



Public Health Emergency Preparedness Cooperative Agreement

Budget Period 1
Performance Measure Specifications and Implementation Guidance

July 1, 2012 – June 30, 2013

Version 1.1



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Acknowledgements

Developing measures and other evaluation strategies for the Public Health Emergency Preparedness (PHEP) cooperative agreement has been a collaborative process – and CDC is fortunate to have benefited from a high level of stakeholder engagement.

Since 2008, the Division of State and Local Readiness' Applied Science and Evaluation Branch (ASEB) has engaged a variety of internal and external subject matter experts, awardees, national partner organizations, measurement workgroups, and contractors. The PHEP Evaluation Workgroup, the Association of State and Territorial Health Officials (ASTHO) Performance Evaluation and Improvement Workgroup, the Council of State and Territorial Epidemiologists, the Association for Public Health Laboratories, the Career Epidemiology Field Officer Program, and the National Association of County and City Health Officials (NACCHO), among many others, have generously shared their subject matter and field expertise. Additionally, PHEP awardees and local health departments (LHDs) have shared critical context regarding the structure, functions, and goals of state and local preparedness programs. They have also weighed in on the relevance, feasibility, and usefulness of the measures and evaluation strategies, and have provided valuable suggestions for improvement – through participation in workgroups, meetings, conference calls, pilot tests and desk reviews, and ad hoc e-mails and phone calls.

We would like to thank them all for their time and thoughtful feedback.

Measurement and Evaluation Team
Applied Science and Evaluation Branch
Division of State and Local Readiness
Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention

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Introduction

Since 1999, the Centers for Disease Control and Prevention (CDC) has awarded more than \$8 billion to 50 states, eight territories, and four directly funded localities through the Public Health Emergency Preparedness (PHEP) cooperative agreement, the agency's largest investment in state and local public health preparedness. Evaluating awardee performance provides critical information needed to report on how well this federal investment in preparedness has improved the nation's ability to prepare for and respond to public health emergencies. The Applied Science and Evaluation Branch (ASEB) within the Division of State and Local Readiness (DSLRL) in CDC's Office of Public Health Preparedness and Response (OPHPR) has been charged with developing and implementing a standardized set of relevant, feasible, and useful performance measures and other evaluation strategies as part of the PHEP cooperative agreement, with a primary emphasis on program improvement and accountability.

Working in close collaboration with internal and external subject matter experts (SMEs), PHEP awardees, national partner organizations and federal partners such as the Assistant Secretary for Preparedness and Response (ASPR), ASEB has developed performance measures that enable CDC and its PHEP awardees to:

- support **program improvement** and **technical assistance** by identifying gaps and areas in need of improvement and tracking performance over time;
- monitor, for **accountability** purposes, the extent to which awardees are able to demonstrate acceptable levels of performance for specific public health preparedness capabilities; and
- report **awardee accomplishments and performance** in publications such as CDC's Public Health Preparedness State Reports.

Primer on Evaluation

This section is intended to provide readers with a basic understanding of evaluation concepts in order to lay the foundation for effective performance measurement.

What is evaluation?

Evaluation can be thought of – in simple terms – as collecting, analyzing and ultimately using data to make decisions.¹ *Program evaluation* entails collecting and analyzing data to make decisions about a program or aspects of a program. Ideally, data are collected and analyzed systematically to determine how well a program is working and why (or why not).²

There are many types of program evaluation, which can be conducted for a variety of purposes as shown in Table 1. Two of the more common types on which this guidance focuses include process evaluation and outcome evaluation. Process evaluations determine whether, and how well, program activities were implemented. Outcome evaluations, on the other hand, determine whether desired program results were achieved and the extent to which program activities contributed to these results.

¹ Patton, M.Q. (1982). *Practical Evaluation*. London: Sage Publications.

² Government Accountability Office. (January 31, 2012). *Designing Evaluations 2012 Revision*. Accessible at <http://www.gao.gov/assets/590/588146.pdf>

Table 1: Evaluation Types

Program Integrity	Formative	<ul style="list-style-type: none"> • Needs assessment • Feasibility studies • Process evaluation (including performance measurement) • Implementation evaluation (including fidelity assessments) • Output evaluations
Program Effectiveness	Summative	<ul style="list-style-type: none"> • Outcome evaluation • Comparative effectiveness studies • Impact evaluation (overall net effects controlling for external influences)
Program Efficiency	Summative	<ul style="list-style-type: none"> • Cost effectiveness studies • Cost-benefit studies

Why do we conduct evaluations?

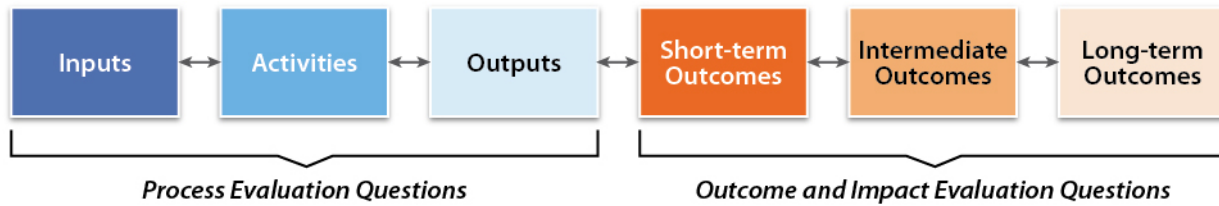
There are two primary reasons evaluations are conducted: to demonstrate accountability to stakeholders, including funders, and to facilitate internal program improvement (also referred to as organizational learning).

The U.S. Congress, federal oversight agencies, state and local legislatures, and taxpayers alike are increasingly interested in knowing the concrete results of PHEP investments and if we are better prepared to respond to public health emergencies. As available PHEP funds continue to decrease, the need to articulate PHEP successes and impacts grows more urgent. Data gathered through program evaluation can enable state, local, and territorial PHEP awardees to respond to requests for information from various stakeholders and provide evidence that PHEP investments are being used as intended to achieve desired outcomes.

Equally as important as demonstrating accountability is improving program performance. Program evaluation can help state, local, and territorial PHEP awardees to benchmark themselves in key areas, against which they can assess improvement over time. Evaluation that seeks to improve program performance tends to focus on the collection of data that organizations can use to learn about their strengths, weaknesses, and the critical chokepoints impeding optimal results.

To evaluate a program, it is helpful to understand the connections between program resources, activities, and goals. Logic modeling is one way to display these connections. Logic models identify and propose relationships between and among program resources, activities, outputs, and outcomes. Figure 1 provides a sample logic model, followed by definitions of its components.

Figure 1: Sample Logic Model



Definitions of Logic Model Components:

- Inputs: Resources that are required to support the program, including staff and volunteers, funding, facilities, and equipment.
- Activities: Actions that use or involve program inputs.
- Outputs: Products and services produced by program activities.
- Outcomes: Changes or benefits resulting from program activities and outputs. Outcomes can be intended or unintended, positive or negative, and are often divided into short-, intermediate, and long-term timeframes.

What are the benefits of program evaluation?

There are numerous benefits to program evaluation, which include:

- Identifying program successes
- Identifying areas for improvement and increased efficiency
- Learning about how well the overall program or portions of the program work and why
- Increasing buy-in of staff, volunteers, collaborators, potential new partners, funders and the public through sharing information about the program
- Improving services provided through better management and monitoring³

Performance Measurement as an Evaluation Strategy

How does measurement link to evaluation?

Measurement is one evaluation strategy, among many others. Measures may be developed for program inputs, activities, outputs, or outcomes, depending on the level of program development and implementation and programmatic areas of interest. Historically, PHEP measures have focused on program activities and outputs, though as the program matures, so too will its measures.

How is measurement data used?

Just as with evaluation more broadly, measurement data can be used to facilitate internal program improvement and demonstrate accountability.

³ Mattesich, P.W. (2003). *The Manager's Guide to Program Evaluation: Planning, Contracting, and Managing for Useful Results*. Saint Paul: Amherst H. Wilder Foundation.

Improvement measures are designed to provide data to awardees and to CDC staff to enable identification of strengths, weaknesses, and areas of improvement, along with opportunities for training and technical assistance. The intended use of this measurement data is to facilitate internal program improvement and learning. *Most PHEP measures have an improvement component.*

Accountability measures are collected in compliance with specific Federal requirements, statutes or initiatives such as the Pandemic and All-Hazards Preparedness Act (PAHPA), the Government Performance and Results Act (GPRA), and the Healthy People 2020 Initiative. Data from these measures are often reported to requesting agencies and other entities such as the US Department of Health and Human Services, the White House Office of Management and Budget, and others. Data from these accountability measures will be used to provide evidence to the aforementioned programs that the PHEP awardees are conforming to funding requirements and demonstrating effectiveness in public health preparedness practice.

How were the PHEP measures developed?

DSLRL began developing PHEP measures in 2008 and currently uses the following measure development process:

1. Review literature and existing measures
2. Identify potential points of measurement with SMEs and program representatives
3. Socialize points of measurement with leadership to ensure they meet information needs of the program
4. Engage workgroups of SMEs, awardees, and program representatives to draft measure specifications, intent, data elements, and reporting criteria
5. Conduct pilot tests and/or desk reviews of draft measures with stakeholders (e.g., state and local PHEP awardees) to determine relevance, feasibility, and usefulness and solicit suggestions for improvement
6. Develop final measures, implementation guidance, and tools
7. Facilitate performance measure training and technical assistance

Is performance measurement always the best evaluation method?

Although much focus has been placed on measurement to date, not all aspects of the PHEP program or its capabilities are amenable to performance measurement. Some aspects may be better evaluated through methods such as descriptive questionnaires, site visits, and document review, as well as other evaluation tools and methods such as special studies. DSLRL will begin to incorporate these and other methods into its evaluation strategy beginning in Budget Period (BP) 1.

Reporting Requirements

Detailed performance measure requirements (including which awardees are required to report and under what circumstances) can be found in **Appendix A**. *Please note that Appendix A supersedes Appendix 9 of the BP1 Funding Opportunity Announcement.*

Starting in BP1, all 15 public health preparedness capabilities have associated measures and/or evaluation tools. *New* measures and evaluation tools have been developed for the following capabilities:

- Community Recovery



- Fatality Management
- Information Sharing
- Mass Care
- Non-Pharmaceutical Interventions
- Responder Safety and Health
- Volunteer Management

At mid-year of BP1, awardees will be required to report measures for these capabilities so that a baseline may be established.

The PHEP BP1 Performance Measures Specifications and Implementation Guidance categorizes measures according to the following types:

- **Core public health** – measures that assess performance in the department’s critical, routine, day-to-day activities such laboratory services, epidemiological investigations and public health surveillance, as well as activities to enhance community preparedness.
- **Pre-incident planning** – process measures that assess crucial preparedness activities such as: identifying and coordinating with partners, defining operational roles, defining triggers for action, and identifying barriers to public health participation in response and recovery.
- **Response** – measures of performance while actually conducting, demonstrating or achieving a capability during an incident, planned event or exercise.

In addition to classification by measure type, each PHEP performance measure is classified as reportable to CDC according to one (and only one) of the following criteria:

- **Annually required** applies to core public health measures as well as measures that are collected for legislative and other federal requirements (e.g., Pandemic and All Hazards Preparedness Act (PAHPA), Healthy People (HP) 2020, and Government Performance and Results Act (GPRA))
- Reportable **if PHEP funds are allocated** to the associated capability (i.e., *any* amount of PHEP funding, from small allocations to sustain the capability to large allocations to build the capability) – applies to pre-incident planning measures
- Reportable **irrespective of allocation of PHEP funds** to the associated capability – applies to most response measures and some core public health measures

One incident, planned event, or exercise that demonstrates multiple capabilities may be used to collect data on multiple performance measures. Awardees will need to identify the name and date of the incident, planned event, or exercise, and report that name and date for each applicable performance measure.

These criteria are indicated throughout the capability sections via a graphic in the right-hand margin.

Table 2: Measure Types

Type of Measure	Reporting Criteria	Exceptions / Notes
Core Public Health	Annually required	
Pre-Incident Planning	Report only if allocating PHEP funds towards the capability in the Capability or Contracts Plan	<p>In BP 1 only, CDC will collect baseline information from all awardees at mid-year for these measures.</p> <p>Lab PFGE measures (<i>E. coli</i> and <i>L. monocytogenes</i>) will be collected by the Epidemiology and Lab Capacity (ELC) grant program as well as CDC’s PulseNet (PN) program; PHEP awardees that allocate PHEP funds to PFGE activities will be required to verify performance measures data collected through ELC and PN.</p>
Response	Report if incident (or exercise or planned event) utilizes the capability, irrespective of allocation of PHEP funds towards the capability	Staff Assembly; AAR/IP; and Public Message Dissemination (EPIW/CERC) are all annually required due to required federal reporting

Awardees have the option of reporting **pre-incident planning measures** at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties versus districts versus regions versus the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question* (e.g., If an awardee provides PHEP funds to five of its 20 LHDs to do work in the fatality management capability, it would include only these five LHDs in the denominator of PHEP 5.2: Identify Role with Partners (LHDs)). In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.

Awardees should maintain appropriate documentation of all data reported for PHEP performance measures. Documentation should contain sufficient information to substantiate performance measure data submitted to CDC. Documentation may be requested by CDC to clarify or verify information submitted by awardees. While a fully automated electronic system is an efficient means to maintain documentation of data for various performance measures, such a system is not necessary to meet measure requirements. Awardees may manually record all data elements.

Document Organization

The chapters in this document consist of measures and evaluation tools for the 15 public health preparedness capabilities found in CDC’s *Public Health Preparedness Capabilities: National Standards for State and Local Planning*. The chapters are organized alphabetically and color-coded by capability. Each capability chapter follows the structure below:

1. Introduction to the capability, identification of the capability functions, and alignment of measures to capability functions
2. Detailed information and instructions to operationalize the measures
3. Key measurement terms and definitions

At the beginning of each capability section, a table is provided to demonstrate how the measures align to the capability functions. Each measure may be reached from this table by clicking on the measure number in the first row. This number serves as a hyperlink to take the reader directly to the selected measure. Reporting requirements for each measure and assessment tool are clearly indicated with bold font in the following table, at the beginning of each measure.

Table 3: Example Reporting Requirements Table

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

Sections within a measure are indicated by the following icons to help users quickly identify and find relevant information.

Figure 2: Measure Section Icons



The **compass** icon indicates the *measure specification*. Depending on the type of measure, this section will identify a numerator and denominator, a start and stop time, or criteria that need to be addressed.



The **checklist** icon indicates *reporting requirements*. This section contains any additional reporting criteria that were not identified previously in the measure.



The **bull's eye** icon indicates the *intent of a measure*. Depending on the type of measure, this may include a description of what the measure will enable health departments to know or do and/or immediate and broader programmatic aims.



The **gears** icon indicates *data elements*. This section contains all questions that should be answered and reported to CDC.



The **open book** icon indicates *implementation guidance*. This section identifies any other relevant information to help awardees collect and report measure data.

Finally, within the measures, certain terms are **bolded**; this is an indicator that the term is hyperlinked to a definition. The reader can access the definition by pressing CTRL + clicking on the text. *Italics* are used to indicate emphasis.

**CAPABILITY-SPECIFIC
PERFORMANCE MEASURES**



1. Community Preparedness

Introduction

The Community Preparedness (CP) capability represents a set of core public health activities related to community resilience. Homeland Security Presidential Directive 21 (HSPD-21), released in 2007, defines community resilience as the following:

“Where local civic leaders, citizens and families are educated regarding threats and are empowered to mitigate their own risk, where they are practiced in responding to events, where they have social networks to fall back upon, and where they have familiarity with local public health and medical systems, there will be community resilience that will significantly attenuate the requirement for additional assistance.”



Capability Functions

This capability consists of the ability to perform the following functions:

1. Determine risks to the health of the jurisdiction
2. Build community partnerships to support health preparedness
3. Engage with community organizations to foster public health, medical, and mental/behavioral health social networks
4. Coordinate training or guidance to ensure community engagement in preparedness efforts

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 1.1		●		
PHEP 1.2	●			
PHEP 1.3				●
PHEP 1.4		●		

PHEP 1.1: Identification of Key Organizations

Median number of **community sectors** in which LHDs identified **key organizations** to participate in **public health, medical, and mental/behavioral health**-related emergency preparedness efforts

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

When the numbers of community sectors engaged by each participating LHD are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.



What other requirements are there for reporting measure data?

All awardees are required to submit self-reported data for this measure. For most awardees, this performance measure requires data collection from LHDs. Please see the sampling strategy section of the guidance (**Appendix B**) for more information.



Why is this measure important?

This process measure demonstrates awardee accountability in relation to LHDs identifying and prioritizing key organizations (across all 11 community sectors as identified in CDC’s National Standards document) with which they wish to engage in emergency preparedness efforts related to public health, medical and/or mental/behavioral health. These sectors encompass a range of constituents and services and should provide services to the general public as well as vulnerable populations within the community in order to prepare for and recover from an **incident** or disaster.

The intent of this measure is for awardee health departments to capture data on the identification and prioritization of those organizations deemed, by LHDs, to be critically important (i.e., key) for inclusion and/or engagement in public health, medical and/or mental/behavioral emergency preparedness, response, and recovery efforts.



What data must be reported?

1. Median number of community sectors in which LHDs identified key organizations to participate in public health, medical, and mental/behavioral health-related emergency preparedness efforts (measure)
2. *Minimum* number of community sectors in which LHDs identified key organizations to participate in public health, medical, and mental/behavioral health-related emergency preparedness efforts
3. *Maximum* number of community sectors in which LHDs identified key organizations to participate in public health, medical, and mental/behavioral health-related emergency preparedness efforts
4. Total number of key organizations, across all 11 community sectors, identified by LHDs
5. Number of key organizations, by community sector, identified by LHDs
6. Number of key organizations that represent multiple community sectors
7. What additional key organizations did LHDs identify that do not fit within any of the 11 specified community sectors? [Text box]
 - a. Briefly describe the type of key organizations and the populations they serve. [Text box]





CAPABILITY 1

8. Names of counties contributing data for this measure [Text box]
9. Number of LHDs reporting data for this measure
10. Briefly describe successes cited by LHDs in terms of identifying key organizations. [Text box]
11. Briefly describe the most frequent barriers or challenges cited by LHDs in terms of identifying key organizations. [Text box]



How is this measure operationalized?

In identifying key organizations, the following should be considered:

- Key organizations should have significant reach within the local community. The make-up of organizations within a community sector should have access to or provide services to one or more vulnerable populations.
- Key organizations may provide services for more than one community sector. Thus, the organization may represent or be counted for multiple sectors.

The intent of this measure is that LHDs identify only those key organizations that they believe are critical in providing services to at-risk populations, or acting as critical response partners, in a significant public health emergency. It is not the intent of this measure to have LHDs identify (and subsequently engage with) all community organizations within their jurisdictions. LHDs should reassess their list of key organizations annually.



PHEP 1.2: Community Engagement in Risk Identification

Median number of community sectors that LHDs engaged in using **jurisdictional risk assessment (JRA)** data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

When the numbers of community sectors that each LHD engaged to determine local hazards, vulnerabilities, and risks are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.

departments should encourage and support LHDs to leverage findings, as applicable, from JRAs undertaken by themselves or other entities (e.g., local, state, or federal emergency management). Irrespective of which agency led the JRA, the findings must be applied in relation to their potential impact on public health, medical, and/or mental/behavioral health systems and services. This helps to ensure that the community preparedness and recovery plan appropriately addresses the mitigation of risk and the restoration of these systems and services in as feasible a manner as possible.



Why is this measure important?

This is a process measure demonstrating awardee accountability by ensuring that LHDs engage key organizations, across all 11 sectors (as identified in CDC's National Standards document) in using JRA data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services. A community's understanding and acknowledgement of the identified hazards, vulnerabilities, and risks is critical to developing appropriate preparedness, response, and recovery plans. Engaging key organizations in these processes ensures their commitment and involvement in implementing these plans.



What other requirements are there for reporting measure data?

All awardees are required to submit self-reported data for this measure. For most awardees, this performance measure requires data collection from LHDs. Please see the sampling strategy section of the guidance (Appendix B) for more information.



What data must be reported?

