.

In fact, a GAO report[29] on emergency preparedness and medical surge reported that, "During fiscal years 2003 through 2007, DHS' HSGP, funds were used for a broad variety of emergency preparedness activities and may have included medical surge activities. However, most of these DHS grant funds were not targeted to medical surge activities…"

When the creation of DHS was proposed, the GAO's director of health care/public health issues feared that the new department would not maintain public health priorities if certain HHS preparedness programs were transferred to the one department.[30] Cuts in HHS preparedness funding had States struggling to prioritize preparedness purchases. According to the 2008 GAO report, "…[a] concern expressed by some State officials was that federal funding for ASPR's Hospital Preparedness Program had decreased while program requirements had increased, making it difficult for States to plan for maintenance of emergency preparedness systems, meet new requirements, and replace expired supplies."

Recommendation #1

Conduct an analysis of DHS and HHS grantee data to determine how the measured decline in Federal preparedness funding has affected prioritizing funding for medical and public health preparedness target capabilities over this six-year period. There is awareness in the medical and public health community that grantees are not prioritizing EMS when spending Federal funding. Various resources, including congressional reports, EMS articles, and an EMS funding survey, focus on the lack of funding given to the EMS community. None of these reports however, contains an analysis that reveals what these preparedness funds do ultimately support. A letter written by the National EMS Management Association to President Obama made the following recommendation, "The Administration should require HHS and DHS to evaluate the distribution of all Federal grant funds across disciplines. This evaluation should be compiled and reported to Congress."[31] The project team concurs and proposes including target capability analysis in this evaluation.

Integration

Finding #2: ***The number of DHS grant programs that support a target capability is not representative of funding amounts allocated to that capability. The government may overestimate the percentage of available funding dedicated to medical and public health preparedness because of the preponderance of medical and public health preparedness grant programs.***

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[29] U.S. Government Accountability Office. (2008, June). *Emergency Preparedness: States are Planning for Medical Surge, but Could Benefit from Shared Guidance for Allocating Scarce Medical Resources (GAO-08-668).* Washington, D.C.

[30] U.S. General Accounting Office. (2002, June 25). *Homeland Security: New Department Could Improve Coordination but May Complicate Public Health Priority Setting* (GAO-02-883T). Washington, D.C.

[31] National Emergency Medical Services Management Association. (2009, January). *Letter to President-Elect Barack Obama and Secretary-Designate Tom Daschle*. San Diego, CA

Discussion #2

After completing the grant selection methodology, team members concluded that there were seven DHS and twelve HHS medical and public health preparedness grant programs. The analysis found that while Medical Surge was the only medical and public health target capability supported by all the DHS grant programs, it received only 2% of the total funding from five of the DHS programs for which team members were able to access grantee data. Many factors drive why this target capability received only a small portion of the funding:

- Grantees may have funded the majority of Medical Surge activities using HHS grant program funding
- States overlooked Medical Surge as a priority due to other critical needs within the State
- Grant guidance did not list Medical Surge as a funding priority; therefore, applicants wrote investment justifications without considering it
- There was a high rejection rate among Medical Surge investment justifications and work plans for DHS grant programs[32]
- Applicants were unaware that they could use DHS funding for Medical Surge

These factors may also be attributed to why the other twelve medical and public health target capabilities received insignificant funding from the five DHS programs analyzed (Figure 6). An in-depth analysis of HHS grantee data would help determine if grantees relied on HHS funding to meet medical and public health preparedness goals. If the results indicate that HHS funding levels for Medical Surge or any other medical and public health target capability are not sufficient to meet target capability levels, the departments should exercise the following options:

- HHS should request more funding from Congress for those medical and public health target capabilities that receive less funding
- DHS should prioritize the thirteen medical and public health capabilities in grant guidance documentation

For FY03–FY08, HHS received a little more than half of the total funding that DHS received for its medical and public health preparedness related grants. It is unclear whether, in the past, DHS was expected to allocate more funding for the needs of hospitals, nursing homes, healthcare facilities, etc. There is an apparent tradeoff between HHS and DHS funding provided to those entities that should be explored further.

