

ATTACHMENT I

I. SERVICES TO BE PROVIDED

A. Definition of Terms

1. **All-Hazards** - An approach for prevention, protection, preparedness, response, and recovery that addresses a full range of threats and hazards, including domestic terrorist attacks, natural and manmade disasters, accidental disruptions, and other emergencies.
2. **Assistant Secretary for Preparedness and Response (ASPR)** – The Federal Program within the U.S. Department of Health and Human Services (HHS). ASPR focuses on preparedness planning and response; building federal emergency medical operational capabilities; countermeasures research, advance development, and procurement; and grants to strengthen the capabilities of hospitals and health care systems in public health emergencies and medical disasters.
3. **Business Day** - Monday through Friday, excluding State holidays.
4. **Department, FDOH, DOH** – means the Florida Department of Health and may be used interchangeably.
5. **HAvBED** - Federally-supported system that provides a centralized, national view of bed availability for supporting the medical response to a Federal, regional, state or local emergency, disaster or disaster training event.
6. **Healthcare Assessment and Monitoring System (HAMS)** - A secure, web-based system developed by the FDOH to automate the Hospital Preparedness Program contracting process. HAMS facilitates online submission of deliverables, invoices and tracks allocated, spent and available funds.
7. **Healthcare Coalitions (HCC)** - Healthcare Coalitions as defined by ASPR – A collaborative network of healthcare organizations and their respective public and private sector response partners which serve as a multi-agency coordination group that assists Emergency Management & Emergency Support Function (ESF 8-Health and Medical) with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations.
To be considered as participating, the HCC must be recognized by FDOH Hospital Preparedness Program.
8. **Healthcare System Partners** – Entities within a community that contribute to all-hazards planning, response and recovery, and mitigation to include long term care providers, behavioral/mental health providers, emergency medical service providers, local emergency management, hospitals, and hospital systems.
9. **Homeland Security Exercise and Evaluation Program (HSEEP)** – Federal Program that includes capabilities and performance-based exercises that provide a standardized methodology and terminology for exercise design, development, conduct, evaluation, and improvement planning.

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- 10. Hospital Preparedness Program (HPP)** - HPP provides leadership and funding through grants and cooperative agreements to States, territories, and eligible municipalities to improve surge capacity and enhance community and hospital preparedness for public health emergencies. The program is coordinated by the ASPR within the HHS. Funding is used to support programs to help strengthen public health emergency preparedness by enhancing planning, increasing integration, and improving infrastructure.
- 11. Licensed Healthcare Facilities** – Healthcare facilities licensed by the Florida Agency for Healthcare Administration under Chapter 395, Florida Statutes.
- 12. Mass Casualty Incident (MCI)** - An incident in which a large number of individuals become ill or injured and require rapid and appropriate care, stressing the available resources within the healthcare system.
- 13. Medical Surge** – The ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare service delivery system to survive a hazard impact and maintain or rapidly recover operations that were compromised.
- 14. Multi-Year Training & Exercise Plan (MYT&EP)** - A proposed training and exercise schedule, and a discussion of the plans for healthcare system exercise development, conduct, evaluation, and improvement planning. This plan needs to be updated annually and include how required sub-capabilities will be tested. The HSEEP website contains several job aids that can be of assistance in conducting and completing a multi year training and exercise workshop and plan, and is available at: https://hseep.dhs.gov/pages/1001_HSEEP7.aspx.
- 15. National Incident Management System (NIMS)** – Federal standards designed to enhance the ability of the United States Government to manage domestic incidents by establishing a single, comprehensive system for incident management.
- 16. Target Capabilities List (TCL)** - A list of public health and healthcare system preparedness capabilities, needed collectively by the U.S. to prevent, protect against, respond to, and recover from incidents of national significance, including terrorism or natural disasters. The list is found at: https://hseep.dhs.gov/eegb/WebHelp/Target_Capabilities.htm
Performance Measures and Functions of the Coalition Capabilities

RESOURCE LINKS

All exhibits and resource documents referenced within the contract, excluding HSEEP-specific references, may be accessed at the following website:

<http://www.doh.state.fl.us/demo/BPR/hospitalcontract.htm>

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B. General Description

1. **General Statement of Work-** The purpose of this contract is to foster relationships and communications between healthcare system partners within a community to collaboratively achieve healthcare preparedness capabilities. This contract specifically provides resources that support state, local and tribal public health departments and healthcare systems/organizations in building and sustaining medical surge capacity.
2. **Authority**
 - a. CFDA 93.889 Hospital Preparedness Program and Public Health Emergency Preparedness Aligned Cooperative Agreements
 - b. Section 252.35(2) (a) 3, Florida Statutes and Section 381.0011(7), Florida Statutes
3. **Scope of Service-** Funding is provided to support the following:
 - a. **Healthcare Coalition Participation** – For the purpose of coordinating and assisting Emergency Support Function-8-Public Health and Medical Services (ESF#8) with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations.
 - b. **Preparedness Training and Exercises-** Provider will develop/participate in disaster preparedness training and exercise program capable of being supported by Provider after the Department ceases to supply this funding. Components of this program include an HSEEP-compliant Training and Exercise Planning Workshop (T&EPW) to develop a MYT&EP which incorporates the principles of NIMS. The training and exercise component will demonstrate Provider's readiness to respond to incidents which require activation of their disaster plan, coalitions and mutual aid agreements and identify areas of strength and those in need of improvement.
 - c. **MCI Equipment and Supplies-** Provider must purchase, maintain and store the necessary MCI Equipment and Supplies ensuring satisfactory operation for the normal life expectancy of the equipment needed to treat patients as a result of a MCI. MCI Equipment and Supplies funded by this contract are to expand a Provider's response capability beyond its usual daily operative capabilities. This cache is to be accessed to mitigate depletion of Provider's existing stock for the duration of Provider's response to an MCI. Provider must maintain an MCI Equipment and Supplies Inventory (Exhibit 8) of all MCI Equipment and Supplies purchased from current and previously funded contracts by this federal funding source.

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- d. **Major Program Goal-** The goal of this contract is to support local level healthcare system preparedness, mitigation, response, and recovery as outlined in the public health and healthcare system preparedness capabilities found at the following link:

<http://www.phe.gov/Preparedness/planning/hpp/reports/Documents/Capabilities.pdf>

II. MANNER OF SERVICE PROVISION

A. Service Tasks

Task 1.0 – Participate in a DOH recognized HCC.

1.1- Provider must attend at least 50% of scheduled meetings with DOH recognized HCC.

1.2- Provider must be able to demonstrate a defined role in its local emergency management plan.

1.3- Provider must demonstrate collaborative planning to ensure there is a strategy to absorb medical surge.

1.4- Provider must participate, as a member of a coalition, in at least one state-approved regional or statewide exercise during the five year grant cycle.

Task 2.0 - Develop the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure of an affected community. Ensure the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

2.1 – Provider must assess its capability to respond to medical surge incidents by identifying gaps, challenges and barriers.

2.2 - The ASPR HPP requires that participating hospitals demonstrate NIMS compliance. Provider must demonstrate that its disaster preparedness training and exercise program reflects the principles of the NIMS and how the Provider plans to implement any NIMS objectives that are not fully implemented. A list of the most current NIMS Objectives can be found at the following link:

<http://www.fachc.org/pdf/EM/NIMSGuidancefor2012.pdf>

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2.3 – Provider must develop strategies to mitigate identified gaps, challenges, and barriers, including:

- a)** Submission of both a written MYT&EP and Schedule (Exhibit 15) based on the PPHP Capability Assessment and Planning Tool for Medical Surge (Exhibit 11).
- b)** Conducting or participating in training to address capability gaps and corrective actions. Provider must maintain or have access to a fully trained Decontamination Team.

Task 3.0 – Provider must purchase, maintain, and store the MCI Equipment and Supplies and complete an MCI Equipment and Supplies Inventory (Exhibit 8).

3.1 - MCI Equipment and Supplies purchases must be based on identified gaps, challenges, and barriers identified in the Provider's completed PPHP Capability Assessment and Planning Tool for Medical Surge (Exhibit 11).

3.2 - Provider must maintain and submit to the Department an inventory of all MCI Equipment and Supplies purchased using this federal funding source.

3.3 – Provider must purchase, maintain and store MCI Equipment and Supplies to ensure satisfactory operation for the normal life expectancy of such equipment and supplies.

a) Purchase –Provider must:

- 1) Obtain written approval from the Department in advance of any purchase of MCI Equipment and Supplies as stated in MCI Purchase Request Process (Exhibit 6). The deadline for purchase requests is May 1 of each year.
- 2) Order, receive and pay for the MCI Equipment and Supplies during the current contract term.

b) Maintain MCI Equipment – includes initial, routine calibration and repairs and rotation of Supplies through the Provider's existing stock, as appropriate.

c) Store – storage of MCI Equipment & Supplies must be:

- 1) Safe for personnel to enter and exit storage area (s); and
- 2) Secure from theft and not used for any other purpose; and
- 3) Climate-controlled according to the manufacturer's instructions for storage.