1. Median number of community sectors that LHDs engaged in using JRA data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services (measure)
2. Total number of key organizations, across all 11 community sectors, engaged in determining the local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services

The intent of this measure is for awardee health departments to capture information about LHD engagement of key organizations in identifying hazards, vulnerabilities, and risks that may impact local public health, medical, and/or mental/behavioral health systems and services. Awardee health



3. Number of key organizations, by community sector, engaged in determining the local hazards, vulnerabilities, and risks that may impact public health, medical and/or mental/behavioral health systems and services
4. *Minimum* number of community sectors engaged by the LHDs reporting data for this measure
5. *Maximum* number of community sectors engaged by the LHDs reporting data for this measure
6. Number of LHDs that engaged all 11 community sectors in using JRA data to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services
7. Type of JRA data that LHDs used to determine local hazards, vulnerabilities, and risks that may impact public health, medical, and/or mental/behavioral health systems and services
 - a. Number of LHDs that conducted their own local JRA
 - b. Number of LHDs that reviewed JRA data conducted by the state health department
 - c. Number of LHDs that reviewed JRA data conducted by the local, state, or federal emergency management agency
 - d. Number of LHDs that reviewed JRA data from more than one source/agency (e.g. local emergency management and the state health department)
8. Names of counties contributing data for this measure [Text box]
9. Number of LHDs reporting data for this measure
10. Briefly describe successes cited by LHDs in terms of engaging key organizations in using JRA data to determine local hazards, vulnerabilities, and risks. [Text box]
11. Briefly describe the most frequent barriers or challenges cited by LHDs in terms of engaging key organizations in using JRA data to determine local hazards, vulnerabilities, and risks. [Text box]

LHDs may either conduct their own JRA or review JRA data collected by other agencies (e.g., the state public health agency, state or local emergency management agency, and FEMA). Additionally, during a BP in which an JRA is not conducted for the local jurisdiction, the LHD should review the hazards, vulnerabilities, and risks previously identified (e.g., in a prior BP) to determine if they are still relevant, and update their local community preparedness and recovery plans as needed.

Engaged in using JRA data to determine local hazards, vulnerabilities, and risks: Key organizations, representing all 11 community sectors, should provide verbal or written input to the LHD for determining the hazards, vulnerabilities, and risks relevant to public health, medical, and/or mental/behavioral health systems and services within their local jurisdiction. LHDs may engage their key organizations in a variety of ways depending on the source of the JRA data.

If the LHD conducted its own local JRA, this may involve (but is not limited to) the following:

- Providing information or input during the risk assessment process via meetings, interviews, or surveys.
- Participating, as a member of a strategic advisory council (SAC), local emergency planning committee (LEPC), community consortia, or planning body to design a risk assessment, review risk assessment data, and/or identify hazards, vulnerabilities, and risks.
- Participation in reviewing and discussing risk assessment data to identify hazards, vulnerabilities, and risks at in-person meetings, by phone, or via the Web or e-mail.
- Voting to identify risks (or in support of identified risks); voting is sponsored by the local public health agency, SAC, community consortia, or planning body, and may occur at in-person meetings, or by paper, phone, Web, or e-mail.
- Reviewing and acknowledging agreement with the identified hazards, vulnerabilities, and risks.
- If the LHD reviewed JRA data conducted by one or more agency (e.g., state health department; local, state or federal emergency management agency), this may involve (but is not limited to) the following:



How is this measure operationalized?

This measure should only include those individuals and organizations (e.g., agency, club, business, or professional association) deemed sufficiently representative of a sector, and essential in providing input and feedback related to local hazards, vulnerabilities, and risks that may impact public health, medical and/or mental/behavioral health systems and services.



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- Participating, as a member of a SAC, LEPC, community consortium, or other type of planning body to secure and/or review risk assessment data and/or to identify hazards, vulnerabilities, and risks.
- Providing information or input that informs the review of previously identified hazards, vulnerabilities, and risks for the current BP.
- Participation in reviewing and discussing current or previously collected JRA data to identify hazards, vulnerabilities, and risks via in-person meetings, paper, phone, the Web or e-mail.
- Voting to identify risks (or in support of identified risks)—currently or as identified in a previous BP. Voting is sponsored by the LHD, SAC, community consortia, or planning body, and may occur at in-person meetings, or by hard copy or electronic survey.
- Reviewing and acknowledging agreement with the identified hazards, vulnerabilities, and risks (current or previously identified/reprioritized) for the BP.

This measure is meant to capture meaningful, *bona fide* participation by community sector representatives. Marginal or non-meaningful participation shall not count toward this performance measure. This measure excludes individuals that do not participate or those who participate marginally in a manner that is not meaningful, as well as those who do not provide explicit input or feedback on risks to public health, medical and/or mental/behavioral health systems or services (e.g., members of the media who show up to observe for the sole purpose of reporting).



PHEP 1.3: Community Engagement in Public Health Preparedness Activities

Proportion of key organizations that LHDs engaged in a significant public health emergency preparedness activity

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of key organizations that LHDs engaged in one or more of the following significant public health emergency preparedness activities:

- Development of key organizations’ emergency operations or response plans related to public health, medical, and/or mental/behavioral health
- **Exercises** containing objectives or challenges (e.g. injects) related to public health, medical, and/or mental/behavioral health.
- **Competency-based training** related to public health, medical, and/or mental/behavioral health emergency preparedness and response

Denominator: Total number of key organizations identified by LHDs



Why is this measure important?

This process measure is intended, over time, to demonstrate program improvement at the local level by assessing the depth of key organizations (across the 11 community sectors identified in the National Standards document) engaged by LHDs in significant emergency preparedness activities related to public health, medical, and/or mental/behavioral health.

The intent of this measure is for awardee health departments to capture information about LHDs’ involvement with key organizations in meaningful activities that build their overall capacity to plan for and/or respond to incidents that impact public health,

medical, and/or mental/behavioral health systems and services in their communities. These activities also help the LHD and key organizations think through ways in which they can restore infrastructure and services as quickly as possible as well as identify potential gaps in their existing plans. Finally, these activities help to ensure that key organizations understand their roles and responsibilities as well as protocols and procedures for responding to and recovering from an incident.



What other requirements are there for reporting measure data?

All awardees are required to submit self-reported data for this measure. For most awardees, this performance measure requires data collection from LHDs. Please see the sampling strategy section of the guidance (Appendix B) for more information.



What data must be reported?

1. Total number of key organizations identified by LHDs (denominator)
2. Number of key organizations that LHDs engaged in one or more significant public health emergency preparedness activities (numerator)
3. Total number of key organizations, across all 11 community sectors, that LHDs engaged in *at least one* significant emergency preparedness activity related to public health, medical, and/or mental/behavioral health
4. Number of key organizations, by community sector, that participated in *more than one* significant preparedness activity related to public health, medical, and/or mental/behavioral health



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5. *Minimum* number of community sectors that participated in a significant preparedness activity related to public health, medical, and/or mental/behavioral health, across reporting LHDs
6. *Maximum* number of community sectors that participated in a significant preparedness activity related to public health, medical, and/or mental/behavioral health, across reporting LHDs
7. Number of LHDs for which all 11 community sectors participated in a significant preparedness activity related to public health, medical, and/or mental/behavioral health
8. Names of counties contributing data for this measure [Text box]
9. Number of LHDs reporting data for this measure
10. Briefly describe successes cited by LHDs in terms of engaging key organizations in significant preparedness activity related to public health, medical, and/or mental/behavioral health. [Text box]
11. Briefly describe the most frequent barriers or challenges cited by LHDs in terms of engaging key organizations in significant preparedness activity related to public health, medical, and/or mental/behavioral health. [Text box]



How is this measure operationalized?

For the purposes of this measure, significant public health emergency preparedness activities are to include endeavors that provide key organizations with the capacity to plan for and/or respond to an incident. For this performance measure, these activities are defined as:

- Development of key organizations' **emergency operations or response plans** related to public health, medical, and/or mental/behavioral health
- Exercises containing objectives or challenges (e.g. injects) related to public health, medical, and/or mental/behavioral health.
- Competency-based training related to public health, medical, and/or mental/behavioral health emergency preparedness and response



PHEP 1.4: Community Engagement in Recovery Planning

Median number of community sectors that LHDs engaged in developing and/or reviewing a **community recovery plan** related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

When the numbers of community sectors that each LHD engaged in developing and/or reviewing their community recovery plan are arranged from highest to lowest [maximum is 11, minimum is zero], the median is the midpoint number where half of the LHDs engaged a number of sectors at or above the midpoint and the other half of the LHDs engaged a number of sectors at or below it.

steps to take toward rebuilding the community following an incident impacting public health, medical and/or mental/behavioral health systems and services.



What other requirements are there for reporting measure data?

All awardees are required to submit self-reported data for this measure. For most awardees, this performance measure requires data collection from LHDs. Please see the sampling strategy section of the guidance (Appendix B) for more information.



Why is this measure important?

The purpose of this process measure is to demonstrate program accountability of cross-sector community engagement by LHDs in pre-incident planning related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services.

The intent of this measure is for awardee health departments to capture information about LHDs' engagement of community sector representatives in pre-incident recovery planning for the restoration of services, providers, facilities, and infrastructure related to Public health, medical, and mental/behavioral health systems. Additionally, this provides a mechanism to track improvements in these efforts over time. Building and maintaining community resilience benefits from deliberate action to plan for recovery from a major incident or disaster. The participation of key organizations in developing and/or reviewing a community recovery plan builds a better understanding of roles and responsibilities as well as



What data must be reported?

1. Median number of community sectors that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services (measure)
2. Total number of key organizations, across the 11 community sectors, that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services
3. Number of key organizations, by the 11 community sectors, that LHDs engaged in developing and/or reviewing a community recovery plan related to the restoration and recovery of public health, medical, and/or mental/behavioral health systems and services





4. *Minimum* number of community sectors that were engaged in developing and/or reviewing a community recovery plan, across LHDs reporting data for this measure
5. *Maximum* number of community sectors that were engaged in developing and/or reviewing a community recovery plan, across LHDs reporting data for this measure
6. Number of LHDs for which all 11 community sectors were engaged in developing and/or reviewing a community recovery plan
7. Names of counties contributing data for this measure [Text box]
8. Number of LHDs reporting data for this measure
9. Briefly describe successes cited by LHDs in terms of engaging key organizations in developing and/or reviewing a community recovery plan. [Text box]
10. Briefly describe the most frequent barriers or challenges cited by LHDs in terms of engaging key organizations in developing and/or reviewing a community recovery plan. [Text box]

- review, and/or update the community recovery plan.
- Participation in reviewing and discussing the community recovery plan at in-person meetings, by paper, phone, or via the Web or e-mail.
- Voting in support of a community recovery plan; voting is sponsored by the local public health agency, SAC, community consortia, or planning body, and may occur at in-person meetings, by paper or phone, or via the Web or e-mail.
- Reviewing and acknowledging agreement with a community recovery plan.

This measure is meant to capture meaningful, *bona fide* participation by community sector representatives. Marginal or non-meaningful participation does not count toward this performance measure. This measure excludes individuals that do not participate or those who participate marginally in a manner that is not meaningful, as well as those who do not provide explicit input or feedback on risks to public health, medical and/or mental/behavioral health systems or services (e.g., members of the media who show up to observe for the sole purpose of reporting).



How is this measure operationalized?

For the purpose of this performance measure, the community recovery plan should include the roles and responsibilities of the LHD and key organizations in restoring public health, medical, and/or mental/behavioral health systems and services.

The review of a community recovery plan should occur annually (if the plan was previously developed).

For the purpose of this performance measure, engagement of key organizations in developing and/or reviewing a community recovery plan is taken to include key organizations, across all 11 community sectors should be involved in developing and/or revisiting the LHD’s (or local emergency management agency’s) community recovery plan. Engagement in this activity may occur in various ways, including, but not limited to:

- Providing information or input to the LHD for the development or review of the community recovery plan.
- Participating, as a member of a strategic advisory council (SAC), local emergency planning committee (LEPC), community consortia, or planning body to develop,



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Key Measurement Terms

Community recovery plan: Community recovery plan is a written, all-hazards or hazard-specific plan that documents objectives, actions, and other information to assist key community public and private sector entities during the recovery phase of a disaster or major incident of public health significance. Importantly, this refers to the *pre-disaster* establishment of processes and protocols for coordinated post-disaster recovery planning and implementation through engagement between public health and key partners and sectors – including emergency management, healthcare providers, community leaders, media, businesses, service providers for at-risk populations, and more. (Definition adapted from the **National Disaster Recovery Framework**).

Community sectors: Community sectors are for the purposes of these performance measures, this refers to segments of a community within which different types of organizations operate. These organizations reach and/or provide a variety of critical services to members of the public, including vulnerable populations (e.g., the elderly; pregnant women; children and infants; individuals with chronic diseases and/or other acute medical conditions; individuals with a reduced ability to hear, speak, understand, remember; individuals who are disabled mentally and/or physically).

The 11 sectors of interest, as specified in the National Standards are listed below. Suggested “leaders” for LHDs to engage are additionally identified. Please note that the definitions and examples within each sector are not all-inclusive. Additionally, key organization membership in one category does not preclude membership in another (i.e. they are not mutually exclusive).

1. **Businesses:** For-profit organizations that engage in commerce. Examples include businesses that are actively involved in and are committed to improving their communities, as well as businesses with a significant presence or footprint in the community (e.g., large employers, key suppliers of goods, etc.). This sector also includes utility services such as electricity, water, and sanitation if they are for-profit organizations. Leaders engaged from this sector should be influential within their own organizations and communities.
2. **Community leadership:** Leaders in policy-making and decision-making, including elected officials (e.g., mayor, members of city councils, members of school boards), leaders of non-governmental organizations (e.g., American Red Cross, United Way, Salvation Army), and other community organizations (e.g., U.S. National Council on Disability, Lion’s Club, Rotary Club, Kiwanis Club, and the Junior League). This sector also includes leaders or representatives of tribal groups.
3. **Cultural and faith-based groups and organizations:** Organizations that represent the various religious and cultural traditions of a community. Leaders of such cultural and faith-based groups and organizations may be directors of cultural centers, elected officials of cultural and faith-based groups (e.g., president of a congregation), and leaders of interfaith councils or similar entities (e.g., National Interfaith Alliance).
4. **Education and childcare settings:** Public and private educational organizations including universities and colleges, school systems, individual schools, institutions serving children with special needs, Head Start programs, and private childcare facilities for young children. Leaders from these organizations make decisions and set policy, such as university and college officials, school superintendents, principals, facility directors, and parent advocates.
5. **Emergency management:** Federal, state and non-governmental organizations in the area of emergency management, homeland security, and first responders. Examples include the local emergency management agency, relevant tribal entities involved in emergency services or emergency management, the state emergency management agency, federal entities such as Federal Emergency Management Agency (FEMA) and other components of the U.S. Department of Homeland Security, the Medical Reserve Corps (MRC), Citizen Corps groups, Community Emergency Response Teams (CERTs) and others. This sector also includes traditional first responder groups including fire, police, and emergency medical services, as well as local public works agencies and nonprofit utility companies (e.g., city/county utilities, energy, water, and sanitation) and tribal utility authorities that may respond to an incident and/or provide services critical for an effective response. Leaders from this sector may include emergency managers or their deputies; chiefs and assistant chiefs for divisions such as special operations, hazardous materials and fire suppression; state



- police, city police and county sheriffs involved in large-scale planning events; special weapons and tactics supervisors; directors and supervisors of emergency medical services; and senior-level public works administrators. Please note that to the extent that this sector covers public safety (e.g., police and sheriffs); it implies engagement to ensure incarcerated individuals are appropriately included in relevant public health preparedness efforts.
6. **Healthcare** : Organizations including private facilities, public hospitals and outpatient clinics, university/academic medical schools and programs, healthcare coalitions, Department of Veterans' Affairs (VA) hospitals and clinics, Indian Health Services facilities, community health centers, non-profit healthcare providers, and private practice settings. Leaders from this sector may include healthcare professionals, especially those experienced in trauma or disaster relief work; physicians, nurses, pharmacists, and senior-level healthcare administrators who have taken an active or leadership role in other health/public health campaigns; healthcare professionals who hold leadership positions in their professional society (e.g. state and/or local chapters of the American Academy of Pediatrics, the American College of Physicians, and other professional societies); and healthcare administrators who promote the work of building community resilience.
 7. **Housing and sheltering**: Organizations that offer and/or provide references or referrals for temporary residence to individuals who are without permanent housing (e.g., state-level housing/shelter departments, homeless shelters, nonprofit housing providers, tribal housing authorities, American Red Cross, etc.). This sector may also include residential facilities for the elderly (e.g., nursing homes and assisted living centers), special needs individuals, and other vulnerable populations (e.g., domestic violence shelters, recovery or "halfway" homes for substance abusers, etc.). Leaders in this sector may include senior-level administrators, executive directors, and other directors and managers.
 8. **Media**: Organizations representing information channels and outlets such as print, radio, television, and the Internet. This sector also includes local means of communication (e.g., local and tribal newsletters and related publications, social networking sites, and listservs). Leadership of these organization include representatives with whom the community is familiar and to whom residents turn for important and accurate information.
 9. **Mental/behavioral health**: Organizations in the public or private sector that provide services related to supporting or enhancing the emotional/mental/behavioral well-being of individuals, families, and communities including state and local mental health authorities, community mental health facilities, VA hospitals and clinics, and the mental/behavioral health units of organizations including hospitals, Indian Health Services facilities, and academic institutions. This sector also includes nonprofit service providers and private practice settings where professionals including psychologists, psychiatrists, social workers, and licensed counselors provide mental/behavioral health services. Leaders in this sector may serve on disaster planning and response committees within their local, state, or national professional organizations.
 10. **Social services**: Organizations providing a range of services to vulnerable populations. Services may include, but not be limited to, medication assistance, assistance with accessing medical care and technology, transportation to needed services, nutrition/food assistance, and case management services. This sector also includes child welfare organizations and non-residential agencies, such as referral agencies and entities that serve individuals with developmental disabilities. Examples of these types of agencies include local nonprofit and faith-based social service providers (e.g. Meals on Wheels, Catholic Charities, and The Salvation Army), state or local level departments of social services, VA, State Councils on Developmental Disabilities, and other related governmental and nongovernmental organizations that serve vulnerable populations. Leaders in this sector may include senior-level administrators, center officers in charge, executive directors, and other directors and managers.
 11. **Senior services**: This sector may include nongovernmental service providers such as nursing homes, assisted living facilities, adult daycare programs targeting primarily seniors, offices of the AARP, and other nongovernmental organizations that have a focus on serving the aging. Additional governmental organizations may include entities such as any state government level office or department (e.g., State Office of Aging or its equivalent) as well as local area agencies on aging that administer various titles under the Federal Older Americans Act of 1965 and its amendments. Such offices may also administer a variety of state-funded programs, which serve the aging, particularly those with the greatest economic or social



need, such as low-income minority elderly. Leaders in this sector may include senior-level administrators, executive directors and other directors and managers.

Competency-based training: Competency-based training entails the provision of standardized instructions/guidance related to disaster prevention, preparedness, response, and recovery role(s) in accordance with established national, state, and local health security and public health policies, laws, and systems. Examples of competency-based training programs include, but are not limited to, National Incident Management System (NIMS) and related training, Hospital Incident Command System (HICS) training, the National Disaster Life Support Program; the American Academy of Pediatrics disaster medicine curriculum; and national and state Voluntary Organizations Active in Disaster planning documents. Additional information on competency-based training is available through the Preparedness and Emergency Response Learning Centers from CDC Information on the Public Health Preparedness and Response Core Competency Model is available through the Association of Schools of Public Health.

Emergency operations and response plans: Emergency operations and response plans are written plans that identify key organizations policies, procedures, and organizational structure for implementation during and following an incident. Continuity of operations plans (COOP) are also within scope for this element.