Recommendation #2

Investigate factors determining why so many grant programs support medical and public health target capabilities, but actual funding is minimal. Conduct an analysis of the programmatic data of the seven DHS and twelve HHS programs, investigating the correlation between expenditures

[32] DHS/FEMA does not reject investment justifications (IJ). Those decisions are wholly the decision of applicants.

for medical and public health target capability development and the number of programs that support them. The results may highlight a need for increased coordination between DHS and HHS in administering funds for the subset of thirteen medical and public health target capabilities. In effect, the Federal government may need to reorganize or consolidate current grant programs to direct funding to these critical areas.

Finding #3: ***DHS programmatic data show that development of medical and public health target capabilities was not well supported by DHS program spending, including those capabilities not supported by HHS programs. For example, although DHS has primary responsibility for the mass care capability under ESF #6, DHS funding did not support development of this capability. Further, while HHS plays a supporting role in ESF #6, no HHS grants supported this target capability. This indicates a likely preparedness gap and the medical and public health communities may lack resources to address a catastrophic health event.***

Discussion #3

HHS grant programs do not support Mass Care, and yet only 1% of the FY06–FY08 DHS funding analyzed was actually spent on this capability. What could State and local government entities do to ramp up their preparedness levels for this capability? Are there other Federal departments that have funding geared toward this capability or are the American Red Cross and other volunteer organizations responsible for raising enough funds to assist States in meeting national levels? Without some type of outside assistance, the existence of preparedness gaps within the medical and public health capability would require grantees to shuffle limited resources.

DHS is the ESF#6 (Mass Care, Emergency Assistance, Housing, and Human Services) coordinator—as well as the primary agency—which likely explains why six of its seven programs support development of this target capability sharing a similar name. Further, although HHS plays a supporting role within ESF#6, Mass Care is not the focus of their medical and public health grants either. According to the National Response Framework (NRF) ESF#6 Annex, HHS plays the following medical and public health services roles under ESF#6:

- Provides HHS medical workers to augment health services personnel as appropriate
- Provides medical care and mental health services for impacted populations—either in or outside shelter locations—in accordance with appropriate guidelines utilized by local health agencies
- Provides technical assistance for shelter operations related to food, vectors, water supply, and waste disposal
- Assists in the provision of medical supplies and services, including durable medical equipment

- Coordinates emergency medical care in shelters as-needed at the request of affected State(s) in accordance with appropriate guidelines utilized by local health agencies[33]

The funding needed to perform all or some of these roles in a health emergency may be covered under other target capabilities or provided by grants covered by other agencies within HHS, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) or Administration for Children and Families (ACF), that did not meet the grant selection criteria. However, the possibility that these activities may be funded through other grants should be explored. Additionally, the CoMPASS project team proposes that any medical and public health target capability supported by a greater number of DHS grants than HHS grants should be further examined. Results show DHS funding for medical and public health and medical target capability development is minimal, therefore capability gaps likely exist if they are not supported by HHS.

Recommendation #3

Conduct an investigative process to determine if States are finding other funding avenues to fill these preparedness gaps. Other Federal departments, DHS, and HHS agencies have a role in supporting State and local capability development; therefore, the Federal government should expand this analysis to capture a complete picture of funding shortfalls. Making the best grant policy decisions requires full knowledge of the medical and public health preparedness landscape; otherwise, achieving and maintaining medical and public health preparedness levels will be challenging and may leave the nation vulnerable to future catastrophic health events.

Finding #4: ***Lesser-funded grant programs are currently more prevalent than in FY03. Therefore, grantees may have to apply to multiple grant programs to sufficiently fund medical and public health target capabilities, which may lead to grant writing and reporting burdens.***

Discussion #4

The increase in the number of minimally funded grant programs in recent years, as reported in Section 3.3, has advantages and drawbacks. The advantages include the ability for Federal agencies to set up a funding opportunity to address a short-term critical need (one-time grant) without diverting funding from largely funded programs. In essence, it allows grantees to focus on a specific issue without having to juggle scarce resources to meet that particular need. It also allows Federal agencies to funnel money to a select group of entities to ensure they receive sufficient funding for preparedness needs. An example of this is the Emergency Communications Network grant. HRSA created this grant specifically for Primary Care Associations (PCA) located in States that had a Federal major disaster declaration because of the 2005 hurricane season. This grant allowed PCAs to buy interoperable communications equipment with the grant funds.