B. HPP Allocations:

- 1. Category allocations cannot be adjusted without prior approval from the DOH Contract Manager.

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2. Provider is required to follow the process outlined in MCI Purchase Request Process (Exhibit 6).

C. Deliverables: Provider shall submit the following deliverables to the Contract Manager in the time and manner specified. Refer to Task-to-Deliverable Matrix (Exhibit 13) for required deliverable submission dates and associated payments. Required Documentation must be submitted via HAMS or using the required template, when applicable.

1. Demonstrated participation in a HCC by attending at least 50% of scheduled HCC meetings. (Task 1.1)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: an HCC Attestation of Attendance (Exhibit 7) from the HCC Chair indicating that Provider has attended at least 50% of scheduled HCC meetings.

2. A documented response role in the local Emergency Management plan. (Task 1.2)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: an attestation from Emergency Management or the County Health Department Planner indicating the defined role of Provider in the local emergency management plan, Attestation of Inclusion in County Emergency Management Plan (Exhibit 9).

3. A facility-level emergency plan that demonstrates how the provider will accommodate a surge in patients. (Task 1.3)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: a copy of the section of the Provider's Emergency Management Plan that demonstrates the steps the Provider will take to ensure their ability to accommodate a surge in patients.

4. Participation in a regional or jurisdictional HCC preparedness exercise. (Task 1.4)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: a submission of the HCC After Action Report and Improvement Plan (AAR/IP).

<https://hseep.dhs.gov/.../hseep%20AAR-IP%20Template%202007.doc>

5. Facility identification of gaps, challenges and barriers related to facility's capability to respond to medical surge incidents. (Task 2.1 & 2.3)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: a completed PHHP Capability Assessment and Planning Tool (Exhibit 11)

6. Identification and completion of at least four risk-based preparedness trainings. (Task 2.3)

Documentation that must be submitted to the Department to evidence completion of this deliverable is:

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- a. Submission of Provider's written MYT&EP and Schedule (Exhibit 15).
 - b. A copy of the sign-in sheet or participants list for each training Provider conducts or participates in. Provider must submit sign in sheets or participants lists for a minimum of four (4) trainings per contractual year which aligns to the accepted MYT&EP.
 - c. Submission of a Training Summary (Exhibit 10) for each training the Provider conducts or participates in. Provider must submit a Training Summary for four (4) trainings which align to the accepted MYT&EP.
7. The purchase of medical surge equipment and supplies based on identified risks. (Task 3.1)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: Provider invoice and supporting documentation as required for the Cost Reimbursement Payment Method (see section III. Method of Payment).

- a. Provider must receive Department approval before making any purchases using MCI Purchase Request Process (Exhibit 6).
 - b. Provider must order, receive, pay for, and submit all required documentation to the Department by May 30. Any documentation postmarked after May 30 could result in non-payment, to be determined at the discretion of the Department.
8. Demonstrated compliance with NIMS objectives. (Task 2.2)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: Submission of the NIMS Objectives Status (Exhibit 5) indicating the Provider's current status related to the 11 recognized NIMS Objectives.

9. A fully-trained and functional Decontamination Team. (Task 2.3)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: submission of the Decontamination Training Certification (Exhibit 12).

10. An up-to-date inventory of all supplies and equipment purchased with HPP funds. (Task 3.2)

Documentation that must be submitted to the Department to evidence completion of this deliverable is: submission of a completed MCI Equipment and Supplies Inventory, (Exhibit 8).

The inventory must include, at a minimum:

- item description
- quantity
- unit cost
- total cost
- date of purchase
- life expectancy
- location (must include hospital name, department and room number)

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- serial number (when applicable)
- condition code
- state if preventative maintenance is required

D. Performance Measures: Unless otherwise specified, Provider shall demonstrate 100% compliance with all deliverables.

E. Additional Provider Responsibilities

1. Provider shall coordinate its work on tasks with the appropriate entities, i.e., the Department and others as the Department may direct. The failure of other entities does not alleviate Provider from any accountability for tasks Provider is obligated to perform pursuant to this contract.
2. Provider must respond timely to all communication requests from the Department.
3. In the event a different Provider's Contract Representative is designated after execution of this contract, the name and address of the new representative shall be sent in writing to the DOH Contract Manager, no later than 3 business days of making the change.

F. Department Responsibilities

1. The Department reserves the exclusive right to make certain determinations in these specifications. The absence of the Department setting forth a specific reservation of rights does not mean that all other areas of this contract are subject to mutual agreement.
2. The Department is not responsible for the maintenance of equipment or software that was purchased for this contract.