Exercises: An exercise is an instrument to train for, assess, practice, and improve performance in prevention, protection, response, and recovery capabilities in a risk-free environment. Exercises can be used for testing and validating policies, plans, procedures, training, equipment, and interagency agreements; clarifying and training personnel in roles and responsibilities; improving interagency coordination and communications; identifying gaps in resources; improving individual performance; and identifying opportunities for improvement. Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at <https://hseep.dhs.gov/support/Volumel.pdf>

- *Discussion-based exercises:* familiarize participants with current plans, policies, agreements, and procedures, or may be used to develop new plans, policies, agreements, and procedures. Types of discussion-based exercises include:
 - *Seminar:* A seminar is an informal discussion, designed to orient participants to new or updated plans, policies, or procedures (e.g., a seminar to review a new evacuation standard operating procedure).
 - *Workshop:* A workshop resembles a seminar but is employed to build specific products, such as a draft plan or policy (e.g., a training and exercise plan workshop is used to develop a multi-year training and exercise plan).
 - *Tabletop exercise (TTX):* A tabletop exercise involves key personnel discussing simulated scenarios in an informal setting. TTXs can be used to assess plans, policies, and procedures.
 - *Operations-based exercises:* validate plans, policies, agreements, and procedures; clarifies roles and responsibilities; and identifies resource gaps in an operational environment. Types of operations-based exercises include:
 - *Drill:* A drill is a coordinated, supervised activity usually employed to test a single specific operation or function within a single entity (e.g., a fire department conducts a decontamination drill).
 - *Functional exercise (FE):* A functional exercise examines and/or validates the coordination, command, and control between various multi-agency coordination centers (e.g., emergency operation center, joint field office, etc.). A functional exercise does not involve any boots on the ground (i.e., first responders or emergency officials responding to an incident in real time).
 - *Full-Scale exercises (FSE):* A full-scale exercise is a multiagency, multijurisdictional, multidiscipline exercise involving functional (e.g., joint field office, emergency operation centers, etc.) and boots on the ground response (e.g., firefighters decontaminating mock victims)

Jurisdictional Risk Assessment (JRA): JRA refers to an appraisal of hazards, vulnerabilities, and risks. For additional information regarding JRA, refer to the National Standards document, or for an example, refer to the UCLA Center for Public Health and Disaster Hazard Risk Assessment Instrument. This was referred to as a Hazard and Vulnerability Assessment (HVA) in previous guidance.

Incident: An incident is any natural or manmade occurrence that negatively affects, or can potentially negatively affect, public health. The incident does not need to be a declared emergency.

Key organization: A key organization is an entity, group, agency, club, business, or professional association, as well as an individual service provider that the LHD deems critical in terms of one or more of the following criteria.

- The entity is expected to provide health and human services (e.g., food, shelter/housing, social services, mental/behavioral) to vulnerable or at-risk populations in the context of a significant disaster or public health emergency.
- The entity is an essential vehicle for community outreach, information dissemination, or other similar communications with vulnerable and hard-to-reach populations, as well as the general public, during response or recovery following an incident. Such key organizations may fit within one or more of the 11 community sectors (e.g. the media, community leaders, cultural and faith-based organizations, businesses).
- The entity is or would be an essential primary partner in a jurisdictional disaster or public health emergency response in terms of resource sharing, provision of goods or services, surge capacity, representation in the Incident Management Structure (e.g., the emergency operations center) or other type of formal integration into an LHD's response to a public health emergency.

Key organizations are often characterized as:

- Having a significant footprint or service area in a community (e.g., hospitals, TV/radio stations, food banks, or the local emergency management agency)
- High-volume or throughput in terms of goods or services provided [e.g., high-volume food providers and distributors (businesses); low-income or publicly funded housing organizations; shelters]
- Serving hard-to-reach, vulnerable, or at-risk populations (e.g., multi-service community- or faith-based organizations)
- Historically significant institutions, or key figures/icons, within a community, often with significant influence within one or more cultural or affinity groups (e.g., community leaders, cultural and faith-based organizations)
- Providers of narrow or unique, but critical, services to the community (e.g., media outlets, hospitals)

It is the specific intent of the CP performance measures that LHDs identify only those key organizations that they plan to engage in a significant public health emergency preparedness, response, or recovery context including, but not limited to, review of hazards, vulnerability, and risk data or other preparedness activities. It is not the intent of these measures to have LHDs identify (and subsequently engage with) all community organizations within their respective jurisdictions. Aspects to consider when collaborating with key organizations include the following:

- Key organizations do not need to be physically located in the LHD's service area, but must be willing and able to engage in planning for and providing services to that area in the event of a public health emergency.
- Total numbers of key organizations are less important than the quality of organizations; a large key organization that is a leader within its sector or the community may suffice to represent that entire sector, whereas in other communities there may be several organizations, even dozens or more in large cities and counties, deemed by the LHD to be key and an appropriate target for engagement in a public health emergency preparedness or response activity
- Key organizations may represent more than one sector. For example, the local chapter of the American Red Cross may represent both the housing and sheltering and social services sectors.
- Representatives of the key organizations should be leaders and hold influence within their own organizations and within the sectors that they represent. They should also be in a position to commit their organization and/or its resources to community preparedness and recovery efforts.

In local jurisdictions in which the emergency management agency is the primary liaison with community organizations and sectors, LHDs are encouraged to partner with emergency management to meet the intent of all four community preparedness performance measures.



Median: A median is a statistical term used to identify a number that, in a sample of numbers arranged from highest value to lowest (or lowest to highest), divides the higher half of that array of numbers from the lower half (i.e., the midpoint). If there are an odd number of items in the sample, the middle number is the median. If there is an even number of items, the median is the mean or average of the two middle numbers.

Public health, medical, and mental/behavioral health: Public health, medical and mental/behavioral health is one or more systems of public and private agencies, and their associated programs, that function to provide services to ensure the overall physical and mental well-being of the community-at-large.

- Public health is concerned with the health of the community as a whole. The Institute of Medicine defines a public health system as executing the core functions of public health agencies at all levels of government: assessment, policy development, and assurance. The mission of public health is to “fulfill society's interest in assuring conditions in which people can be healthy.” The three core public health functions are:
 1. The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
 2. The formulation of public policies designed to solve identified local and national health problems and priorities;
 3. To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.
- Medical or healthcare systems generally focus on diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments. Healthcare is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other relevant areas of care. It refers to the work done in providing primary care, secondary care, and tertiary care, as well as in public health.
- Mental/behavioral health refers to “a broad array of activities directly or indirectly related to the mental well-being. It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.” In the National Standards, this is an overarching term used to encompass behavioral, psychosocial, substance abuse, and psychological health.

2. Community Recovery

Introduction

This capability includes activities related to the recovery of public health, medical and mental/behavioral health systems and services, including planning, advocacy, collaboration, and monitoring by health departments and community partners. These activities enable public health to prepare for alternative delivery and continuity of services during response and recovery operations as well as to plan for the restoration of impacted services.



The community recovery evaluation tool included in this section is designed to capture *descriptive* information about a health department’s response and recovery activities – as a means to better understand how health departments, and systems of public health,

medical and mental/behavioral health services, recover after major disasters. The tool primarily focuses on response and recovery planning, service disruption and restoration, and risk communication.

Capability Functions

This capability consists of the ability to perform the following functions:

1. Identify and monitor public health, medical, and mental/behavioral health system recovery needs
2. Coordinate community public health, medical, and mental/behavioral health system recovery operations
3. Implement corrective actions to mitigate damages from future incidents

Alignment of Evaluation Tool to Capability

	Function 1	Function 2	Function 3
Evaluation Tool	●	●	

Evaluation Tool

This instrument is intended to be completed by any state or local health department(s) within the awardee jurisdiction involved in response and recovery of some aspect of the public health, medical, or mental/behavioral health system. However, the awardee will always be responsible for submitting these data to CDC.

Tool Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

Incident Categorization

- Type of incident: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane / tropical storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text box]
 - Radiation
 - Other, please specify: [Text box]
- Health-related outcomes, if known
 - Number of injured
 - Number of injured ≤ 18 years
 - Number of ill (physical, mental/behavioral)
 - Number of ill ≤ 18 years
 - Number of exposed individuals (biological, chemical, radiological)
 - Number of exposed ≤ 18 years
 - Number of fatalities
 - Number of fatalities ≤ 18 years
 - Please indicate whether these are estimates or exact. [Select one]
 - Please describe how these data were collected. [Text box]
- Please provide the name and date of the incident/planned event/exercise [Text box]
- Approximate duration of recovery in days (please define start and stop dates, and indicate if ongoing)
 - Indicate if recovery is ongoing [Yes/No]
 - a. If no, indicate approximate end date of recovery [Text box]
- Was a public health emergency declared by any authorized official for the impacted area? [Yes/No]
- What type of disaster declaration was made? [Select one]
 - None
 - Local
 - State-Gubernatorial
 - Federal-Presidential
 - Other, please specify: [Text Box]
- Which county/counties were directly impacted by the incident? [Text box]
- How many local (i.e., county, district, regional, city, etc.) health departments will you be reporting recovery data on?

Health Department Information (repeat for each reporting health department)

- What is the name of this health department? [Text box]
- This health department is: [Select one]
 - The awardee health department
 - A local/district/regional/municipal health department that is a unit of state government
 - A local/district/regional/municipal health department that is a unit of local government



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3. What routine services were provided by this health department prior to the incident? [Select all that apply] **NOTE: For subsequent questions that state "Select all that apply" (when no list is provided), please reference the following list.**

- Disease prevention
 - Adult immunization provision
 - Child immunization provision
 - Tobacco prevention
 - Population-based nutrition services
 - Food safety education
 - Other, please specify: [Text Box]
- Primary care and clinical services
 - Tuberculosis screening / treatment
 - HIV/AIDS screening / treatment
 - STD screening / treatment
 - Cancer screening
 - Chronic disease treatment (e.g., diabetes, cancer, heart disease)
 - Oral health
 - Behavioral/mental health
 - Well child clinic
 - Obstetrical care
 - Newborn screening
 - Prenatal care
 - Other, please specify: [Text box]
- Epidemiology, surveillance and monitoring
 - Communicable/infectious disease surveillance (e.g., enteric, zoonotic, vaccine preventable, hepatitis)
 - Environmental health surveillance
 - Other, please specify: [Text Box]
- Specific prevention programs
 - Women, Infants, and Children (WIC)
 - MSCH Home visits
 - Family planning
 - Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
 - Other, please specify: [Text Box]
- Regulation
 - Healthcare regulation

- Environmental health regulation
- Schools/daycare center inspection
- Food service establishment inspection (e.g., Licensure and permits)
- Other, please specify: [Text Box]
- Other
 - Data analysis
 - Laboratory services
 - Medical examiner/forensics
 - Emergency medical services
 - Wellness, health promotion, and health communications
 - Health insurance
 - Vital records/statistics
 - Animal control
 - Health disparities
 - Other, please specify: [Text Box]

Response Planning Phase

1. Did the health department have an approved or accepted/reviewed *Continuity of Operations (COOP)* or similar plan prior to the incident? [Yes/No]
 - a. Were mission critical services (essential functions and activities necessary to continue or be stood up during a disaster) identified in the COOP (or similar plan) prior to the incident? [Yes/No]
 - i. If yes, what *routine* services were identified as mission critical prior to the incident? [Select all that apply]
 - ii. What *additional* services were identified as mission critical prior to the incident [Text box]
 - iii. Was restoration of services to vulnerable populations (such as those ≤ 18 years) a priority when identifying mission critical services? [Yes/No]
 - iv. Did the health department communicate its COOP to the emergency management agency as part of the jurisdiction’s planning process [Yes/No]
 - b. Was risk communication a component of the COOP (or similar plan)? [Yes/No]
 - c. Did the health department train its staff on COOP roles and responsibilities in the year leading up to the incident? [Yes/No]





- d. Did the health department exercise its COOP in the year leading up to the incident? [Yes/No]
- 2. Prior to the incident, did the health department engage in any **jurisdictional or community pre-disaster recovery planning** [e.g., with state/local emergency management]? [Yes/No]
 - a. If yes, which sectors were engaged as part of jurisdictional or community pre-disaster recovery planning? [Select all that apply]
 - Business
 - Community leadership
 - Cultural and faith-based groups and organizations
 - Emergency management
 - Healthcare
 - Social services
 - Housing and sheltering
 - Media
 - Mental/behavioral health
 - Senior services
 - Education and childcare settings
 - Other, please specify: [Text Box]
 - None
 - b. What were the main areas of focus or outcomes of the jurisdictional or community pre-disaster recovery planning process? [Text box]
 - c. Did the health department conduct or participate in an exercise in which recovery was an objective in the year leading up to the incident? [Yes/No]
 - d. Please describe the extent to which, and how, health department engagement in jurisdictional or community pre-disaster recovery planning was helpful, or not, in actual recovery-related efforts [Text box]
- 3. Prior to the incident, did the health department engage organizations that provide public health/medical and/or mental/behavioral health services *to children* ≤ 18 years (including those with special needs)? [Yes/No]
 - a. Which partners did the health department engage, and for which services? [Text box]
 - i. If no, briefly describe key barriers or challenges to partnering with these organizations [Text box]

- 4. To what extent and how has the health department and/or its partners located pediatric populations for the purpose of planning for major public health emergencies? [Text box]

Response Phase

- 1. Which routine services were *disrupted* as a result of the incident (not including those electively stood down)? [Select all that apply]
- 2. Which routine services were *electively stood down* by the health department as a result of the incident? [Select all that apply]
- 3. Did the health department activate its COOP? [Yes/No]
 - a. If yes, which mission critical (routine) services identified in the COOP did the health department provide during the response? [Select all that apply]
- 4. Please describe in detail additional activities/operations that were implemented or activated by the health department during the acute response phase of the incident. (Examples include, but are not limited to, activating or supporting ICS/EOC, surge, providing technical assistance, deploying responders, active surveillance, etc.). [Text box]

Recovery Phase

- 1. Of the routine health department services *disrupted* as a result of the incident (independent of those electively stood down), which ones were restored and/or modified? [Select all that apply]
 - a. How many days after each service was disrupted was it restored and/or modified?
 - b. Please describe any particular challenges or barriers in restoring/modifying the service. [Text box]
- 2. Of the routine health department services that were *electively stood down* following the incident, which ones were restored and/or modified? [Select all that apply]
 - a. How many days after each service was stood down was it restored and/or modified?
 - b. Please describe any particular challenges or barriers in restoring/modifying the service. [Text box]
- 3. What key health service (public health, medical, mental/behavioral health) recovery needs were identified during and following the acute response phase of the incident? [Text box]



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- a. Which sectors did the health department engage to assess these needs? [Select all that apply]
 - Business
 - Community leadership
 - Cultural and faith-based groups and organizations
 - Emergency management
 - Healthcare
 - Social services
 - Housing and sheltering
 - Media
 - Mental/behavioral health
 - Senior services
 - Education and childcare settings
 - Other, please specify: [Text Box]
 - None
- 4. Briefly describe how each of these needs was met or addressed, including (if applicable) the health department’s role in providing, coordinating, or assuring a service or function to meet the need identified. [Text box]
- 5. What key health services (public health, medical, mental/behavioral health) recovery *needs related to pediatric populations* (if any) were identified during and following the acute response phase of the incident? [Text box]
- 6. Briefly describe how each of these needs was met or addressed, including (if applicable) the health department’s role in providing, coordinating, or assuring a service or function to meet the need identified. [Text box]
 - a. Briefly describe key barriers or challenges to meeting/addressing these needs [Text box]
- 7. Of the activities/operations initiated by the health department during the acute response phase, which ones have been/will be incorporated into recovery or daily operations? [Text box]
- 8. Please describe in detail any new methods or innovations (including non-traditional public health roles) developed during the response or recovery phases to modify or adapt services to meet new needs. [Text box]
- 9. Did other health departments (state or local) provide material or substantive assistance during the response or recovery phases of the incident? [Yes/No]

- a. If yes, which health departments provided assistance? [Text box]
- b. Briefly describe types of services provided by the other health departments. [Text box]
- 10. Did the Federal government provide material or substantive assistance during the response or recovery phases of the incident? [Yes/No]
 - a. If yes, which agencies or entities provided assistance? [Text box]
 - b. Briefly describe types of services provided by the federal government. [Text box]

Risk Communications

- 1. Were health-related risk communication messages disseminated by the health department to the public or targeted populations? [Yes/No]
 - a. If yes, what types of messages were delivered? [Select all that apply]
 - Impact on services
 - Service restoration**
 - Morbidity updates
 - Mortality updates
 - Food/water Safety
 - Access and functional needs**
 - Vector safety**
 - Hope/improvement
 - Mental and behavioral health services**
 - Physical health services
 - Shelter information**
 - Lost/found animals
 - Missing people
 - Volunteer information**
 - Self-sufficiency**
 - Normalcy
 - Collaboration/importance of working together
 - Other, please specify: [Text Box]
 - b. Please identify the audiences: [Select all that apply]
 - Children/adolescents/parents
 - Seniors
 - Women/pregnant women
 - Immigrants/non-native English speakers



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Response



CAPABILITY 2

- Other individuals with access and functional needs
- General public
- Other, please specify: [Text Box]
- c. How were the messages disseminated?
[Select all that apply]
 - Face-to-face meetings (e.g., community and town hall meetings)
 - TV
 - Radio
 - Print media (e.g., newspapers, newsletters, pamphlets, brochures)
 - Billboard posting
 - Internet web site posting
 - Email
 - Text messaging
 - Social media (e.g., Facebook, Twitter)
 - Other methods, please specify: [Text Box]
- d. What was the frequency/duration of the message dissemination? [Text box]
- e. Please list any barriers to message dissemination (e.g., using social media)? [Text box]



Key Measurement Terms

Access and Functional Needs: Access and functional needs refers to individuals who may have needs before, during and after an incident in functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; live in institutionalized settings; are seniors; are children; are from diverse cultures; have limited English proficiency or are non-English speaking; or are transportation disadvantaged.

Mental and Behavioral Health Services: Mental and behavioral health services are health services that restore hand/or provide coping strategies for a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, work productively and fruitfully, and is able to make a contribution to his or her community.

Pre-disaster Recovery Planning (Jurisdictional or Community): Pre-disaster recovery planning describes the establishment of processes and protocols, prior to a disaster, for coordinated post-disaster recovery planning and implementation through engagement between public health and key partners and sectors – including emergency management, healthcare providers, community leaders, media, businesses, service providers for at-risk populations, and more. (Definition adapted from the National Disaster Recovery Framework).

Self-Sufficiency: Self-sufficiency refers to messages describing methods, tips, and strategies to assist members of the public focus on independence and self-reliance for health and well-being. Examples include: providing tips on self-care and staying safe and secure in one’s environment.

Service Restoration: Service restoration refers to re-establishment of a service offered by a public or private entity (e.g., electricity, access to a hospital or clinic, day care)

Shelter Information: Shelter information is content describing the pertinent features and characteristics (location, access/transportation, services offered, etc.) of one or more congregate locations that houses, feeds and provides basic services to individuals in need in the context of a disaster or other emergency.

Vector Safety: Vector safety is an activity focused on the prevention of illness, exposure, and/or death in humans due to an organism (e.g., ticks, mosquitoes) that transmits a pathogen (e.g., virus, bacteria, parasite)

Volunteer Information: Volunteer information is content distributed and/or posted to solicit individuals who voluntarily undertake or render a service.

3. Emergency Operations Coordination

Introduction

Emergency Operations Coordination (EOC) is required to direct and coordinate the implementation of other public health preparedness capabilities, and is therefore critical to public health emergency preparedness and response. As part of the Incident Management (IM) concept, EOC allows public health agencies to make informed, timely, and effective decisions that direct resources and personnel to adaptively address ongoing and evolving health needs arising from emergencies.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Conduct preliminary assessment to determine need for public activation
2. Activate public health emergency operations
3. Develop incident response strategy
4. Manage and sustain the public health response
5. Demobilize and evaluate public health emergency operations

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4	Function 5
PHEP 3.1		●			
PHEP 3.2			●		
PHEP 3.3					●

PHEP 3.1: Staff Assembly

Time for **pre-identified staff** covering activated public health agency **incident** management lead roles (or equivalent) to report for immediate duty

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: GPRA Measure
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start time: Date and time that a **designated official** began notifying staff to report for immediate duty to cover activated **incident management lead roles**

Stop time: Date and time that the last staff person notified to cover an activated incident management lead role reported for immediate duty



Why is this measure important?

To ensure a timely and effective response to an incident, awardees must demonstrate the ability to immediately assemble public health staff with senior incident management lead roles.

This performance measure is designed to capture the ability to assemble appropriate leadership staff, e.g., key decision-makers, to cover all of the activated incident management lead roles needed to lead and manage an agency’s response. It is *not* intended to measure an awardee’s ability to assemble all of their staff nor a deployment or strike team. In addition, this measure is *not* focused on the total number of staff assembled in comparison with the number of staff notified within a given time frame.



What other requirements are there for reporting measure data?