A disadvantage of having minimally funded grant programs is that grantees must search multiple grant programs for which they meet eligibility requirements, determine which preparedness

[33] http://www.fema.gov/emergency/nrf/.

needs each individual program supports, and write various grant applications to address differing funding priorities. The CoMPASS team reported that for FY08 alone, 50% of the nineteen grants available represented less than 1% of the total funding available. GAO performed a similar analysis in 2001 and found similar results.[34] The project team echoes GAO's response to these findings: "While these funds undoubtedly served important purposes, the question is whether the funds could have been provided through more efficient means."[35]

Small grant programs are more focused, but having to apply to a collection of them to meet preparedness goals can be burdensome. This also will likely result in increased administrative costs, which may force grantees to divert funding from other efforts including capability development. Alternatively, large block grants can ease user burden and are more sustainable (examples include HSGP), but funding does not target specific medical and public health preparedness needs. Neither is the right approach for every circumstance. The purpose of grant funds should drive how grant programs are established. For instance, if there is a critical short-term need for funding in a specific preparedness area, then a grant like the Emergency Communication Network program is in order. However, if the need persists and is continually underfunded through larger grants, the Federal government should establish a higher funded grant program, such as AFG, which focuses specifically on fire incident response support operations.

The EMS community has been asking for an AFG-equivalent grant program that caters to its unique preparedness needs.[36] In fact, having multiple funding streams available has made it harder to argue its case for this. The EMS community has stated that although in 2005, non-affiliated EMS were eligible to receive AFG funds, "Taking money from the fire service for EMS is not a solution to the problem..." It was reported that, "EMS response entities submitted (AFG) applications seeking in excess of $138 million or 1066% more than the available funds."[37] To heighten frustration among the EMS community, the three other traditional first responders— fire, law enforcement,[38] and emergency managers[39]—have specific homeland security preparedness programs.

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[34] U.S. General Accounting Office. (2003, April 29). *Testimony of federal assistance: Grant system continues to be* highly fragmented (GAO-03-718T). Washington, D.C..

[35] Ibid.

[36] A National Association of State EMS Directors. (2004). *NASEMSD Survey: Identification of Obstacles to EMS Terrorism Preparedness*. Falls Church, VA.

[37] I Maniscalco, P. and Lord, G. (2005). Ice Cube on a Plate Glass Window. *Homeland First Response July/August,*32.

[38] Law enforcement had DHS' Law Enforcement Terrorism Prevention Program until 2007. The 9/11 Act and FY 2008 Consolidated Appropriations Act removed appropriations specific for LETPP. (www.rkb.us)

[39] Emergency managers have DHS' Emergency Management Performance Grant.

Recommendation #4

Implement minimally funded programs judiciously, as in the event of a short-term critical need grant like Emergency Communications Network or an audience-specific grant like AFG. The analysis suggested in the previous recommendation—along with conducting a needs assessment for the medical and public health communities—will assist Federal agencies in determining whether a need for a discipline-specific grant program such as EMS exists.

Accessibility

Finding #5: ***Disbursement of funding is a complicated and inefficient process across departments. Grantees may have to interface with multiple program representatives across all levels of government and meet various reporting requirements, thereby complicating the process to meet national priorities.***

Discussion #5

The analysis of medical and public health grant funding disbursement process in Section 3.5 suggests that funding distributed from multiple funding sources to a single beneficiary can be complex. There often exists multiple paths that funding has to channel through before reaching the designated recipient. This phenomenon adds complexity to recipient responsibilities as reporting requirements increase with an increase of grant funding sources.