III. METHOD OF PAYMENT

A. The Method of Payment is a combination of Fixed Fee and Cost Reimbursement. The total contract amount is found on the Standard Contract and Task to Deliverable Matrix (Exhibit 13).

1. **Fixed Fee** – when submitting an invoice for payment, Provider must submit the following:

An original provider signed invoice (Exhibit 14) – must be on Provider's letterhead; must identify the Deliverable # for which payment is being requested, the current contract number, an invoice number, the amount being requested for payment, and the 'Remit To' address exactly as it appears in this contract. The following attestation must be included in the invoice: "The Provider certifies that the services have been performed and/or received."

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2. **Cost Reimbursement** - when submitting an invoice for reimbursement, Provider must submit the following:

- a) An original provider signed invoice (Exhibit 14) – must be on Provider's letterhead; must identify the Deliverable # for which payment is being requested, the current contract number, an invoice number, the amount being requested for reimbursement, and the 'Remit To' address exactly as it appears in this contract. The following attestation must be included in the invoice: "The Provider certifies that the goods have been received."
- b) Vendor invoice(s) – must be a detailed vendor invoice that totals the amount listed in Provider invoice.
- c) Proof of payment – a copy of a payment instrument, check number, or accounting department detail sheet. The detail information must correspond to the copies of the vendor invoices.
- d) MBE Expenditure Report (Attachment IV) – must be submitted each time a subcontractor is used to purchase MCI equipment and supplies.

B. Payments shall be made pursuant to the Task-to-Deliverable Matrix (Exhibit 13).

C. No payment will be made for deliverables that are not submitted.

D. Final contract invoices must be submitted by Provider within five business days after the expiration of the contract. Notwithstanding the Standard Contract, II. B., the Department shall have 30 business days to inspect and approve goods and services (deliverables) under this contract.

E. Financial Consequences – If Provider fails to submit a deliverable in the time and in a manner acceptable to the Department, the payment for each deliverable not met shall be reduced by 5%.

Additionally, the payment for deliverables that are submitted late will be reduced by 5% for each business day they are late, even if otherwise in compliance with the contract.

IV. SPECIAL PROVISIONS

A. General Procurement Standards - Provider cannot order MCI Equipment or Supplies, conduct Training or Exercises, or perform any other action related to this contract until notified that this contract has been executed by the Department. These same actions cannot take place after the contract has expired.

B. In-Kind / Match Contribution Letter - Provider must submit a letter which documents its in-kind contribution for this contract. For the purposes of this contract, in-kind is defined as non-Federal, non-cash contributions. These contributions are generally of fair market value referred to as property, space, personnel, equipment, or contributions of services. The in-kind letter must include verifiable details that document the amount and type of in-kind contribution Provider is contributing, and an attestation from Provider's Finance Director which states no federal funds were used, nor has any duplication of

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cost sharing occurred. The in-kind letter is due to the Department's Contract Manager no later than February 28 of each year of this contract.

- C. *Monitoring*** - The primary, secondary or signatory of the contract must be present for any on-site programmatic monitoring visit. The Department reserves the right to conduct an on-site visit unannounced by persons duly authorized by the Department.
- D. *Property Management*** - This contract contains federal funds and must be in compliance with 45 CFR, Part 74 and Part 92, as appropriate. Notwithstanding any other section hereof and where not prohibited under 60-A1.017, F.A.C., all right and title in and to property purchased, produced or developed, in whole or in part, with funds provided hereby vests in the Department. The Department retains a fully vested interest in the inventory, maintenance and disposition of property, the title to which resides with the Provider pursuant to this contract, absent Provider breach.
- E. *Renewal*** - This contract may be renewed on a yearly basis for no more than three years beyond the initial contract or for the term of the original contract, whichever is longer. Such renewals shall be made in writing, made by mutual agreement, and shall be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Department and shall be subject to the availability of funds.
- F. *Supplanting*** - For the purposes of this contract, supplanting is defined as: "to remove or displace, substitute for or take the place of." Provider can not use funding allocated in this contract to replace normal funding appropriated to purchase like equipment, supplies and/or services. The purpose of these contract funds is to increase the overall amount of resources available at Provider's location to strengthen preparedness and response capabilities. Equipment and supplies shall be readily accessible to the trained staff that will be expected to utilize the equipment and/or respond in a MCI. If it appears Provider has been supplanting during this contract, Provider will be required to supply documentation to ensure that the par levels have not been adjusted or reduced because of the additional funding provided in this contract.

END OF TEXT