All awardees are required to submit self-reported data for this measure. Awardees may report data from multiple exercises and/or incidents. However,

awardees are required to report data from their health department on their one best demonstration of a **staff assembly** that occurred during the budget period. The demonstration must have occurred during one of the following:

- **Drill**
- **Functional exercise**
- **Full-scale exercise**
- Incident
- Planned event

Staff assembly must be both **unannounced** and **immediate**.



What data must be reported?

1. Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management lead roles (Start time)
2. Date and time that the last staff person notified to cover an activated incident management lead role reported for immediate duty (Stop time)

For each unannounced and immediate staff assembly being reported:

3. Was the staff assembly part of a ... : [Select one]
 - Drill
 - Functional exercise
 - Full-scale exercise
 - Incident
 - Planned event





CAPABILITY 3

4. Please provide the name and date of the incident/planned event/exercise [Text box]
5. If reporting data from a incident: What was the **incident type**: [Select one]
 - Type 4
 - Type 3
 - Type 2
 - Type 1
6. Was the staff assembly unannounced? [Yes/No]
7. Did the staff assembly occur **outside of normal business hours**? [Yes/No]
8. Notification method(s) used: [Select all that apply]
 - Cell phone
 - Email outside of rapid notification system
 - Rapid notification system (e.g., HAN)
 - Land-line telephone
 - Pager
 - Satellite communication system
 - Other, please specify: [Text Box]
9. **Acknowledgement** method(s) used by staff: [Select all that apply]
 - Cell phone
 - Email outside of rapid notification system
 - Rapid notification system (e.g., HAN)
 - Land-line telephone
 - Pager
 - Satellite communication system
 - Other, please specify: [Text Box]
10. Was the staff assembly immediate? [Yes/No]
11. Type of incident or event/incident upon which exercise scenario was based [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane / Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
12. Was staff assembly virtual, physical, or a combination? [Select one]
 - Virtual
 - Physical
 - Combination
13. Was the **DOC** activated? [Yes/No]
14. IM lead roles (or equivalent lead roles) activated at the time of initial notification: [Select all that apply]
 - Incident commander
 - Public information Officer
 - Safety officer
 - Liaison officer
 - Operations section chief
 - Planning section chief
 - Logistics section chief
 - Finance/Administration section chief
 - Additional lead roles, please specify: [Text Box]
15. Number of staff notified to cover activated IM lead roles (must be greater than zero)
16. Date and time that the last staff person needed to cover an activated IM lead role acknowledged notification.
17. Number of staff who reported for duty to cover activated IM lead roles (must be greater than zero)
18. Were all of the activated IM lead roles (see response to question # 14) covered by those staff who reported for duty (see response to question #17)?
19. Does this exercise or incident represent the best demonstration of your agency's staff assembly capability? [Yes/No]
20. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of a staff assembly: [Select one]
 - Context of the public health response – Potential for substantial public health impact
 - Incident
 - Agency was **acting in a lead role** or was **acting in an assisting role**
 - Complexity of the demonstration/response – scale of the demonstration / response required staffing all or most of the IM lead roles





CAPABILITY 3

- Multiple partners in a coordinated demonstration/response
- Duration of the demonstration/response
- Required the mobilization of resources outside of the affected area
- Quickest time
- Only example/demonstration available
- Other, please specify: [Text Box]

21. Was this your quickest time? [Yes/No]
22. Total number of operations-based exercises (drill, FE or FSE only) testing staff assembly conducted
 - a. Number of operations-based exercises testing unannounced and immediate staff assembly
23. Total number of incidents involving staff assembly that occurred
 - a. Number of incidents involving unannounced and immediate staff assembly



How is this measure operationalized?

Incident management lead role: For the purposes of reporting data for this performance measure, the generic term “incident management lead role” refers to senior ICS functions or roles in an awardee health department including the command and general staff (i.e., Operations Section Chief, PIO, etc.). Not all lead roles may be activated for a given response; also it is possible that agencies will use different titles for equivalent roles. Awardees may not report notification or assembly of staff at other agencies, including LHDs.

Up-to-date contact list for pre-identified staff: Since rapid notification of staff depends on maintaining accurate contact information for pre-identified staff, awardees should keep a complete list of contact information for all public health personnel with IM lead responsibilities. Awardees should update this list at least once every six months, and record the date of each update.



PHEP 3.2: IAP

Production of the approved Incident Action Plan (IAP) before the start of the second operational period

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input checked="" type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Was a written IAP approved before the start of the second operational period? [Yes/No]

- Incident
- Planned event

The exercise or incident must include the following characteristics:



Why is this measure important?

To ensure a timely and effective response, awardees must engage in sound, timely planning during the response to guide the incident management decision process. A critical component of this planning is the ability to produce an approved IAP for each operational period.

- The exercise scenario or incident continues over two or more operational periods;
- Command and General staff sections (not necessarily all) are activated; and
- The IAP is comprised of the following components:
 - ICS Form 202 - “**Incident objective**”;
 - ICS Form 203 - “**Organization assignment list**”;
 - ICS Form 204 - “**Assignment List**” and
 - ICS Form 215a - “**Hazard risk analysis**” or equivalent documentation.

This is a binary measure in which time is judged relative to the beginning of the second operational period. While it is recognized that the quality of an IAP is variable and dependent on many different attributes, the intent of this performance measure does not include assessment of the quality of an IAP for a given response.



What other requirements are there for reporting measure data?

Awardees are encouraged to report data from multiple incidents and exercises. However, awardees are required to report data on their one best demonstration of a written IAP that occurred during the BP. The demonstration must have occurred during one of the following:

- Drill
- Functional exercise
- Full-Scale exercise



What data must be reported?

1. Was a written IAP approved before the start of the second operational period? [Yes/No] (measure)

For each written IAP being reported:

2. Did you have any operations-based exercises or incidents resulting in the production of a written IAP? [Yes/No]
3. Was the IAP produced during a drill, functional exercise, full-scale exercise, incident, or planned event? [Select one]
 - Drill
 - Functional exercise
 - Full-scale exercise
 - Incident





- Planned event
- 4. Please provide the name and date of the incident/planned event/exercise [Text box]
- 5. What was the complexity of the simulated or incident at the time that the IAP was written? [Select one]
 - Type 4
 - Type 3
 - Type 2
 - Type 1
- 6. The type of incident/exercise/planned event: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane / Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
- 7. Number of federal and **state agencies** involved in the exercise or incident. (Include your health department if awardee is a state agency)
- 8. Number of **local** and **tribal agencies** involved in the exercise or incident. (Include your health department if awardee is a directly-funded locality)
- 9. Did your agency act in a lead or assisting role? [Select one of the following]
- 10. Did you partner with any other public, private or voluntary sector agencies during this exercise or incident? [Select all that apply]
 - Yes - Private sector
 - Yes - Public sector
 - Yes - Voluntary sector
 - No
 - a. If responded Yes – Private Sector:
 - i. What was the total number of **private sector partners**?
 - b. If responded Yes – Public Sector:
 - i. What was the total number of **public sector partners**?
 - c. If responded Yes – Voluntary Sector:
 - i. What was the total number of **voluntary sector partners**?
- 11. Did the IAP include “Incident Objectives” documented on ICS Form 202 or equivalent documentation? [Yes/No]
- 12. Did the IAP include an “Organization Assignment List” on ICS Form 203 or equivalent documentation? [Yes/No]
- 13. Did the IAP include an “Assignment List” on ICS Form 204 or equivalent documentation? [Yes/No]
- 14. Did the IAP include a “Hazard Risk Analysis”? [Yes/No]
- 15. IM lead roles (or equivalent) activated during the first operational period: [Select all that apply]
 - IC
 - PIO
 - Safety officer
 - Liaison officer
 - Operations section chief
 - Planning section chief
 - Logistics section chief
 - Finance/administration section chief
 - Additional lead roles, please specify: [Text Box]
- 16. Number of staff who covered activated IM lead roles during the first operational period. (must be greater than zero)
- 17. Does this exercise or incident represent the best demonstration of your agency’s capability to complete a written IAP? [Yes/No]
- 18. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of a written IAP. [Select one]
 - Context of the public health response – Potential for substantial public health impact
 - Incident
 - Agency was acting in a lead role
 - Complexity of the demonstration/response (incident type) – scale of the demonstration/response required staffing all or most IM lead roles
 - Multiple partners in a coordinated demonstration/response
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time



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- Only example/demonstration available
- Other, please specify: [Text Box]
- 19. Total number of operations-based exercises (drill, FE, or FSE only) conducted that extended two or more operational periods during which a written IAP was produced
 - a. Total number of operations-based exercises (drill, FE, or FSE only) during which a written IAP was produced before the second operational period
- 20. Total number of incidents extending two or more operational periods during which a written IAP was produced during the BP
 - a. Total number of incidents during which a written IAP was completed before the second operational period



How is this measure operationalized?

Descriptions and templates for the ICS Forms can be found in NIMS, available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf



PHEP 3.3: AAR and IP

Time to complete a draft of an **After Action Report (AAR) and Improvement Plan (IP)**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: HP2020 Measure
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start time: Date exercise or public health emergency operations completed

Stop time: Date the draft AAR and IP were submitted for **clearance** within the public health agency



Why is this measure important?

Through the use of after-action reporting and improvement planning, awardees must demonstrate the capability to analyze real or simulated response actions, describe needed improvements, and prepare a plan for making improvements within an acceptable timeframe.



What other requirements are there for reporting measure data?

Awardees are encouraged to report data from multiple incidents and exercises. However, awardees are required to report data on their one best demonstration of an AAR and IP drafted during the budget period. This AAR and IP must have been drafted as a result of one of the following:

- **Tabletop exercise**
- Drill
- Functional exercise
- Full-scale exercise
- Incident
- Planned event

While the exercise, planned event, or incident can have occurred either prior to or during the budget

period, the AAR and IP submission date must fall within the budget period.



What data must be reported?

1. Date exercise or public health emergency operations completed (Start time)
2. Date the draft AAR and IP were submitted for clearance within the public health agency (Stop time)

For each example of the completion of a draft AAR and IP being reported:

3. Was the AAR and IP the result of a tabletop exercise, drill, functional exercise, full-scale exercise, incident, or planned event? [Select one]
 - Tabletop exercise
 - Drill
 - Functional exercise
 - Full-scale exercise
 - Incident
 - Planned event
4. Please provide the name and date of the incident/planned event/exercise [Text box]
5. If reporting data from a incident: what was the incident type: [Select one]
 - Type 4
 - Type 3
 - Type 2
 - Type 1
6. The type of incident/exercise/planned event: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding



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- Earthquake
 - Hurricane / Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
7. Number of federal and state agencies involved in the exercise or incident. (Include your health department if awardee is a state agency)
 8. Number of local and tribal agencies involved in the exercise or incident. (Include your health department if awardee is a directly-funded locality)
 9. Did your agency act in a lead or an assisting role? [Select one of the following]
 10. Did you partner with any other public, private, or voluntary sector agencies during this exercise or incident? [Select all that apply]
 - Yes - Private sector
 - Yes - Public sector
 - Yes - Voluntary sector
 - No
 - a. If responded Yes – Private Sector:
 - i. What was the total number of **private sector partners**?
 - b. If responded Yes – Public Sector:
 - ii. What was the total number of **public sector partners**?
 - c. If responded Yes – Voluntary Sector:
 - iii. What was the total number of **voluntary sector partners**?
 11. Date AAR and IP were approved by the public health agency
 12. Does this exercise or incident represent the best demonstration of your agency’s capability to complete an AAR and IP? [Yes/No]
 13. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of the completion of an AAR and IP [Select one]
 - Context of the public health response – potential for substantial public health impact
 - Incident
 - Agency was the lead responder
 - Complexity of the demonstration/response – Scale of the demonstration/response required staffing all or most of the incident management lead roles
 - Multiple partners in a coordinated demonstration/response
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/demonstration available
 - Other, please specify: [Text Box]
 14. Was this your quickest time? [Yes/No]
 15. Total number of exercises (TTX, drill, FE or FSE only) that resulted in the completion of a draft AAR and IP between 07/01/2012 and 06/30/2013
 16. Total number of incidents that resulted in the completion of a draft of an AAR and IP between 07/01/2012 and 06/30/2013



How is this measure operationalized?

Not applicable



Pre-Incident

Core Public Health

Response

Key Measurement Terms

Acknowledgement: Acknowledgment is when notified staff confirms receipt of notification to designated official. Examples of acknowledgement methods include email, Health Alert Network (HAN), or cell phone. Acknowledgement methods may differ from notification methods used.

Acting in an assisting role: Acting in an assisting role is when during some exercises or incidents, more than one agency may be required to respond. When the public health agency supports another agency in the response and / or recovery from an incident, either simulated or real, but is not responsible for the overall coordination of responding agencies and resources, the public health agency is considered to act in an assisting role during the response. For example, *if the awardee participated in an exercise led by the state emergency management agency, and the awardee had responsibility for drafting either its own AAR and IP or a portion of a larger AAR and IP for the entire exercise, the public health agency's draft AAR and IP (or portion drafted by the public health agency) can be reported for this measure.*

Acting in a lead role: Acting in a leading role is when the public health agency assumes primary responsibility for managing the response and recovery to an incident, either simulated or real, including the coordination of resources in order to respond to an incident in an efficient manner, the public health agency is acting in a lead role.

After Action Report (AAR) and Improvement Plan (IP): After action reporting and improvement plan is the main product of the evaluation and improvement planning process, consisting of two components. The AAR captures observations of an exercise and makes recommendations for post-incident or post-exercise improvements. The IP identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion. The report should include how response operations did and did not meet objectives, recommendations for correcting gaps or weaknesses, and a plan for improving response operations (NIMS, Aug 2007). The AAR and IP are the units that define a single exercise, regardless of how many political jurisdictions were involved in the exercise.

Clearance: Clearance is the process (whether formal or informal) that the public health agency uses to approve and finalize AAR and IPs. "Clearance" depends on accepted practice in the public health agency. It does not have to be a formalized process involving upper level management. For example, submission for review of the AAR and IP to an exercise director or emergency preparedness director would count as clearance as long as there is a written AAR and IP and documentation of the date that person receives the AAR and IP. In this example, the stop time for this measure would be when the AAR and IP draft was submitted to the exercise director or preparedness director. If the person who clears the AAR and IP draft is the same person who drafts it, then the stop time is the time at which that person determines that the AAR and IP draft is complete.

Department Operations Center (DOC): A Department Operations Center is an emergency operations center specific to a single department or agency. The focus is on internal agency incident management and response. A DOC is often linked to and, in most cases, physically represented in a combined agency EOC by authorized agent(s) for the department or agency (NIMS, Aug 2007).

Designated official: The designated official is any individual in the health department who has the authority to take the necessary action (e.g., decide to activate incident management roles).

Division/group assignment list: A division/group assignment list provides a description of the specific actions that assigned personnel will be taking in support of the overall incident objectives. This list is based on the organizational structure of the Operations Section for the operational period and is documented using Form ICS 204 or equivalent. Further information and guidance on incident objectives is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf (NIMS, December 2008).

Drill: A drill is a coordinated, supervised activity usually employed to test a single specific operation or function in a single agency. Drills are commonly used to provide training on new equipment, develop or test new policies or procedures, or practice and maintain current skills. Drills are considered operations-based exercises.

Federal agencies: Federal agencies include all federal governmental agencies.

Full-scale exercise (FSE): A full-scale exercise is a multi-agency, multi-jurisdictional activity involving actual deployment of resources in a coordinated response as if an incident had occurred. An FSE tests many components of one or more capabilities within emergency response and recovery, and is typically used to assess plans, procedures, and coordinated response under crisis conditions. Characteristics of an FSE include mobilized units, personnel, and equipment; a stressful, realistic environment; and scripted exercise scenarios. FSEs are considered operations-based exercises.

Functional exercise (FE): A functional exercise is a single or multi-agency activity designed to evaluate capabilities and multiple functions using a simulated response. An FE is typically used to: evaluate the management of Emergency Operations Centers (aka DOCs), command posts, and headquarters; and assess the adequacy of response plans and resources. Characteristics of an FE include simulated deployment of resources and personnel, rapid problem solving, and a highly stressful environment. FEs are considered operations-based exercises

Hazard risk analysis: A hazard risk analysis communicates safety and health issues for emergency responders for a given incident / event by the Safety Officer and identifies mitigation measures to address those issues (NIMS, 2008). Detailed information is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf.

Immediate: Immediate means performed with no delay. There is the expectation that upon receipt of notification the pre-identified staff is to report for duty within 60 minutes.

Incident: An incident is any natural or manmade occurrence that negatively affects or can potentially negatively affect public health. The incident does not need to be a declared emergency.

Incident Action Plan (IAP): An incident action plan is a plan containing general objectives reflecting the overall response strategy for managing an incident. It may include identification of operational resources and assignments, as well as attachments that provide direction and important information for management of the incident during one or more operational periods (NIMS, 2008). Additional information and guidance is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf.

Approved Incident Action Plan: An approved incident action plan is a plan the Incident Commander has signed and dated (including the time) the IAP

Incident management lead roles: Incident management lead roles refers to the Command Staff (Incident Commander, Public Information Officer, Safety Officer, Liaison Officer) required to support the command function in an incident and General Staff (Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance / Administration Section Chief), or their equivalent titles and/or roles, in an awardee health department. Not all lead roles may be activated for a given response.

As stated by NIMS (December 2008):

“Incident management, by distinction, includes directing specific incident operations; acquiring, coordinating and delivering resources to incident sites; and sharing information about the incident with the public Overall management includes Command Staff assignments required to support the command function The General Staff is responsible for the functional aspects of the incident command structure.”

Note: The level of complexity of an incident will direct the activation of certain IM lead roles. In certain scenarios, IM staff may cover more than one role at a time.

IM lead roles include personnel required to manage the incident such as:

- Incident commander (IC) – has overall IM responsibility including developing incident objectives on which subsequent incident action planning will be based, approve the IAP, and all requests pertaining to ordering and releasing incident resources.
- Public information officer (PIO) – responsible for communicating with the media, public and other agencies with incident-related information needs.
- Safety officer – monitors operations and advises the IC on all matters relating to operational safety, including the health and safety of public health responders.



- Liaison officer – designated point of contact for representatives of other governmental agencies, nongovernmental organizations and private organizations to provide input on their agency’s policies, resource availability, and other incident-related topics.
- Additional command staff – Depending on the nature and location(s) of the incident or specific requirements established by IC, additional command staff positions may be necessary. For example, a medical advisor may be required to provide advice and recommendations to the IC about medical and mental health services, mass casualty, acute care, vector control, epidemiology, or mass prophylaxis considerations.
- Operations section chief – Responsibilities include the direct management of all tactical activities.
- Planning section chief – Responsible for the collection, evaluation and dissemination of incident situation information and intelligence to the IM personnel.
- Logistics section chief – Responsible for all service support requirements needed to facilitate an effective and efficient response including, but not limited to, providing facilities, transportation, supplies, and equipment.
- Finance / administration section chief – Established when the IM activities require on-scene or incident-specific finance and other administrative support services. Some of the functions and responsibilities include recording personnel time, maintaining vendor contracts, administering compensation and claims, and conducting an overall cost analysis for the incident.

It is possible that an agency may use different titles for equivalent lead roles (e.g., Chief Science Officer). Detailed description about the responsibilities for each of these roles is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf (NIMS, December 2008).

Incident objectives: Incident objectives are statements of guidance and direction necessary for the selection of appropriate strategy, and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow for strategic and tactical alternatives. Incident objectives are the first page of an IAP (ICS Form 202 or equivalent documentation). Further information and guidance on incident objectives is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf (NIMS, 2008).

Incident type: Incident types characterize the complexity of an incident. For reporting purposes, please choose one of the incident types defined below that best describes the exercise/incident being reported. This applies even if an awardee agency uses a different incident complexity scale.

- Type 4 incidents are characterized as follows:
 - Command staff and general staff lead functions are activated only if needed;
 - Several resources (e.g., task force or strike team) are required to mitigate the incident;
 - Usually limited to one operational period in the control phase;
 - Agency administrator may have briefings, and ensure the complexity analysis and delegation of authority are updated; and
 - The role of the agency administrator/official includes completing the operational plans, including objectives and priorities.
- Type 3 incidents are characterized as follows:
 - Some or all of the Command and General staff lead positions may be activated, as well as Division/Group Supervisor and/or Unit Leader level positions;
 - An Incident Management Team (IMT) or incident command organization manages initial action incidents with a significant number of resources; and
 - The incident may extend into multiple operational periods.
- Type 2 incidents are characterized as follows:
 - May require the response of resources out of area, including regional and/or national resources to effectively manage the operations and command and general staffing;
 - Most or all of the Command and General Staff positions are filled;
 - Many of the functional units are needed and staffed;



- The incident is expected to go into multiple operational periods; and
- The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority.
- Type 1 incidents are the most complex and are characterized as follows:
 - Requires national resources to safely and effectively manage and operate;
 - All of the Command and General staff lead positions are activated;
 - Branches need to be established;
 - The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority;
 - Use of resource advisors at the incident base is recommended; and
 - There is a high impact on the local jurisdiction, requiring additional staff for office administrative and support functions.