Consider the fire department/non-affiliated EMS organization community that can interface with up to four State and Federal entities. Therefore, local recipients may be responsible for at least four separate sets of agency reporting requirements as well as other non-agency requirements (as shown in Figure 8). For example, the fire department/non-affiliated EMS community has to adhere to reporting requirements set forth by FEMA for the AFG Program in addition to the National Fire Incident Reporting System (NFIRS) requirements. Additionally, they have to report directly to HRSA to fulfill Rural EMS Training & Equipment Assistance Program grant reporting requirements of submitting a Financial Status Report (FSR), Payment System Quarterly Report, and Annual and Final Program Performance Reports. The local entity will also have to work indirectly through the designated HHS and DHS State representative, to meet reporting requirements for HPP, RCPGP, UASI, SHSP, MMRS, and CCP.

For ASPR's HPP requirements, an EMS beneficiary has to submit multiple reports in addition to collecting and reporting performance data. HHS analyzes performance data collected at both the State and hospital level. Grant guidance states that recipients are responsible for collecting and tracking appropriate data that will assist HHS in measuring performance progress and supply that information to Federal staff during site visits or when requested.[40] These specific requirements—coupled with the other additional reporting requirements levied by FEMA and HRSA grant programs—can make the reporting process cumbersome. In fact, these reports which help the Federal government measure a State's preparedness could result in funding being

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[40] Office of Preparedness and Emergency Operations. (2008). *Announcement of availability of funds for the hospital preparedness program*. Washington, D.C.: U.S. Department of Health and Human Service.

diverted from other activities such as capability development, to fulfill administrative requirements.

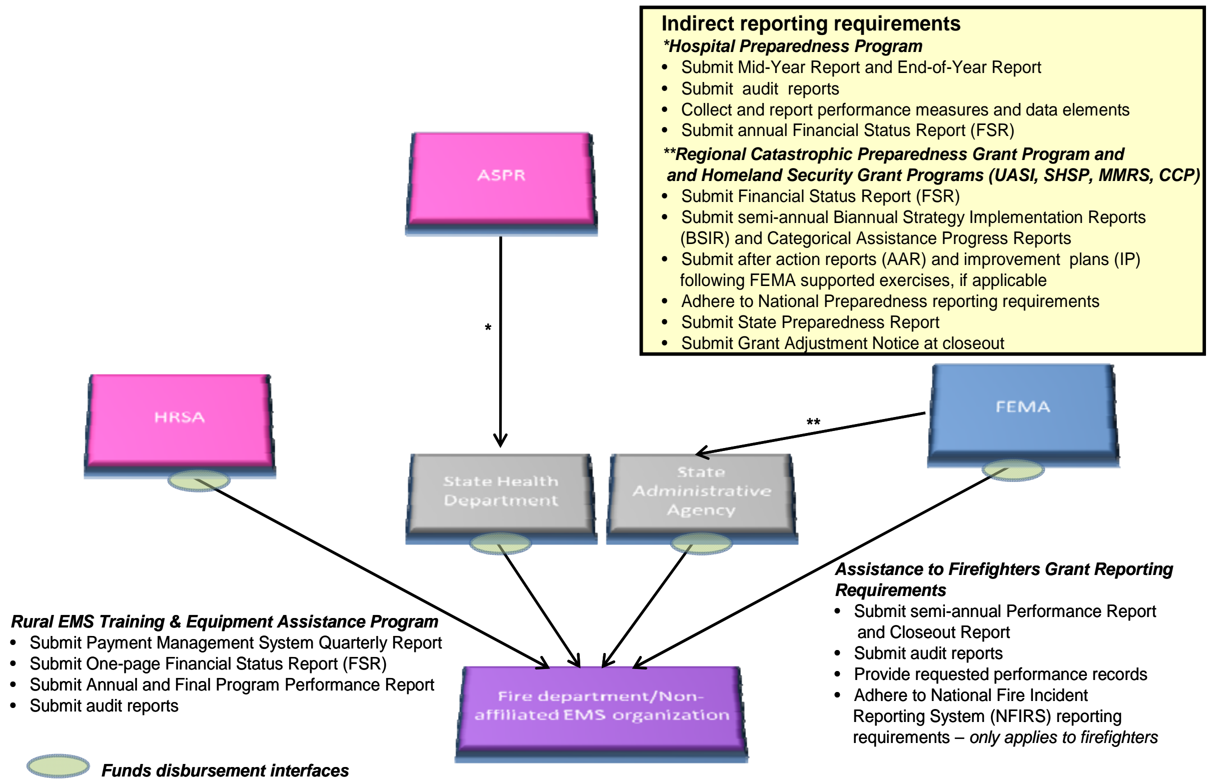

Figure 8. Funding Disbursement Interfaces and Reporting Requirements for Fire Department or Non-Affiliated EMS Organizations