For counting purposes, a Type 5 incident should not be included since it does not require a written IAP and usually has only one operational period. Additional information on incident types is available from the Federal Emergency Management Agency (FEMA) at <http://www.training.fema.gov/EMIWeb/IS/ICSResource/assets/IncidentTypes.pdf>

Local agencies: Local agencies include all local governmental agencies (e.g., city/county).

Operational period: An operational period is the established time scheduled for executing a given set of operation actions, as specified in the IAP. Operational periods can be of various lengths, although usually they last 12-24 hours. The responsibility for establishing the length of time for each operational period rests with Incident Command for each agency. (NIMS, 2008) Additional information and guidance is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

Note: If data are being reported for an exercise, the second operational period may be simulated.

Organization assignment list: An organization assignment list provides a full accounting of incident management and supervisory staff during a given operational period and is a component of the IAP. This list is typically the second page of the IAP using ICS Form 203 or equivalent documentation. Further information and guidance on the organization assignment list is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf (NIMS, 2008).

Pre-identified staff: Pre-identified staff is staff selected in advance of an incident through to fill the incident management roles adequate to a given response. Contact information for public health staff members with incident management roles is maintained on an up-to-date list.

Private sector partners: Private sector partners are non-governmental agencies run by private individuals or groups, usually as a means of enterprise for profit, and not controlled by the state (e.g., businesses, hospitals, media, private universities).

Production of IAP: Production of IAP signifies that the written IAP is completed and approved before the second operational period, including date and time or approval. For the purposes of this measure, the IAP is comprised of the following components: ICS Form 202 – “Incident Objectives”, ICS Form 203 – “Organization Assignment List” and ICS Form 204 – “Division / Group Assignment List”, or equivalent documentation.

Public sector partners: Public sector partners are departments, agencies and other entities controlled by federal, state, local, tribal or territorial governments. These can include non-public health agencies in areas such as agricultural, education, emergency management, Emergency Medical Services (EMS), environmental health, fire department, HHS Indian Health Services, law enforcement, National Guard, etc.

Staff assembly: Staff assembly can occur at a physical location (e.g., DOC), virtual location (e.g., web-based interface such as Web EOC, conference call), or combination of both.

State agencies: State agencies include all state governmental agencies.

Tabletop Exercise (TTX): Table top exercises are intended to stimulate discussion of various issues regarding a hypothetical situation. They can be used to assess plans, policies, and procedures or to assess types of systems



CAPABILITY 3

needed to guide the prevention of, response to, or recovery from a defined incident. During a TTX, senior staff, elected or appointed officials, or other key personnel meet in an informal setting to discuss simulated situations. TTXs are typically aimed at facilitating understanding of concepts, identifying strengths and shortfalls, and/or achieving a change in attitude. Participants are encouraged to discuss issues in depth and develop decisions through slow-paced problem-solving rather than the rapid, spontaneous decision-making that occurs under actual or simulated emergency conditions. TTXs can be breakout (i.e. groups split into functional areas) or plenary (i.e. one large group). *Data from tabletop exercises may only be reported for the EOC – AAR and IP performance measure.*

Tribal agencies: Tribal agencies include all tribal governmental agencies.

Outside of normal business hours: Outside of business hours are those hours not included during which most business is conducted (other than working hours).

Unannounced: Unannounced means without advanced warning or notice.

Voluntary sector partners: Voluntary sector partners are non-profit, non-governmental agencies formed to serve some public or mutual benefit. These partners usually fall into one of five categories: foundations, charities, religious organizations, professional or trade organizations, and social welfare organizations (e.g., American Red Cross, community foundations, American Medical Association, churches).

4. Emergency Public Information and Warning

Introduction

Emergency Public Information and Warning (EPIW) is a term used by CDC to describe communications with the public during an emergency. EPIW is closely related to routine risk communication in that its purpose is to provide information to the public to reduce uncertainty and inform decision making. However, the emergency conditions under which messages must be developed and disseminated impose much tighter time constraints than are generally faced during routine operations.

EPIW represents a critical leverage point in shaping the perceptions, decisions, and actions of the public, who are a key partner in preventing, preparing for, responding to, and recovering from public health emergencies. Public involvement and cooperation are required to facilitate response activities such as evacuation, sheltering in place, social distancing, and queuing at points of dispensing. EPIW can be effective in influencing how the public responds to these activities.

Note: EPIW is distinguished from tactical communication, which involves communication among responders, as well as other types of information sharing. For more information on EPIW, including training curricula and tools, go to <http://emergency.cdc.gov/cerc/index.asp>



Capability Functions

This capability consists of the ability to perform the following functions:

1. **Activate the emergency public information system**
2. **Determine the need for a joint public information system**
3. **Establish and participate in information system operations**
4. **Establish avenues for public interaction and information exchange**
5. **Issue public information, alerts, warnings, and notifications**

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4	Function 5
PHEP 4.1					●

PHEP 4.1: Public Message Dissemination

Time to **issue** a risk communication message for dissemination to the public

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: HP2020 Measure
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start time: Date and time that a **designated official** requested that the first risk communication message be developed

Stop time: Date and time that a designated official approved the first risk communication message for dissemination

and dissemination of a risk communication message that occurred during the budget period. This demonstration must have occurred during one of the following:

- **Drill**
- **Functional exercise**
- **Full-scale exercise**
- Incident
- Planned event



Why is this measure important?

To inform decision making by the public and reduce uncertainty before, during, and after a public health emergency, awardees must demonstrate the ability to develop, coordinate, and disseminate timely information to the public about the public health emergency.

It is critical that a public health agency be able to disseminate the first risk communication message to the public during a public health emergency to ensure that the public is first made aware of the **incident** and necessary actions in a timely manner and from a credible source (see <http://emergency.cdc.gov/cerc/pdf/CERC-SEPT02.pdf> for additional information).

This performance measure pertains specifically to the first EPIW message disseminated in the context of an emergency. The focus is on the first measure because research has shown that the first message is critical as it sets the stage for comparison of all subsequent messages on a topic.



What other requirements are there for reporting measure data?

Awardees are encouraged to report data from multiple incidents and exercises. However, awardees are required to report data from their health department on their one best demonstration of the development



What data must be reported?

1. Date and time that a designated official requested that the first risk communication message be developed (Start time)
2. Date and time that a designated official approved the first risk communication message for dissemination (Stop time)

For each example of the development of a risk communication message for dissemination to the public being reported:

3. Was the message dissemination part of a drill, FE, FSE or incident? [Select one]
 - Drill
 - Functional exercise
 - Full-scale exercise





CAPABILITY 4

- Incident
- Planned event
- 4. Please provide the name and date of the incident/planned event/exercise [Text box]
- 5. If reporting data from a incident: What was the **incident type** when the first message was approved for dissemination: [Select one]
 - Type 4
 - Type 3
 - Type 2
 - Type 1
- 6. The type of incident/exercise/planned event: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane / Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
- 7. Number of **federal** and **state agencies** involved in the exercise or incident. (Include your health department if awardee is a state agency)
- 8. Number of **local** or **tribal agencies** involved in the exercise or incident. (Include your health department if awardee is a directly-funded locality)
- 9. Did your agency act in a **lead role** or an **assisting role**? [Select one of the following]
- 10. Did you partner with any other private, public, or voluntary sector agencies during this exercise or incident? [Select all that apply]
 - Yes - Private sector
 - Yes - Public sector
 - Yes - Voluntary sector
 - No
 - a. If responded Yes – Private Sector:
 - i. What was the total number of **private sector partners**?
 - b. If responded Yes – Public Sector:
 - i. What was the total number of **public sector partners**?
 - c. If responded Yes – Voluntary Sector:
 - i. What was the total number of **voluntary sector partners**?
- 11. Was the message developed from a pre-drafted template? [Yes/No]
- 12. Was the message written either at or below a 6th grade reading level? [Yes/No/Not Assessed]
- 13. Who was the intended audience of the message? (**General population**, Population(s) with **special needs** – specify)
- 14. In which language(s) was the message developed? [List all]
- 15. Who was the immediate recipient of the approved message? [Select all that apply]
 - Clearance or dissemination authority beyond the public health agency Flooding
 - Dissemination Partner – Specify: [Text box]
 - Public Information Line
 - Public Information Website
 - Other – Please Specify: [Text box]
- 16. If reporting data from a incident: approximate date and time the message was disseminated to the public.
- 17. Does this exercise or incident represent the best demonstration of your agency’s capability to develop an EPIW message? [Yes/No]
- 18. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of the development of a risk communication message for dissemination to the public. [Select one]
 - Context of the Public Health Response – Potential for substantial public health impact
 - Incident
 - Agency was the lead responder
 - Complexity of the demonstration/response – Scale of the demonstration/response required staffing all or most of the incident management lead roles
 - Multiple partners in a coordinated demonstration/response
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/- demonstration available
 - Other, please specify: [Text Box]
- 19. Was this your quickest time? [Yes/No]



Pre-Incident

Core Public Health

Response



CAPABILITY 4

- 20. Total number of operations-based exercises (drill, FE or FSE only) occurring that tested the process of risk communication message dissemination to the public
- 21. Total number of incidents occurring that involved risk communication message dissemination to the public



How is this measure operationalized?

This measure pertains specifically to the first EPIW message released in the context of an emergency.



Pre-Incident

Core Public Health

Response

Key Measurement Terms

Acting in an assisting role: Acting in an assisting role is when during some exercises or incidents, more than one agency may be required to respond. When the public health agency is supporting another agency in the response and / or recovery to an incident, either simulated or real, but not responsible for the coordination of all responding agencies and resources, the public health agency is acting in an assisting role during the response.

Acting in a lead role: Acting in a lead role is when the public health agency assumes primary responsibility for managing the response and recovery to an incident, either simulated or real, including the coordination of resources in order to respond to an incident in an efficient manner, the public health agency is acting in a lead role. For example, if the awardee participated in an exercise led by the State emergency management agency, and the awardee had responsibility for drafting either its own risk communication message on the public-health related aspects of the scenario (lead role) or a portion of a broader risk communication message (assisting role), the public health agency can report either

Designated official: A designated official is any individual in the public health agency who has the authority to take necessary action (e.g., approve a message). A designated official may be a Public Information Officer, an Incident Commander, or any other individual with such authority.

Dissemination partner: A designated partner is news media, commercial partners, community partners, or other organizations that partner with the public health agency to release crisis and emergency risk communication messages to the public.

Drill: A drill is a coordinated, supervised activity usually employed to test a single specific operation or function in a single agency. Drills are commonly used to provide training on new equipment, develop or test new policies or procedures, or practice and maintain current skills. Drills are considered operations-based exercises.

Federal agencies: Federal agencies include all federal governmental agencies (e.g., CDC).

Full-scale exercise (FSE): A full-scale exercise is a multi-agency, multi-jurisdictional activity involving actual deployment of resources in a coordinated response as if an incident had occurred. An FSE tests many components of one or more capabilities within emergency response and recovery, and is typically used to assess plans, procedures, and coordinated response under crisis conditions. Characteristics of an FSE include mobilized units, personnel, and equipment; a stressful, realistic environment; and scripted exercise scenarios. FSEs are considered operations-based exercises.

Functional exercise (FE): A functional exercise is a single or multi-agency activity designed to evaluate capabilities and multiple functions using a simulated response. An FE is typically used to: evaluate the management of Emergency Operations Centers, command posts, and headquarters; and assess the adequacy of response plans and resources. Characteristics of an FE include simulated deployment of resources and personnel, rapid problem solving, and a highly stressful environment. FEs are considered operations-based exercises.

General population: The general population is the entire population within the jurisdiction, that is, all population subgroups.

Immediate Recipient: An immediate recipient is the immediate recipient refers to the first group(s) to receive a message approved within the health department prior to dissemination. For example, if an agency is required to receive clearance approval of a message from an authority outside of the public health department (e.g., governor's office) prior to dissemination, then the immediate recipient of the message would be "clearance or dissemination authority beyond the public health agency". However, if an agency releases a message approved for clearance by the health department to a news media outlet, then the immediate recipient is "Dissemination partner". Likewise, if an agency sends a message approved for clearance by the health department to an established call center or hotline for dissemination, then the immediate recipient is "Public information line".

Incident: An incident is any natural or manmade occurrence that negatively affects or can potentially negatively affect public health. The incident does not need to be a declared emergency.

Incident type: The incident type characterizes the complexity of an incident. For reporting purposes, please choose one of the incident types defined below that best describes the exercise/incident being reported. This applies even if an awardee agency uses a different incident complexity scale.

- Type 4 incidents are characterized as follows:
 - Command staff and general staff lead functions are activated only if needed;
 - Several resources (e.g., task force or strike team) are required to mitigate the incident;
 - Usually limited to one operational period in the control phase;
 - Agency administrator may have briefings, and ensure the complexity analysis and delegation of authority are updated; and
 - The role of the agency administrator/official includes completing the operational plans, including objectives and priorities.
- Type 3 incidents are characterized as follows:
 - Some or all of the Command and General staff lead positions may be activated, as well as Division/Group Supervisor and/or Unit Leader level positions;
 - An Incident Management Team (IMT) or incident command organization manages initial action incidents with a significant number of resources; and
 - The incident may extend into multiple operational periods.
- Type 2 incidents are characterized as follows:
 - May require the response of resources out of area, including regional and/or national resources to effectively manage the operations and command and general staffing;
 - Most or all of the Command and General Staff positions are filled;
 - Many of the functional units are needed and staffed;
 - The incident is expected to go into multiple operational periods; and
 - The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority.
- Type 1 incidents are the most complex and are characterized as follows:
 - Requires national resources to safely and effectively manage and operate;
 - All of the Command and General staff lead positions are activated;
 - Branches need to be established;
 - The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority;
 - Use of resource advisors at the incident base is recommended; and
 - There is a high impact on the local jurisdiction, requiring additional staff for office administrative and support functions.

For counting purposes, a Type 5 incident should not be included since it does not require a written IAP and usually has only one operational period. Additional information on incident types is available from the Federal Emergency Management Agency (FEMA) at <http://www.training.fema.gov/EMIWeb/IS/ICSResource/assets/IncidentTypes.pdf>

Issue: Issues are, within the context of this measure, “issue” refers to distributing the approved message for the public to either the dissemination partners, the next level of authority beyond the public health agency for approval or dissemination, or directly to the public.

Local agencies: Local agencies include all local governmental agencies (e.g., city/county).

Method of delivery: The method of delivery is the media type used to disseminate the message to the public, e.g. website posting, press release, public information line fact sheet. Data collection for this element includes the following categories:

- Print media release refers to any communication that is disseminated through printed material such as newspapers, magazines, direct mail, signs and billboards.
- Radio



CAPABILITY 4

- Spokesperson refers to any message delivered through an appearance on Television news release, at a conference, community meeting, or any other in-person appearance (whether delivered by health department personnel, spokesperson, or news anchor).
- Web release refers to any publication or posting of a message on a public website.
- Other captures any alternative delivery method.

Populations with special needs: Populations with special needs includes those groups of individuals with specific needs including, but not limited to, people with disabilities, people with serious mental illness, the non-English speaking, children, and the elderly.

Private sector partners: Private sector partners are non-governmental agencies run by private individuals or groups, usually as a means of enterprise for profit, and is not controlled by the state (e.g., businesses, hospitals, media, universities, volunteer health professionals).

Public sector partners: Public sector partners are agencies controlled by national, state or provincial, and local governments (e.g., agricultural agency, education, emergency management, Emergency Medical Services, environmental agency, fire department, Indian Health Services, law enforcement, National Guard).

State agencies: State agencies include all state governmental agencies.

Tribal agencies: Tribal agencies include all tribal governmental agencies.

Voluntary sector partners: Voluntary sector partners include non-profit, non-governmental agencies formed to serve some public or mutual benefit. These partners usually fall into one of five categories: foundations, charities, religious organizations, professional or trade organizations, and social welfare organizations (e.g., American Red Cross, community foundations, American Medical Association, churches).

5. Fatality Management

Introduction

Fatality management refers to the recovery, handling, identification, transportation, tracking, storage and disposal of human remains, certifying cause of death, and facilitating access to mental/behavioral health services. Preparing for mass fatality incidents requires collaboration among a variety of agencies, including health departments, to help ensure a coordinated and thorough response.

The fatality management pre-incident process measure is designed to encourage health departments to collaborate with emergency management and other key partners to determine what role public health will play in managing fatalities. *It is understood that a health department’s role in this capability (i.e., from no role due to legislation/regulation to a supporting role in any number of the capability functions) will vary depending on the jurisdiction.* As long as a health department determines its role in conjunction with emergency management and other key partners, it has met the intent of this measure.



Capability Functions

This capability consists of the ability to perform the following functions:

1. **Determine role for public health in fatality management**
2. **Activate public health fatality management operations**
3. **Assist in the collection and dissemination of antemortem data**
4. **Participate in survivor mental/behavioral health services**
5. **Participate in fatality processing and storage operations**

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4	Function 5
PHEP 5.1	●				
PHEP 5.2	●				

PHEP 5.1: Identify Role with Partners (Awardee)

The awardee health department has defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors) [Yes/No]

Awardees should only report on this measure (PHEP 5.1) if public health-related support of fatality management is or will be a role carried out at the awardee level. If public health-related support of fatality management is an LHD responsibility, awardees should report on PHEP 5.2. If public health-related support of fatality management is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Identification of roles and responsibilities includes all of the following elements:

- Identify planning and/or response duties of public health and key partners
- Identify legal/regulatory authority governing fatality management in the jurisdiction (e.g., determining cause of death, identifying remains, family notification, burial permits)
- Identify critical pathways/trigger points/circumstances leading to public health response actions
- Sign an MOA/MOU/Mutual Aid Agreement (MAA)/contracts/letters of agreement to support fatality management activities in the jurisdiction if requested by fatality management lead
- Identify any legal waivers that would need to be in place in order to carry out public health's fatality management activities



Why is this measure important?

The immediate intent of this measure is to encourage public health agencies to coordinate with

leaders/officials who manage fatalities, as well as other jurisdictional partners, to develop a shared understanding of roles and responsibilities related to fatality management.

The broader programmatic intent of this measure is to ensure that key fatality management partners are able to effectively coordinate a mass fatality response, including determining cause of death, identifying human remains, collecting and communicating antemortem data, and providing access to mental/behavioral health services.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Which of the following elements have been addressed by the awardee health department as a part of pre-incident planning? [Select all that apply]
 - Identify planning and/or response duties of public health and key local partners



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- Identify legal/regulatory authority governing fatality management in the local jurisdiction (e.g., determining cause of death, identifying remains, family notification, burial permits)
 - Identify critical pathways/trigger points/circumstances leading to public health response actions
 - Sign an MOA/MOU/MAA/contracts/letters of agreement to support fatality management activities in the jurisdiction, if requested by fatality management lead
 - Identify any legal waivers that would need to be in place in order to carry out public health’s fatality management activities
2. Briefly describe key barriers to defining public health’s fatality management roles and responsibilities. [Text box]
 3. For state awardees only: Please describe how the awardee is coordinating or assisting LHDs in carrying out fatality management planning, if applicable. [Text box]

department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



How is this measure operationalized?