Recommendation #5

Continue attempts to streamline reporting processes and/or ensure the reporting format/content is mutually beneficial to the recipient. While many initiatives have been undertaken to reduce grant-reporting burdens across agencies and departments, reporting requirements remain cumbersome. This is especially true if the content of program reports vary from one grant program to another or if deliverable dates are uncoordinated.

5 ACRONYM LISTING

AAR .... After Action Report
ACF .... Administration for Children and Families
AFG .... Assistance to Firefighters Grant
ASPR .... Assistant Secretary for Preparedness and Response
CCP .... Citizen Corps Program
CDC .... Centers for Disease Control and Prevention
CFDA .... Catalog of Federal Domestic Assistance
CoMPASS .... Clearinghouse of Medical and Public Health Preparedness Allocations, Skill Development, and Standards
DHS .... Department of Homeland Security
DoD .... Department of Defense
DOT .... Department of Transportation
EMA .... Emergency Management Agency
EMPG .... Emergency Management Performance Grant
EMS .... Emergency Medical Services
ESF .... Emergency Support Function
FDA .... Food and Drug Administration
FEMA .... Federal Emergency Management Agency
FSR .... Financial Status Report
FY .... Fiscal Year
GAO .... United States General Accounting Office/United States Government
GMO .... Grant Management Office
GMS .... Grant Management Specialist
GPD .... Grant Programs Directorate
GRT .... Grants Reporting Tool
HHS .... Department of Health and Human Services
HPP .... Hospital Preparedness Program
HRSA .... Health Resources and Service Administration
HSGP .... Homeland Security Grant Program
HSPD .... Homeland Security Presidential Directive
IJ .... Investment Justification
MRRS .... Metropolitan Medical Response System
NBHPP .... National Bioterrorism Hospital Preparedness Program
NC .... North Carolina
NFIRS .... National Fire Incident Reporting System
NIH .... National Institutes of Health
NPD .... National Preparedness Directorate
NRF .... National Response Framework
OHA .... Office of Health Affairs
OSG .... Office of Surgeon General
PAHPA .... Pandemic and All-Hazards Preparedness Act
PCA .... Primary Care Association

PHEP .... Public Health Emergency Preparedness
PSD .... Public Safety Department
POC .... Point of Contact
R&D .... Research and Development
RCPGP .... Regional Catastrophic Preparedness Grant Program
RKB .... Responder Knowledge Base
SAA .... State Administrative Agency
SAMHSA .... Substance Abuse and Mental Health Services Administration
SHSA .... State Homeland Security Agency
SHSGP .... State Homeland Security Grant Program
SHSP .... State Homeland Security Program
SME .... Subject Matter Expert
TCL .... Target Capabilities List
UASI .... Urban Areas Security Initiative
USDA .... United States Department of Agriculture
USPHS .... United States Public Health Service

6 Appendix A: Medical and public health Target Capability Vetting Process

In this section, the CoMPASS project team proposes an approach to aid in the establishment and publication of medical and public health target capabilities. The recommended approach includes establishing a task group to convene for a one-time meeting to develop a list of medical and public health target capabilities and summarize results of their vetting process in a final report. This task group should include representatives from the Department of Homeland Security (DHS)/Health and Human Services (HHS) Interagency Committee and other interagency organizations whose mission fits within the goal of this vetting process. At a minimum, the task team should include representatives from the following eight agencies:

- **Department of Homeland Security**: (1) Office of Health Affairs; (2) Grant Programs Directorate; (3) National Preparedness Directorate

- **Department of Health and Human Services**: (4) Office of the Assistant Secretary for Preparedness and Response; (5) Centers for Disease Control; (6) Food and Drug Administration; (7) Health Resources and Services Administration; (8) Office of the Surgeon General

Initially, at least one representative (preferably one familiar with grants, training, and standards associated with the medical and public health community) from each participating agency would be identified/selected and the meeting date/time established. Each agency representative would then be provided a read-ahead listing of proposed medical and public health target capabilities developed for this report (Figure 3). Based on their expertise, the representative should come to the meeting with their own draft list of medical and public health target capabilities and be prepared to discuss supporting information for each of their selections.