Key partners should be jointly determined by the awardee health department and emergency management/other appropriate partners.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health



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PHEP 5.2: Identify Role with Partners (LHDs)

Proportion of PHEP-funded LHDs that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (e.g., emergency management, coroners and medical examiners, and funeral directors)

Awardees should only report on this measure (PHEP 5.2) if public health-related support of fatality management is or will be a role carried out at the local level. If public health-related support of fatality management is an awardee health department responsibility, awardees should report on PHEP 5.1. If public health-related support of fatality management is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

*** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding**



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that have defined fatality management roles and responsibilities of public health in relation to those of key local partners

- Sign an MOA/MOU/MAA/contracts/letters of agreement to support fatality management activities in the jurisdiction
- Identify any legal waivers that would need to be in place in order to carry out public health's fatality management activities

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities

In order for an LHD to be included in the numerator for this measure, it must coordinate with emergency management, the coroner/medical examiner, and other appropriate partners to identify roles and responsibilities, which includes all of the following elements:

- Identify planning and/or response actions duties of public health and key local partners
- Identify legal/regulatory authority governing fatality management in the local jurisdiction (e.g., determining cause of death, identifying remains, family notification, burial permits)
- Identify critical pathways/trigger points/circumstances leading to public health response actions



Why is this measure important?

The immediate intent of this measure is to assess the extent to which local public health agencies coordinate with leaders/officials who manage fatalities, as well as other jurisdictional partners, to develop a shared understanding of roles and responsibilities related to fatality management.

The broader programmatic intent of this measure is to ensure that key local fatality management partners are able to effectively coordinate a mass fatality response, including determining cause of death, identifying human remains, collecting and communicating antemortem data, and providing access to mental/behavioral health services.





What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities (denominator)
2. Number of LHDs, receiving PHEP funds directly or through contracts, that have defined fatality management roles and responsibilities of public health in relation to those of key local partners (numerator)
3. For those LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities that have not addressed all five elements, please identify the *minimum* number that they have addressed.
4. For those LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities s that have not addressed all five elements, please identify the *maximum* number that they have addressed.
5. For those LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities that have not addressed all five elements, please identify the elements that are most frequently missing: [Select all that apply]
 - Identify planning and/or response duties of public health and key local partners
 - Identify legal/regulatory authority governing fatality management in the local jurisdiction (e.g., determining cause of death, identifying remains, family notification, burial permits)
 - Identify critical pathways/trigger points/circumstances leading to public health response actions
 - Sign an MOA/MOU/MAA/contracts/letters of agreement to support fatality management activities in the jurisdiction, if requested by fatality management lead
 - Identify any legal waivers that would need to be in place in order to carry out public health’s fatality management activities
6. Briefly describe successes cited by LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities in

defining fatality management roles and responsibilities. [Text box]

7. Briefly describe the most frequent barriers or challenges associated with LHDs that receive PHEP funds (directly or through contracts) to implement Fatality Management activities in defining fatality management roles and responsibilities. [Text box]



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for fatality management activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

Key local partners should be jointly determined by the LHD and emergency management/other appropriate partners.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.





Key Measurement Terms

There are currently no key measurement terms for the Fatality Management capability.

6. Information Sharing

Introduction

The Information Sharing capability refers to the exchange of information among federal, state, local, territorial and tribal governmental agencies and their key partners. Sharing information and maintaining situational awareness are essential for routine activities, as well as during an incident, so that leaders can make timely and informed decisions, including the appropriate allocation of resources.



The information sharing pre-incident process measure gauges the extent to which health departments can “push” basic epidemiological and/or clinical data to healthcare organization (HCOs) by determining whether points of contact, minimum sets of data elements, and processes to share data have been identified and communicated. The joint HPP-PHEP information sharing performance measure is designed to assess whether requests for information from the health and medical lead to local partners are fulfilled in a timely manner (this performance measure also covers the Medical Surge capability).

Capability Functions

This capability consists of the ability to perform the following functions:

1. **Identify stakeholders to be incorporated into information flow**
2. **Identify and develop rules and data elements for sharing**
3. **Exchange information to determine a common operating picture**

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3
PHEP 6.1	●		●
PHEP 6.2	●		●
HPP-PHEP 6.1			●

PHEP 6.1: Share Epidemiological/Clinical Data (Awardee)

The awardee health department can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs) [Yes/No]

Awardees should only report on this measure (PHEP 6.1) if public health-related support of information sharing is or will be a role carried out at the awardee level. If public health-related support of information sharing is an LHD responsibility, awardees should report on PHEP 6.2. If public health-related support of information sharing is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Sharing epidemiological/clinical data includes identifying all of the following elements:

- All relevant HCOs with which it plans to share data
- A position or specific point of contact for all relevant HCOs
- A minimum set of data elements that would need to be shared with relevant HCOs
- A platform or process to share data with relevant HCOs



Why is this measure important?

The immediate intent of this measure is to capture the extent to which awardee health departments know with which HCOs they would need to share data and have dedicated points of contact at these organizations. The measure is also designed to ensure that awardee health departments have pre-identified and communicated a minimum set of data elements, as well as processes they would use to share these data, with HCOs.

A broader programmatic aim is to ensure that relevant HCOs are able to receive basic epidemiological and/or clinical data they would need to make surge-related

decisions (e.g., patient diversions and changes in treatment modalities).



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Which of the following elements have been identified by the awardee health department as a part of pre-incident planning? [Select all that apply]
 - All relevant HCOs with which it plans to share data
 - A position or specific point of contact for all relevant HCOs
 - A minimum set of data elements that would need to be shared with relevant HCOs
 - A platform or process to share data with relevant HCOs
2. Please identify the types of HCOs identified: [Select all that apply]
 - Hospital(s)
 - Private provider(s)
 - Community clinic(s)





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- Long-term care facility(ies)
 - Occupational health center(s)
 - Healthcare coalition(s) (as stand-alone entities with response functions)
 - Other, please specify: [Text Box]
3. Please describe the types of data elements the awardee health department would share with HCOs. [Text box]
 4. Please describe the types of platforms/processes used to share data with HCOs. [Text box]

state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



How is this measure operationalized?

Health departments are encouraged to review their JRA or other relevant planning documents to determine the most common types of incidents expected in their jurisdiction. For these incidents:

- Health departments should determine relevant HCOs. Examples include hospitals, private providers, community clinics, long-term care facilities, healthcare coalitions with response functions, and occupational health.
- Health departments should determine the minimum set of data elements related to epidemiological and/or clinical data. Data elements may be all-hazard or scenario- or incident-specific. Examples of basic epidemiological data include information related to person, place and time. Examples of clinical data include acuity, unusual cases, co-morbidities, adverse events, and treatment modalities.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of



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PHEP 6.2: Share Epidemiological/Clinical Data (LHDs)

Proportion of PHEP-funded LHDs that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs)

Awardees should only report on this measure (PHEP 6.2) if public health-related support of information sharing is or will be a role carried out at the local level. If public health-related support of information sharing is an awardee health department responsibility, awardees should report on PHEP 6.1. If public health-related support of information sharing is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

* BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that can share basic epidemiological and/or clinical data with relevant healthcare organizations (HCOs)

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities

In order for a health department to fulfill this measure, it must have identified these four elements:

- All relevant HCOs with which it plans to share data
- A position or specific point of contact for all relevant HCOs
- A minimum set of data elements that would need to be shared with relevant HCOs
- A platform or process to share data with relevant HCOs



Why is this measure important?

The immediate intent of this measure is to ensure that LHDs know which HCOs they would need to share data with and have dedicated points of contact at these

organizations. Another immediate intent is to ensure that LHDs have pre-identified and communicated a minimum set of data elements, as well as the process they would use to share these data, with HCOs.

A broader programmatic aim is to ensure that relevant HCOs are receiving the basic epidemiological and/or clinical data they would need to make surge-related decisions (e.g., patient diversions and changes in treatment modalities).



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities (denominator)
2. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities that can share basic epidemiological and/or clinical data with relevant HCOs (numerator)
3. Please identify the types of HCOs identified: [Select all that apply]
 - Hospital(s)





- Private provider(s)
 - Community clinic(s)
 - Long-term care facility(ies)
 - Occupational health center(s)
 - Healthcare coalition(s) (as a stand-alone entity with response functions)
 - Other, please specify: [Text Box]
4. Please describe the types of data elements local health departments would share with HCOs. [Text box]
 5. Please describe the types of platforms/processes used to share data with HCOs. [Text box]
 6. For those LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities that have not addressed all four elements, please identify the *minimum* number that they have addressed. (Please see data element 8, below, for a list of the four elements)
 7. For those LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities that have not addressed all four elements, please identify the *maximum* number that they have addressed. (Please see data element 8, below, for a list of the four elements)
 8. For those LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities that have not addressed all four elements please identify the elements that are most frequently missing: [Select all that apply]
 - All relevant HCOs
 - A position or specific point of contact for all relevant HCOs
 - A minimum set of data elements that would need to be shared with relevant HCOs
 - A platform or process to share data with relevant HCOs
 9. Briefly describe successes cited by LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities in regards to sharing epidemiological and/or clinical data with HCOs. [Text box]
 10. Briefly describe the most frequent barriers or challenges experienced by LHDs that receive PHEP funds (directly or through contracts) to implement Information Sharing activities in sharing epidemiological and/or clinical data with HCOs. [Text box]



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for information sharing activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

LHDs are encouraged to review their JRA or other relevant planning documents to determine the most common types of incidents expected in their jurisdiction. For these incidents:

- LHDs should determine relevant HCOs. Examples include hospitals, private providers, community clinics, long-term care facilities, and occupational health.
- LHDs should determine the minimum set of data elements related to epidemiological and/or clinical data. Data elements may be all-hazard or scenario- or incident-specific. Examples of basic epidemiological data include information related to person, place and time as well as aggregate information such as case or exposure counts, and factors associated with illness, injury or exposure. Examples of clinical data include acuity, unusual cases, co-morbidities, adverse events, and treatment modalities.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and





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response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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HPP-PHEP 6.1: Information Sharing

Percent of **local partners** that reported requested **Essential Elements of Information (EEI)** to the health/medical lead within the **requested timeframe**

Measure Applies To :	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding *	<input checked="" type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: HPP and/or PHEP

** Mid-Year and End-of-Year Reporting Required in BP1, Irrespective of Funding*



How is the measure calculated?

Numerator: Number of local partners that reported requested EEI to the health/medical lead within the requested timeframe

Denominator: Number of local partners that received a request for EEI

- Reporting on 2 operational periods over at least 2 incidents, if possible
- Reporting on 2 operational periods from at least 2 exercises or planned events if no incidents.



What data must be reported?

For each incident/planned event/exercise reported on, please answer the following information:

1. Number of local partners that received a request for EEI (denominator)
2. Number of local partners that reported requested EEI to the health/medical lead within the requested timeframe (numerator)
3. The request for EEI occurred during a: [Select one]
 - Incident
 - Full scale exercise
 - Functional exercise
 - Drill
 - Planned event
4. Please identify the type of incident/exercise/planned event upon which the request for EEI was based: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane/tropical storm
 - Hazardous material



Why is this measure important?

The intent of this measure is to assess the extent to which local response entities communicate requested information to the health/medical lead in order to facilitate situational awareness and the effective management of resources in a timely manner.



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.
- Reporting for this measure is required annually.
- Reporting for this measure is required at mid-year and end-of-year for BP1.
- Awardees should report the numerator and denominator of this measure *by incident, planned event or exercise*.
- Reporting should be based on an incident (preferred) and/or planned events and exercises





- Fire
- Tornado
- Biological hazard or disease, please specify: [Text box]
- Radiation
- Other, please specify: [Text box]
- 5. Please provide the name and date of the incident/planned event/exercise [Text box]
- 6. Please state how many of each type(s) of local partners responded to the request:
 - HCOs
 - Healthcare coalitions
 - LHDs
 - Other, please specify: [Text box]
- 7. Please identify the requesting entity (e.g., health/medical lead at the state, sub-state regional, or local level). [Select one]
 - State health/medical lead (or designee)
 - Sub-state regional health/medical lead (or designee)
 - Local health/medical lead (or designee)
 - Other, please specify: [Text box]
- 8. Please identify the types of EEI requested. [Select all that apply]
 - Facility operating status
 - Facility structural integrity
 - Status of evacuations/shelter in-place operations
 - Status of critical medical services (e.g., trauma, critical care)
 - Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
 - Bed or patient status
 - Equipment/supplies/medications/vaccine status or needs
 - Staffing status
 - Emergency Medical Services (EMS) status
 - Epidemiological, surveillance or lab data (e.g., test results, case counts, deaths)
 - School-related data (closure, absenteeism, etc.)

- POD/mass vaccination sites data (e.g., throughput, open/set-up status, etc.), please specify: [Text box]
- Other, please specify: [Text box]
- 9. Please identify the type of IT or other communication system used to request EEI from local partners. [Text box]
- 10. Please identify the type of IT or other communication system used by local partners to report requested EEI. [Text box]
- 11. Barriers /challenges to submitting requested EEI within the requested timeframe (please describe types of local partners experiencing challenges and types of EEI not submitted within requested timeframe). [Text box]



How is this measure operationalized?

This measure can also be found in the HPP BP1 Healthcare Systems Preparedness: Performance Measures Specifications and Implementation Guidance.

This measure intends to capture information on the communication of incident-specific EEIs. Data elements for this measure should be based on: the incident commander’s determination of specifically required health and medical EEI for that incident (and tasked to the health/medical lead, or equivalent entity, to collect), specific local partners (i.e., entities that will report EEI to the incident commander or designee) and the requested timeframe determined by the incident commander or designee.



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Key Measurement Terms

Essential Elements of Information: Essential elements of information are discrete types of reportable public health or healthcare-related incident-specific information, preferably reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon pre-incident (and communicated to local partners) as part of information collection request templates and emergency response playbooks.

Local partners: Local partners are entities, at the local level, which receive requests for EEIs. Local partners may differ based on the type of incident/exercise/planned event (e.g., HCOs, LHDs, healthcare coalitions).

Requested timeframe: Requested timeframe is an awardee-defined timeframe for receiving requested EEI (e.g., operational period, set time to meet special request – e.g., 1500 hours)

7. Mass Care

Introduction

The Mass Care capability includes planning for, responding to, and recovering from a public health incident requiring care for displaced or impacted individuals. In terms of public health involvement, coordinated mass care services in congregate locations are necessary to ensure that health and environmental assessments are conducted; needed public health, medical, and mental/behavioral health services are provided or referred out; and appropriate surveillance is conducted. Mass care service coordination can help to reduce the risk of communicable disease transmission and ensure that the functional and access needs of individuals presenting at a congregate location are addressed, including those of children, older adults, and people with disabilities.



The Mass Care pre-incident process measure gauges the extent to which health departments have coordinated with ESF-6 and other partners to define their roles and responsibilities with respect to mass care operations. The evaluation tool is designed to capture activities a health department conducted in congregate locations, which could include surveillance, assessments and assuring the provision public health, medical, and mental/behavioral health services.

Capability Functions

This capability consists of the ability to perform the following functions:

- 1. Determine public health role in mass care operations**
- 2. Determine mass care needs of the impacted population**
- 3. Coordinate public health, medical, and mental/behavioral health services**
- 4. Monitor mass care population health**

Alignment of Performance Measures/Evaluation Tool to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 7.1	●			
PHEP 7.2	●			
Evaluation Tool	●	●	●	●

PHEP 7.1: Define Role with Partners (Awardee)

The awardee health department has defined its role in mass care operations in coordination with ESF-6 and other key partners [Yes/No]

Awardees should only report on this measure (PHEP 7.1) if public health-related support of mass care is or will be a role carried out at the awardee level. If public health-related support of mass care is an LHD responsibility, awardees should report on PHEP 7.2. If public health-related support of mass care is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Role definition includes all of the following elements:

- The health department emergency response plan identifies:
 - Public health mass care response actions (e.g., conducting pre-, ongoing, and post-shelter, health, and **environmental assessments** and monitoring; decontamination)
 - Triggers for mass care response actions
- Identification of needed resources to carry out mass care response actions (e.g., staff, supplies, and transportation)
- Signing letter(s) of agreement or MOU(s) that support coordinated mass care service provision, if requested by mass care lead
- Identifying local legal statutes or policies that define or inhibit public health involvement in mass care operations
- Identifying systems to communicate about the opening, location and/or closing of **congregate locations**
- Identifying tools or mechanisms to collect and receive health-related data from congregate locations



Why is this measure important?

Public health plays a critical support role in mass care operations by conducting surveillance as well as environmental, **functional needs** and other assessments, in addition to providing or referring individuals to services, at congregate locations. In some instances, health departments even play a lead role by establishing and operating congregate locations such as medical shelters. Engaging in rigorous planning with key partners, including the identification of roles and responsibilities, is an important first step to ensure effective public health support of mass care operations.

The immediate intent of this measure is to capture the extent to which awardee health departments have established their role, if any, in a mass care response through engagement with ESF-6 and other key partners.

The broader programmatic aim of this measure is to ensure effective public health support of mass care operations with a particular emphasis on surveillance, various shelter and health assessment activities, and the provision of services to sheltered individuals – if requested or referred to public health.





What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Which of the following elements have been addressed by the awardee health department as a part of pre-incident planning? [Select all that apply]

- The health department emergency response plan identifies:
 - Public health mass care response actions (e.g., conducting pre-, ongoing, and post-shelter, health, and environmental assessments and monitoring; decontamination)
 - Triggers for mass care response actions
- Identification of needed resources to carry out mass care response actions (e.g., staff, supplies, and transportation)
- Signing letter(s) of agreement or MOU(s) that support coordinated mass care service provision, if requested by mass care lead
- Identifying local legal statutes or policies that define or inhibit public health involvement in mass care operations
- Identifying systems to communicate about the opening, location and/or closing of congregate locations
- Identifying tools or mechanisms to collect and receive health-related data from congregate locations

2. Please identify key partners that participated in defining public health's mass care roles/responsibilities in relation to other entities. [Select all that apply]

- Voluntary organizations (e.g., Volunteer Organizations Active in Disasters (VOADs), Faith-Based Organizations, Non-Governmental Organizations)
- Red Cross
- Law enforcement
- EMS
- Media
- Transportation

- Local emergency management agency
- State emergency management agency
- Healthcare (e.g., hospitals)
- Military (e.g., National Guard)
- State disability services agency
- State social services agency
- State mental/behavioral health agency
- State education agency
- State parks and recreation agency
- State substance abuse agency
- Other partners, please specify: [Text Box]

3. Please indicate if awardee health department performs the following roles in mass care operations: [Select all that apply]

- Set up and/or operation of a general congregate location
- Set up and/or operation of a medical congregate location
- Surveillance in a congregate location
- Conducting assessments in a congregate location
- Other, please specify: [Text Box]

4. Please select how the health department collects health-related information from congregate locations within the jurisdiction: [Select all that apply]

- From ESF-6 desk
- From ESF-8, health/medical lead, or liaison
- Directly from congregate location(s)
- Directly from FEMA National Sheltering System
- Directly from Red Cross National Sheltering System
- Other, please specify: [Text Box]

5. Please identify key barriers to coordination with key partners [Select all that apply]

- Lack of health department personnel due to funding issues
- Lack of health department personnel due to hiring issues
- Lack of health department contacts with key partners
- Other health department priorities





CAPABILITY 7

- Lack of partner availability/capacity to participate
- Lack of partner cooperation/willingness
- Lack of communication between PH and other disparate response agencies
- Legal barriers
- Other, please specify: [Text Box]



How is this measure operationalized?

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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PHEP 7.2: Define Role with Partners (LHDs)

Proportion of PHEP-funded LHDs that have defined their role in mass care operations in coordination with ESF-6 and other key partners

Awardees should only report on this measure (PHEP 7.2) if public health-related support of mass care is or will be a role carried out at the local level. If public health-related support of mass care is an awardee health department responsibility, awardees should report on PHEP 7.1. If public health-related support of mass care is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that have defined their role in mass care operations in coordination with ESF-6 and other key partners

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities

Role definition includes all of the following elements:

- The health department emergency response plan identifies:
 - Public health mass care response actions (e.g., conducting pre-, ongoing, and post-shelter, health, and environmental assessments and monitoring; decontamination)
 - Triggers for mass care response actions
- Identification of needed resources to carry out mass care response actions (e.g., staff, supplies, and transportation)
- Signing letter(s) of agreement or MOU(s) that support coordinated mass care service provision, if requested by mass care lead
- Identifying local legal statutes or policies that define or inhibit public health involvement in mass care operations

- Identifying systems to communicate about the opening, location and/or closing of congregate locations
- Identifying tools or mechanisms to collect and receive health-related data from congregate locations



Why is this measure important?

Public health plays a critical support role in mass care operations by conducting surveillance as well as environmental, functional needs and other assessments, in addition to providing or referring services, at congregate locations. In some instances, health departments even play a lead role by establishing and operating congregate locations such as medical shelters. Engaging in rigorous planning with key partners, including the identification of roles and responsibilities, is an important first step to ensure effective public health support of mass care operations.

The immediate intent of this measure is to capture the extent to which awardee health departments have established their role, if any, in a mass care response through engagement with ESF-6 and other key partners.





The broader programmatic aim of this measure is to ensure effective public health support of mass care operations with a particular emphasis on surveillance, various shelter and health assessment activities, and the provision of services to sheltered individuals – if requested or referred to public health.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities (denominator)
2. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities that have defined their role in mass care operations in coordination with ESF-6 and other key partners (numerator)
 - a. Of those that have defined their role in mass care operations, identify the number of LHDs that have a lead or supporting role in the following:
 - i. Set up and/or operation of a general shelter
 - ii. Set up and/or operation of a medical shelter
 - iii. Surveillance in a shelter
 - iv. Conducting assessments in a shelter
3. For those LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities that have not addressed all six elements, please identify the *minimum* number that they have addressed. *(Please see data element 5, below, for a list of the six elements)*
4. For those LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities that have not addressed all six elements, please identify the *maximum* number that they have addressed. *(Please see data element 5, below, for a list of the six elements)*
5. For those LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities that have not addressed all six elements please identify the elements that are most frequently missing. [Select all that apply]
 - The health department emergency response plan identifies:

- o Public health mass care response actions (e.g., conducting pre-, ongoing, and post-shelter, health, and environmental assessments and monitoring; decontamination; risk communication)
 - o Triggers for mass care response actions
 - o Needed resources to carry out mass care response actions (e.g., staff, supplies, and transportation)
- Signing letter(s) of agreement or MOU(s) that support coordinated mass care service provision, if requested by mass care lead
 - Identifying local legal statutes or policies that define or inhibit public health involvement in mass care operations
 - Identifying systems to communicate about the opening, location and/or closing of congregate locations
 - Identifying tools or mechanisms to collect and receive health-related data from congregate locations
6. Please identify the most frequently listed key partners reported by LHDs that participated in defining public health’s mass care roles/responsibilities in relation to other local entities. [Select all that apply]
 - Voluntary Organizations (e.g., Volunteer Organizations Active in Disasters (VOADs), Faith-Based Organizations, Non-Governmental Organizations)
 - Red Cross
 - Law enforcement
 - EMS
 - Media
 - Transportation
 - Local Emergency Management Agency
 - State Emergency Management Agency
 - Healthcare (e.g., hospitals)
 - Military (e.g., National Guard)
 - State or local disability services agency
 - State or local social services agency
 - State or local mental/behavioral health agency
 - State or local education agency
 - State or local parks and recreation agency





- State or local substance abuse agency
 - Other partners, please specify: [Text Box]
7. Please identify the most frequently *missing* key partners reported by LHDs that participated in defining public health’s mass care roles/responsibilities in relation to other local entities. [Select all that apply]
- Voluntary Organizations: e.g., Volunteer Organizations Active in Disasters (VOADs), Faith-Based Organizations, Non-Governmental Organizations
 - Red Cross
 - Law enforcement
 - EMS
 - Media
 - Transportation
 - Local Emergency Management Agency
 - State Emergency Management Agency
 - Healthcare (e.g., hospitals)
 - Military (e.g., National Guard)
 - State or local disability services agency
 - State or local social services agency
 - State or local mental/behavioral health agency
 - State or local education agency
 - State or local parks and recreation agency
 - State or local substance abuse agency
 - Other partners, please specify: [Text Box]
8. Please identify the most frequent barriers (up to 5) to coordinating with key partners: [Select up to 5]
- Lack of health department personnel due to funding issues
 - Lack of health department personnel due to hiring issues
 - Lack of health department contacts with key partners
 - Other health department priorities
 - Lack of partner availability/capacity to participate
 - Lack of partner cooperation/willingness
 - Lack of communication between PH and other disparate response agencies
 - Legal barriers

- Other, please specify: [Text Box]
9. Briefly describe successes cited by LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities in regards to defining their roles for mass care operations. [Text box]
10. Briefly describe the most frequent barriers or challenges experienced LHDs that receive PHEP funds (directly or through contracts) to implement Mass Care activities in defining their roles for mass care operations. [Text box]



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for mass care activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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Evaluation Tool

This instrument is intended to be completed by any state or local health department(s) within the awardee jurisdiction involved in mass care operations. However, the awardee will always be responsible for submitting these data to CDC. Health departments not involved in mass care operations are not required to complete this tool.

Tool Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

Incident Categorization

- Type of incident: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane/tropical Storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
- Duration of incident/response in days
- Was a public health emergency declared by any authorized official in the impacted area? [Yes/No]
- What type of disaster declaration was made? [Select one]
 - None
 - Local
 - State-Gubernatorial
 - Federal-Presidential
 - Other, please specify: [Text Box]
- Which county/counties were directly impacted by the incident? [Text box]
- How many local (e.g., county, district, regional, and city) health departments will you be reporting mass care operations data on?

Health Department Information (repeat for each reporting health department)

- What is the name of this health department? [Text box]
- This health department is: [Select one]
 - The awardee health department
 - A local/district/regional/municipal health department that is a unit of state government
 - A local/district/regional/municipal health department that is a unit of local government

Pre-incident Planning

- Did the health department have a pre-defined role in mass care operations? [Yes/No]
 - If yes, please describe this role [Text box]
 - If yes, was this role defined in partnership with ESF-6 and other key partners? [Yes/No]
 - If yes, please identify the key partners: [Select all that apply]
 - Voluntary organizations (e.g., Volunteer Organizations Active in Disasters (VOADs), Faith-Based Organizations, Non-Governmental Organizations)
 - Red Cross
 - Law enforcement
 - EMS
 - Media
 - Transportation
 - Local emergency management agency





- State emergency management agency
 - Healthcare (e.g., hospitals, private medical providers)
 - Military (e.g., National Guard)
 - State or local disability services agency
 - State or local social services agency
 - State or local mental/behavioral health agency
 - State or local education agency
 - State or local parks and recreation agency
 - State or local substance abuse agency
 - Other partners, please specify: [Text Box]
- ii. If yes, did the health department have the lead role in establishing or operating any mass care congregate locations (i.e. general population or medical shelter)? [Yes/No]
- a. If yes, which type:
 - General population shelter
 - Medical shelter
 - Other, please specify: [Text Box]
 - b. If no, who led the establishment or operation of medical shelters? [Text box]
- iii. Please identify any barriers to coordinating with key partners: [Select all that apply]
- Lack of health department personnel due to funding issues
 - Lack of health department personnel due to hiring issues
 - Lack of health department contacts with key partners
 - Other health department priorities
 - Lack of partner availability/capacity to participate
 - Lack of partner cooperation/willingness

- Lack of communication between PH and other disparate response agencies
- Legal barriers
- Other, please specify: [Text Box]

Response

1. How many congregate locations were opened for this incident?

For each congregate location opened in which public health had a lead or supporting role in mass care operations, please provide the following information:

2. Type of congregate location:
- General population shelter
 - Medical shelter
 - Combined shelter (general and medical)
 - Other, please specify: [Text Box]
3. Total number of individuals sheltered in the congregate location
- a. Please indicate whether this is an estimate or an exact figure. [Select one]
 - b. Please describe how these data were collected. [Text box]
 - i. If unable to provide numbers for individuals sheltered, please describe the challenges or barriers to collecting this information [Text box]
4. Who was the lead agency to operate the congregate location? [Text box]
- a. If public health was the lead to establish/set-up the congregate location, please indicate the time in hours or days from request/decision to establish the shelter to actual establishment. Please define the start time (e.g., request from Emergency Management Agency) and stop time (e.g., doors open; first evacuees) used to calculate this time [Text box]
 - i. Please describe challenges or barriers to establishing/setting-up this shelter [Text box]
5. Did public health conduct surveillance at the congregate location? [Yes/No]
- a. If yes, was surveillance conducted based on a request from the shelter operator? [Yes/No]
 - b. If no, did the lead operator of the congregate location communicate health-related findings to public health (i.e., directly or via incident command)? [Yes/No]



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- i. If yes, please describe types of information shared, how findings were communicated (phone, data link, etc.), and the frequency of communication. [Text box]
- ii. If no, please describe barriers or challenges to receiving surveillance data. [Text box]
- c. Please describe the type of surveillance information collected by public health. [Text box]
- 6. Did public health provide services to individuals at the congregate location? [Yes/No]
 - a. Only if public health provided services, how many persons received services (please enter a number, state "unable to determine", or "other")? [Text box]
 - i. If a number is entered, how many were 0-18 years of age?
 - ii. If other, please explain [Text box]
 - iii. If unable to determine, please describe the barriers or challenges to collecting this information [Text box]
 - b. What types of services did public health provide? [Select all that apply]
 - Medical treatment
 - Mental/behavioral health treatment
 - Referral for medical treatment
 - Referral for mental/behavioral health treatment
 - Counseling
 - Equipment
 - Supplies
 - Food/water
 - Transportation
 - Other social services/assistance
 - Other, please specify: [Text Box]
 - None
- 7. Did public health conduct any assessments (other than surveillance) at the congregate location? [Yes/No]
 - a. If yes, which of the following assessment did public health conduct: [Select all that apply]
 - Access and functional needs (e.g., disability/assistive; non-/limited English; dietary, etc.)
 - Medical (e.g., infectious disease, chronic disease, injury, etc.)
 - Mental/behavioral health needs
 - Other, please specify [Text box]
- 8. Please describe additional public health activities undertaken either at the congregate location or in support of it (e.g., deploying volunteers) [Text box]



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Key Measurement Terms

Congregate location: A congregate location is defined as a physical location designated to provide shelter and access to other health-related services for a population impacted by an incident. *For the purposes of measurement, congregate locations refer to those locations of which public health has knowledge and to which it has access.*

Environmental assessment: An environmental assessment is a process by which environmental- and facility-related information is collected for the purpose of evaluating and addressing facility needs during an incident (either prior to, or after, shelter set-up). Examples of environmental assessments include the examination food and water, availability of power, and presence of functioning lavatories.

Functional needs (or access and functional needs) assessment: A functional needs assessment refers to a process to determine whether sheltered individuals with specific requirements to assist with daily living and functioning have the appropriate assistance they need to remain safe, healthy, and function relatively independently in a congregate location. In general, individuals with functional needs are able to act on their own or with specialized support. Functional needs include, but are not limited to: specific services for the elderly, dietary needs, chronic medical conditions requiring durable medical equipment (e.g., oxygen tank) or medication (e.g., insulin), hearing and vision loss, mental/behavioral health issues, physical/cognitive/developmental disability, substance abuse, and limited English-speaking.



8./9. Medical Countermeasure Dispensing and Medical Materiel Management and Distribution

Summary and Description of the Composite Measure

The Medical Countermeasure Distribution and Dispensing (MCMDD) composite measure is a collective measure of the ability to receive, stage, store, distribute and dispense medical countermeasures. This measure reflects contributions from established preparedness activities and serves a demonstration of the Medical Materiel Management and Distribution and Medical Countermeasure Dispensing capability standards.

A MCMDD composite score will be calculated annually for each state, directly funded locality, U.S. territory, and freely associated state awardee during each PHEP performance period. MCMDD composite computations for the 50 awardee states will include all of the Cities Readiness Initiative (CRI) local/planning jurisdictions within the PHEP awardees' boundary, including the directly funded local jurisdiction. Preparedness activities and contributions from CRI jurisdictions in multistate CRI Metropolitan Statistical Areas (MSAs) will contribute to the MCMDD composite score only for the governing state. Beginning in Budget Period 1, the MCMDD composite measure will be calculated by the Division of State and Local Readiness within the Office of Public Health Preparedness and Response (OPHPR) at CDC.

Each MCMDD composite measure score will be calculated based on data collected from the following preparedness activities:

- Technical Assistance Review
- DSNS operational drills (annual requirement beginning 2011-2012)
- Compliance with programmatic standards (annual requirement beginning 2012-2013)
 - Points of dispensing standards
 - Medical countermeasure distribution standards
- Full-scale exercises (FSE)
 - Medical countermeasure distribution (one state-level FSE required during the 2011-2016 time period)
 - Medical countermeasure dispensing (one CRI-level FSE during the 2011-2016 time period).

Detailed guidance related to the data collection requirements for each awardee state, directly funded locality, U.S. territory, and freely associated state is provided in the PHEP Cooperative Agreement Budget Period 1 (2012-2013): Medical Countermeasure Distribution and Dispensing Composite Measure Guide. The composite measure guide can be accessed and downloaded from the SNS Extranet site (www.bt.cdc.gov/stockpile/extranet) and the SNS SharePoint site (www.orau.gov/sns).



Capability Functions

Capability 8 consists of the ability to perform the following functions:

1. Identify and initiate medical countermeasure dispensing strategies
2. Receive medical countermeasures
3. Activate dispensing modalities
4. Dispense medical countermeasures to identified population
5. Report adverse events

Capability 9 consists of the ability to perform the following functions:

1. Direct and activate medical material management and distribution
2. Acquire medical materiel
3. Maintain updated inventory management and reporting system
4. Establish and maintain security
5. Distribute medical materiel
6. Recover medical materiel and demobilize distribution operations

Alignment of Composite Measure to Capability 8

Measure	Function 1	Function 2	Function 3	Function 4	Function 5
MCMD	●	●	●	●	●

Alignment of Composite Measure to Capability 9

Measure	Function 1	Function 2	Function 3	Function 4	Function 5	Function 6
MCMD	●	●	●	●	●	●

10. Medical Surge

Introduction

The Medical Surge capability refers to the ability to provide adequate medical evaluation and care when the normal medical infrastructure of an affected community is overwhelmed. Health departments generally assume a support and coordination role for this capability and fulfill the critical role of collecting, synthesizing, and exchanging information with response partners to support surge operations.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Assess the nature and scope of the incident
2. Support activation of medical surge
3. Support jurisdictional medical surge operations
4. Support demobilization of medical surge operations

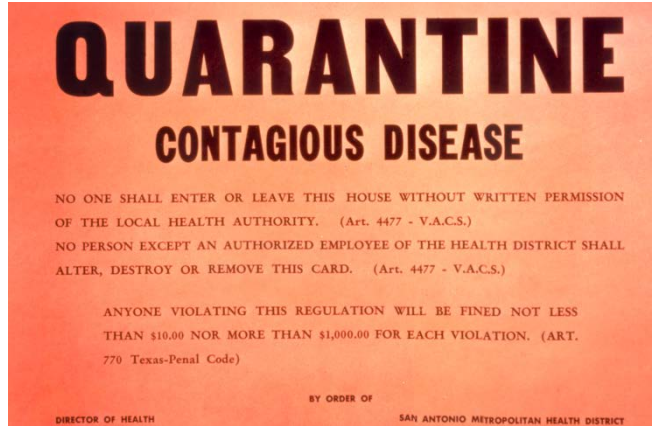
CDC and ASPR have developed a joint performance measure that covers both the PHEP Information Sharing and Medical Surge capabilities. This performance measure (i.e., HPP-PHEP 6.1: Information Sharing) can be found in the Information Sharing chapter and in the HPP BP1 Healthcare Systems Preparedness: Performance Measures Specifications and Implementation Guidance.

11. Non-Pharmaceutical Interventions

Introduction

The Non-Pharmaceutical Interventions (NPI) capability refers to the ability of health departments, in coordination with their partners, to recommend or implement non-drug and non-vaccine-based containment, mitigation or decontamination strategies in order to prevent or control disease, injuries, and exposures. NPIs are designed both to save lives and to alleviate the surge of individuals placing demands on the healthcare system during an emergency.

The NPI pre-incident process measure gauges the ability of health departments to identify and collaborate with partners to define roles for the development and implementation of NPIs and to identify factors that affect NPI implementation (e.g., legal barriers, intended and unintended consequences). The NPI response measure assesses a health department’s ability to bring key partners to the table to develop and/or implement an NPI at the time of an incident.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Engage partners and identify factors that impact non-pharmaceutical interventions
2. Determine non-pharmaceutical interventions
3. Implement non-pharmaceutical interventions
4. Monitor non-pharmaceutical interventions

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 11.1	●			
PHEP 11.2	●			
PHEP 11.3	●	●	●	

PHEP 11.1: Determine Role with Partners (Awardee)

The awardee health department has collaborated with legal, scientific and **community partners** to determine roles and responsibilities for the development and implementation of NPI recommendations

Awardees should only report on this measure (PHEP 11.1) if public health-related support of non-pharmaceutical interventions is or will be a role carried out at the awardee level. If public health-related support of non-pharmaceutical interventions is an LHD responsibility, awardees should report on PHEP 11.2. If public health-related support of non-pharmaceutical interventions is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Role determination includes all of the following elements:

Legal

- Identification of legal authorities for NPI implementation (hazard-specific)
- Identification of legal barriers to NPI implementation
- Identification of authorities able to alter legal statutes as needed

Scientific

- Identification of SMEs needed to assess the severity of exposure and/or transmission
- Identification of triggers for needing an NPI
- Development of NPI recommendations prior to incidents
- Agreement to participate in NPI recommendation development/adjustment at the time of an incident

Community

- Identification of community organizations needed for NPI implementation (hazard-specific)
- Contact Information for 2 representatives from each community organization

- Development of letters of agreement, MOUs, or jointly developed operational plans
- Identification of **secondary factors** (e.g., those based on intended and unintended consequences) that affect NPI implementation



Why is this measure important?

Development and implementation of non-pharmaceutical interventions is made more effective through the establishment of partnerships and a determination of roles and responsibilities among a range of legal, scientific and community partners.

The immediate intent of this measure is to assess the extent to which health departments engage in pre-incident planning with partners to determine roles and responsibilities for the development and implementation of NPI recommendations.

The broader programmatic aim of this measure is to increase the likelihood that NPI recommendations will be effectively implemented in the community by ensuring that the right partners are engaged at the right time to produce the right NPI recommendations should an incident necessitating NPI arise.



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What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

- Which of the following elements have been addressed by the awardee health department as part of pre-incident planning? [Select all that apply]
 - Legal: Identification of legal authorities for NPI implementation (hazard-specific)
 - Legal: Identification of legal barriers to NPI implementation
 - Legal: Identification of authorities able to alter legal statutes as needed
 - Scientific: Identification of SMEs needed to assess the severity of exposure and/or transmission
 - Scientific: Identification of triggers for needing an NPI
 - Scientific: Development of NPI recommendations prior to incidents
 - Scientific: Agreement to participate in NPI recommendation development/adjustment at the time of an incident
 - Community: Identification of community organizations needed for NPI implementation (hazard-specific)
 - Community: Contact information for 2 representatives from each community organization
 - Community: Development of Letters of Agreement, MOUs, or jointly developed operational plans
 - Community: Identification of secondary factors (e.g., those based on intended and unintended consequences) that affect NPI implementation (please see additional guidance, below)
- Please select the hazards for which pre-incident NPI planning is being conducted with partners. [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding

- Earthquake
- Hurricane/tropical Storm
- Hazardous material
- Fire
- Tornado
- Biological hazard or disease, please specify: [Text Box]
- Radiation
- Other, please specify: [Text Box]

- Please select all applicable barriers associated with engaging key partners to develop/implement NPIs: [Select all that apply]
 - Lack of health department personnel due to funding issues
 - Lack of health department personnel due to hiring issues
 - Lack of health department contacts with key partners
 - Lack of partner availability/capacity to participate
 - Lack of partner cooperation/willingness
 - Lack of partner in subject matter area (e.g., radiation)
 - Legal barriers
 - Other, please specify: [Text Box]



How is this measure operationalized?

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should*



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include only those LHDs that the awardee has funded (via contracts OR via a centralized state's direct funding or support) to do work in the capability in question. In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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PHEP 11.2: Determine Role with Partners (LHDs)

Proportion of PHEP-funded LHDs that have collaborated with legal, scientific and community partners to determine roles and responsibilities for the development and implementation of NPI recommendations

Awardees should only report on this measure (PHEP 11.2) if public health-related support of non-pharmaceutical interventions is or will be a role carried out at the local level. If public health-related support of non-pharmaceutical interventions is an awardee health department responsibility, awardees should report on PHEP 11.1. If public health-related support of non-pharmaceutical interventions is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

* BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that have collaborated with legal, scientific and community partners to determine NPI roles and responsibilities for the development and implementation of NPI recommendations

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Interventions activities

Role determination includes all of the following elements:

Legal

- Identification of legal authorities for NPI implementation (hazard-specific)
- Identification of legal barriers to NPI implementation
- Identification of authorities able to alter legal statutes as needed

Scientific

- Identification of SMEs needed to assess the severity of exposure and/or transmission
- Identification of triggers for needing an NPI

- Development of NPI recommendations prior to incidents
- Agreement to participate in NPI recommendation development/adjustment at the time of an incident

Community

- Identification of community organizations needed for NPI implementation (hazard-specific)
- Contact Information for 2 representatives from each community organization
- Development of letters of agreement, MOUs, or jointly developed operational plans
- Identification of secondary factors (e.g., those based on intended and unintended consequences) that affect NPI implementation (please see operationalization guidance)



Why is this measure important?