If funding is available, the hosting agency should provide an outside facilitator to oversee the meeting. The facilitator would be in charge of overseeing administrative details, preparing reports, upholding the meeting agenda, and keeping meeting records/minutes.[41] After the facilitated discussion of the current list of medical and public health target capabilities and the proposed lists prepared by the participants, a vote will be conducted. Each agency represented will cast a single vote (for one of the three following selections) for each proposed target capability:

- Primary Medical and Public Health Target Capability (1 point)
- Secondary Medical and Public Health Target Capability (0.5 point)
- Not a Medical and Public Health Target Capability (0 points)

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[41] Sholtes, P., Joiner, B., & Streibel, B. (2003). *The Team Handbook.* (3rd ed.). Madison: Oriel Incorporated.

Receiving greater than 50% of the total possible points (i.e., one point for each proposed target capability) would be required for inclusion on the final medical and public health target capability list. The task team would appoint representatives to assist in writing the final report.

Below is a sample agenda for the meeting:

- Introductions
  - Task team member roles
  - Nominate the facilitator (optional)
  - Establish ground rules for the meeting and final report

- Roundtable discussions
  - Each target capability will be discussed and representatives should voice concerns or opinions as to which should be designated as medical and public health
  - Facilitator will use a "parking lot" to identify/record all issues that are not relevant to the objectives of the meeting
  - The facilitator will lead a discussion to address any major conflicts in opinion, if necessary

- Break

- Voting
  - Each representative agency (regardless of the number of representatives from that agency) will cast a vote for one of the three label selections for each target capability identified during the roundtable discussion.
  - Once the vote has been taken place, the facilitator will tally the scores of each target capability and report results to the group

- Final report
  - The working meeting minutes will be used to create the final report
  - The facilitator will delegate responsibility for the final report write-up.

7 APPENDIX B: GRANT PROGRAM AVAILABILITY BY YEAR

Grant Title	Agency/Sub-agency	2003	2004	2005	2006	2007	2008
Assistance to Firefighters Grant Program	FEMA	x	x	x	x	x	x
Citizen Corps Program	FEMA	x	x	x	x	x	x
Emergency Management Performance Grant Program	FEMA	x	x	x	x	x	x
Metropolitan Medical Response System	FEMA	x	x	x	x	x	x
Regional Catastrophic Planning Grant Program*	FEMA					x	x
State Homeland Security Grant Program	FEMA	x	x	x	x	x	x
Urban Areas Security Initiative	FEMA	x	x	x	x	x	x
Healthcare Facilities Emergency Care Partnership Program	ASPR					x	
Healthcare Facilities Partnership Program	ASPR					x	
Hospital Preparedness Program	ASPR					x	x
National Bioterrorism Hospital Preparedness Program**	HRSA	x	x	x	x		
Rural Emergency Medical Service Training and Equipment Assistance Program	HRSA		x				
Emergency Communication Networks	HRSA				x		
Pandemic Influenza Supplemental	CDC			x	x	x	
Public Health Emergency Preparedness	CDC	x	x	x	x	x	x
Food Protection Rapid Response Team and Program Infrastructure Improvement Prototype Project	FDA						x
Food Safety & Security Monitoring Project-Radiological Health	FDA				x	x	
Food Safety & Security Monitoring Project-Chemical	FDA			x			x
Ruminant Feed Ban Support Project	FDA			x			x
Cooperative Agreement Demonstration Project for the Medical Reserve Corps	OSG	x					

x	Received and analyzed grant guidance document
	No grant guidance document released
x	Could not access grant guidance document

* FEMA's Regional Catastrophic Planning Grant Program had one grant guidance document that covered both FY07and FY08.
** HRSA's National Bioterrorism Hospital Preparedness Program was transferred to ASPR and renamed the Hospital Preparedness Program in FY07.

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