Development and implementation of non-pharmaceutical interventions is made more effective through the establishment of partnerships and a determination of roles and responsibilities among a range of legal, scientific and community partners.





The immediate intent of this measure is to assess the extent to which health departments engage in pre-incident planning with partners to determine roles and responsibilities for the development and implementation of NPI recommendations.

The broader programmatic aim of this measure is to increase the likelihood that NPI recommendations will be effectively implemented in the community by ensuring that the right partners are engaged at the right time to produce the right NPI recommendations should an incident necessitating NPI arise.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Interventions activities (denominator)
2. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Interventions activities that have collaborated with legal, scientific and community partners to determine NPI roles and responsibilities for the development and implementation of NPI recommendations (numerator)
3. For those LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Intervention activities that have not addressed all eleven elements, please identify the *minimum* number that they have addressed.
4. For those LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Intervention activities that have not addressed all eleven elements, please identify the *maximum* number that they have addressed.
5. If LHDs that receive PHEP funds (directly or through contracts) to implement Non-Pharmaceutical Interventions activities have not addressed all elements, please identify the elements that are most frequently missing across LHDs responding to this measure. [Select all that apply]
 - Legal: Identification of legal authorities for NPI implementation (hazard-specific)

- Legal: Identification of legal barriers to NPI implementation
 - Legal: Identification of authorities able to alter legal statutes as needed
 - Scientific: Identification of SMEs needed to assess the severity of exposure and/or transmission
 - Scientific: Identification of triggers for needing an NPI
 - Scientific: Development of NPI recommendations prior to incidents
 - Scientific: Agreement to participate in NPI recommendation development/adjustment at the time of an incident
 - Community: Identification of community organizations needed for NPI implementation (hazard-specific)
 - Community: Contact Information for 2 representatives from each community organization
 - Community: Development of Letters of Agreement, MOUs, or jointly developed operational plans
 - Community: Identification of secondary factors (e.g., those based on intended and unintended consequences) that affect NPI implementation (please see operationalization guidance)
6. Please select the hazards for which pre-incident NPI planning is being conducted with partners. [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane/tropical Storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify
 - Radiation
 - Other, please specify: [Text Box]
 7. Which non-pharmaceutical interventions do LHDs have the authority to *recommend* independent of state authorization? [Select all that apply]
 - Isolation



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- Quarantine
- Restrictions on movement
- Travel advisories/warnings
- Halting public transportation
- School closure
- Childcare closure
- Mass gathering postponement/cancellation
- Recommendation to avoid crowded places
- External decontamination
- Other, please specify: [Text Box]

8. Which non-pharmaceutical interventions do LHDs have the authority to *implement* independent of state authorization? [Select all that apply]

- Isolation
- Quarantine
- Restrictions on movement
- Travel advisories/warnings
- Halting public transportation
- School closure
- Childcare closure
- Mass gathering postponement/cancellation
- Recommendation to avoid crowded places
- External decontamination
- Other, please specify: [Text Box]

9. Please list the top *three* most frequently reported barriers associated with engaging key partners to develop or implement NPIs by LHDs: [Select up to 3 options]

- Lack of health department personnel due to funding issues
- Lack of health department personnel due to hiring issues
- Lack of health department contacts with key partners
- Lack of partner availability/capacity to participate
- Lack of partner cooperation/willingness
- Lack of partner in subject matter area (e.g., radiation)
- Legal barriers
- Other, please specify: [Text Box]



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for non-pharmaceutical interventions activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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PHEP 11.3: Develop NPI Recommendations with Partners

Proportion of key partners identified to have an **incident-specific role** that participated in the development or implementation of NPI during an incident

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding *	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By:

* For BP1 only: Awardees who have had an incident involving NPI by Dec. 31, 2012, must report this measure at mid-year



How is the measure calculated?

Numerator: Number of key partners that participated in the development/implementation of NPI (for a specific hazard) at the time of the incident

Denominator: Total number of key partners identified (pre-incident and at the time of the incident) to have a role in developing/implementing NPI for a specific hazard



Why is this measure important?

An important dimension for evaluating the effectiveness of NPI planning and collaboration prior to an incident is assessing the participation of needed partners during an incident. If the right partners can be incorporated into the response, it is more likely that timely and better NPI recommendations can be developed, with a greater chance for more effective implementation and uptake in the community. In combination with special studies to assess the effectiveness of NPIs and specific outcomes (e.g., implementation, uptake, morbidity/mortality), this measure is intended to provide awardees with data to address challenges and barriers in bringing the right partners into discussions to develop and implement NPIs prior to, and during, a response.

The immediate intent of this response measure is to assess the extent to which partners targeted by the health department to participate in the development or implementation of an incident-specific non-pharmaceutical intervention actually did participate.

The broader programmatic aim of this response measure is to increase engagement of public health partners in developing non-pharmaceutical intervention recommendations and implementation strategies prior to an incident, expediting the development and implementation of recommendations during incidents that will assist disease, injury and exposure control.



What other requirements are there for reporting measure data?

Awardees should report the numerator and denominator of this measure *by incident* at the state, regional or local level.

For the purposes of reporting, awardees should include *at least two* incidents.



What data must be reported?

- How many key partners were identified, *in pre-incident planning*, to have a role in developing /implementing NPI for the specified hazard(s) in this incident (part of denominator):
 - Legal partners?**
 - Scientific partners?**
 - Community partners?**
- How many *additional* key partners (not part of the pre-incident planning process), were identified/requested to have a role in developing/implementing NPI for the specified hazard(s) in this incident (part of denominator):
 - Legal partners?



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- b. Scientific partners?
- c. Community partners?
- 3. Out of the total number of key partners identified for participation, how many key partners participated in the development/implementation of NPI (for a specific hazard) during an incident? (numerator)
- 4. Which entity is reporting on this measure?
 - a. Awardee health department
 - b. LHD
- 5. Please provide the name and date of the incident [Text box]
- 6. Please identify/describe the NPI recommendation. [Select all that apply]
 - Isolation [Text box]
 - Quarantine [Text box]
 - Restrictions on movement [Text box]
 - Travel advisories/warnings [Text box]
 - Halting public transportation [Text box]
 - School closure [Text box]
 - Childcare closure [Text box]
 - Mass gathering postponement/cancellation [Text box]
 - Recommendation to avoid crowded places [Text box]
 - External decontamination [Text box]
 - Other, please specify: [Text Box]
- 7. Barriers to engagement between the health department and key partners. Please select all barriers reported by the health department in engaging key partners to develop or implement NPIs: [Select all that apply]
 - Lack of health department personnel due to funding issues
 - Lack of health department personnel due to hiring issues
 - Lack of health department personnel availability due to competing incident priorities
 - Lack of health department contacts with key partners
 - Lack of partner availability/capacity to participate
 - Lack of partner cooperation/willingness
 - Lack of partner in subject matter area (e.g., radiation)

- Legal barriers
- Other, please specify: [Text Box]



How is this measure operationalized?

Any health department within an awardee jurisdiction that experiences a significant public health incident involving recommendations or implementation of NPI should collect and report data for this measure. In all cases, the awardee shall submit these data to CDC.

This measure is meant to *exclude* frequent public health or environmental concerns, including but not limited to common or low-acuity illness stemming from food-borne pathogens, unremarkable seasonal influenza, standard public health campaigns (e.g., interventions for common sexually-transmitted diseases) and general water, air or other environmental quality issues – including mold, lead asbestos, and noise.

There is no expectation that all key planning partners (for NPI) are expected to be incorporated into all responses for all hazards. For example, if an incident only requires 2 out of 10 key planning partners, and 5 additional (i.e., new) partners for the specific response/hazard in question, then that is what should be reported in Data Elements 1 and 2, respectively. If a different incident, involving a different hazard, requires participation by a different set (and number) of key partners, then those numbers should be reported for those data elements.

To be considered to have participated in the development/implementation of an NPI, a key partner must have satisfactorily have met at least one of the following criteria:

- Substantial engagement in review and approval or revision of an existing/planned NPI recommendation
- Substantial engagement in the development of a new NPI recommendation or adjustment of existing non-pharmaceutical intervention
- Provided information considered central to the development of an NPI recommendation, including: describing circumstances, triggers, populations, risks, policies, strategies, etc., in which an NPI might be used, as well as consequences of NPI implementation
- Implementation of a non-pharmaceutical intervention



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Key Measurement Terms

Community partners: Community partners represent jurisdictions, sectors, agencies, organizations and segments of a population having a stake in the recommendation, implementation, and/or termination of non-pharmaceutical interventions. Examples of community partners include schools, businesses, faith-based organizations and the media as well as emergency management, relevant healthcare entities.

Incident-specific role: Incident-specific role indicates a key partner role based on a specific hazard (e.g., flooding, pandemic flu, radiation) The intent of delineating this term is to ensure that reporting health departments only include in this measure those key partners deemed necessary for the specific hazard(s) in question.

Legal partners: Legal partners include, but are not limited to, individuals and organizations with the legal and jurisdictional authority to recommend, implement, and/or terminate non-pharmaceutical interventions. Examples of legal partners include elected officials, general counsel of a health department or other agencies, court/judicial officials, law enforcement, and municipal or state authorities such as a board of education, (state) office of education or superintendent.

Scientific partners: Scientific partners include, but are not limited to, individuals and organizations with the ability to provide the rationale and science-based expert opinion for the recommendation, implementation, and/or termination of non-pharmaceutical interventions. Examples of scientific partners include subject-matter experts in areas such as infectious disease, radiation and environmental health as well as public health nurses, physicians, and those in academia.

Secondary factors of non-pharmaceutical interventions: Secondary factors of non-pharmaceutical interventions are indirect, often unintentional, effects of an NPI which, if not properly mitigated, may lead to decreased adoption of the intervention. Examples of secondary factors include: lost revenue due to implementation of social distancing measures, lack of child supervision (potentially causing inability to report to work) for working parents of children affected by school closure; or lack of meals for poor or homeless children resulting from school closure.

12. Public Health Laboratory Testing

Introduction

Public health laboratories are critical to the nation’s ability to rapidly detect and respond to a variety of public health incidents. The laboratory testing performance measures were developed to assess routine and other frequent activities that occur at PHEP-funded laboratories (primarily, but not exclusively, state public health laboratories) across the nation. In addition, several measures utilized by the Laboratory Response Network (LRN-B and LRN-C) have been incorporated. Although not encompassing of all aspects of laboratory functions, the intent of these performance measures is to serve as a foundation for describing and assessing laboratory capabilities among PHEP-funded laboratories.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Manage laboratory activities
2. Perform sample management
3. Conduct testing and analysis for routine and surge capacity
4. Support public health investigations
5. Report results

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4	Function 5
PHEP 12.1	●				
PHEP 12.2				●	
PHEP 12.3			●		
PHEP 12.4					●
PHEP 12.5			●		
PHEP 12.6			●		
PHEP 12.7		●			
PHEP 12.8			●		
PHEP 12.9	●				
PHEP 12.10					●
PHEP 12.11			●		
PHEP 12.12		●			
PHEP 12.13		●			
PHEP 12.14					●
PHEP 12.15					●

PHEP 12.1: Laboratorian Reporting

Time for initial laboratorian to **report for duty** at the PHEP-funded laboratory

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input checked="" type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start Time: Date and time that a public health designated official began notifying **on-call laboratorian(s)** to report for duty at the PHEP-funded laboratory

Stop Time: Date and time that the first laboratorian reported for duty at the PHEP-funded laboratory



Why is this measure important?

Timely specimen testing is crucial for the recognition of a public health emergency. PHEP-funded laboratories must be able to receive specimens 24 hours a day, seven days a week to initiate testing. The intent of this measure is to ensure that a laboratorian can report for duty to a PHEP-funded public health laboratory in a timely manner, if notified to do so.



What other requirements are there for reporting measure data?

Laboratorian reporting for duty to the PHEP-funded laboratory must be **unannounced** and occur **outside of normal business hours**.



What data must be reported?

1. Date and time that a public health designated official began notifying on-call laboratorian(s) to report for duty at the PHEP-funded laboratory (Start time)

2. Date and time that the first laboratorian reported for duty at the PHEP-funded laboratory (Stop time)
3. Name/location of PHEP-funded LRN-C laboratory [Text box]
 - Level of lab (i.e., 1,2, or 3)
4. Normal/regular hours of operation for the lab:
 - Start of day Monday – Friday (e.g., 08:00am)
 - End of day Monday - Friday (e.g., 05:00 pm)
5. Routine weekend hours? [Yes/No]
 - If yes, please note [Text box]
6. Total number of operations-based exercises (drill, functional, or full-scale only) that tested laboratorian reporting
 - Number of operations-based exercises that tested unannounced and outside of normal business hours laboratorian reporting
7. Total number of incidents, if any, involving laboratorian reporting
 - Number of incidents involving unannounced and outside of normal business hours laboratorian reporting

For each instance of unannounced and outside of normal business hours laboratorian reporting on which the awardee has chosen to report:

8. Was the laboratorian reporting part of a drill, functional exercise, full-scale exercise, planned event or incident? [Select one]
 - Drill
 - Functional exercise
 - Full-scale exercise
 - Planned event
 - Incident





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9. Was the laboratorian reporting unannounced? [Yes/No]
10. Did the laboratorian reporting occur outside of normal business hours? [Yes/No]
11. Type of incident or event upon which exercise scenario was based [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane/tropical storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
12. For incidents only: Provide the date and time that the specimen arrived at the PHEP-funded laboratory.
Note: It is possible that the specimen may arrive before or after the laboratorian.
13. Does this incident, planned event or exercise represent the best demonstration of your agency's laboratorian reporting for duty capability? [Yes/No]
14. Please select why this exercise, planned event or incident was chosen as the best demonstration of a laboratorian reporting [Select all that apply]
 - Context of the public health response – potential for substantial public health impact
 - Incident
 - Complexity of the demonstration/response – scale of the demonstration/response requiring significant laboratory resources (staff, resources, etc.)
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/demonstration available
 - Other, please specify: [Text Box]
15. Was this your quickest time? [Yes/No]



How is this measure operationalized?

Awardees are strongly encouraged to report data elements from multiple incidents or exercises that necessitated unannounced, off-hours reporting by a laboratorian at the PHEP-funded laboratory. However, awardees that choose to report on this measure are required, at a minimum, to report data on one best demonstration of a laboratorian reporting for duty at the PHEP-funded laboratory. Ideally, the demonstration would have occurred during an incident. If a incident did not occur in your jurisdiction, the demonstration must have taken place during a drill, functional exercise, or full-scale exercise.

Note: This measure applies to both biological and chemical laboratories. If the awardee's biological and chemical laboratories function as a single entity (e.g. same laboratory director) the awardee would only report once for this measure.



PHEP 12.2: 24/7 Emergency Contact Drill (Bi-Directional)

Time to complete **notification** between CDC, on-call laboratorian, and **on-call epidemiologist** or between CDC, on-call epidemiologist and on-call laboratorian – depending on drill direction

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC EOC



How is the measure calculated?

Start Time: Date/time that CDC EOC initiated contact with the on-call laboratorian or epidemiologist, depending on drill direction

Stop Time: Date/time that on-call laboratorian or epidemiologist (depending on drill direction) contacted the CDC EOC to complete the drill cycle.

Performance Target: 45 minutes



Why is this measure important?

Timely communication between on-call epidemiologists and laboratorians (and vice versa) is critical for effective public health emergency response. As stewards of PHEP funds, the awardee plays a crucial role in assuring good communication between laboratory and epidemiology staff, and for fostering improvements in communication in response to gaps revealed by exercises and incidents.

The purpose of 24/7 Emergency Contact Drill is to ensure a timely and effective response to incidents of public health significance by promoting rapid communication between the epidemiologist and the laboratorian. The measure is *not intended to adhere to, or assess, an awardee’s or CDC’s emergency notification protocol*. Although conducted by the CDC Emergency Operations Center (EOC), the drill is not an EOC or LRN measure; it is strictly a PHEP measure. It does not replace or substitute any other CDC drill (e.g., LRN notification drill).



What other requirements are there for reporting measure data?

Data will be generated from CDC-initiated drills; start- and stop-time data will be collected by CDC’s Emergency Operations Center and shared with the Division of State and Local Readiness (DSLRL).



What data must be reported?

Additional data may be collected by DSLRL for this performance measure (e.g., factors accounting for not meeting the performance target, barriers in communication).



How is this measure operationalized?

The 24/7 Emergency Contact Drill can occur at any time during a Budget Period (BP). Two drills are held per budget period; one in each “direction.” In “Direction 1” the on-call *laboratorian* is contacted first by the CDC EOC. In “Direction 2” the on-call *epidemiologist* is contacted first by the CDC EOC. Drills will be conducted between 8PM and 11PM (awardee local time) over a 5-7 day period. The order of the drills may vary (e.g. Direction 2 of a drill cycle may be conducted before Direction 1 of the cycle). During PHEP BP1, the drills will be conducted in the following manner *for awardees with separate biological and chemical laboratories*:



BP1 drill direction:

Direction 1: CDC EOC→LRN-C→EPI→CDC EOC

Direction 2: CDC EOC→EPI→LRN-B→ CDC EOC

For awardees with joint biological and chemical laboratories, the drills will be conducted as follows:

BP1 drill direction:

Direction 1: CDC EOC→LRN-B/C→EPI→CDC EOC

Direction 2: CDC EOC→EPI→LRN-B/C→CDC EOC

The term “LRN” (B, C, or B/C) refers to the on-call laboratorian in the awardee’s LRN lab; the term EPI refers to the awardee’s on-call epidemiologist.

The 24/7 Emergency Contact Drill is composed of three major segments—pre-drill, drill, and post drill. Each segment is comprised of various activities which must be completed in order to ensure the successful completion of the 24/7 drill. Failure to complete a critical activity within each drill segment may result in pitfalls that may prevent the awardee either from successfully completing the drill or completing it within the 45-minute time target. Please see **Appendix C** for an overview of pre-drill, drill, and post-drill activities and activities that PHEP directors can do to ensure drill success, including how to update contact information for the on-call laboratorian and on-call epidemiologist.

PHEP 12.3: LRN Emergency Response Pop Proficiency Test (PopPT) Exercise

Ability of PHEP-funded LRN-C Level 1 and/or Level 2 laboratories to detect and quantify biomarkers of chemical agents in clinical samples during the LRN Emergency Response Pop Proficiency Test (PopPT) Exercise

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program



How is the measure calculated?

Numerator: Number of biomarkers of chemical agents detected by Level 1 and/or Level 2 laboratories

Denominator: Number of biomarkers of chemical agents included in the exercise.

at least one scheduled PT exercise. Laboratories participating in the PopPT exercise are called the day before the exercise, sent approximately 10 clinical samples, and must test these samples within a certain number of hours (depending on the methods needed).

Data are collected internally by the CDC LRN-C program. Results will be shared with DSLR.



Why is this measure important?

This exercise focuses on a laboratory’s ability to detect, identify, and quantify biomarkers of chemical agents in clinical samples in which the presence and amount of the biomarkers are unknown. This exercise also tests the laboratory’s emergency contact process and its ability to report results.

Proficiency testing data must be validated by the awardee preparedness office in the PHEP reporting system.

No new data collection will be required (outside of the existing data collected by CDC’s LRN-C), but the intent is to ensure that awardee preparedness offices are aware of the PopPT exercise results and validate the information on an annual basis.



What data must be reported?

Not applicable



How is this measure operationalized?

Awardees should see LRN-C “Pop” PT Exercise Guidelines available from the CDC LRN-C program.



What other requirements are there for reporting measure data?

Data will be collected for PHEP-funded LRN-C laboratories Level 1 and 2 only.

To participate in a PopPT exercise, the laboratory must have attained a “Qualified” status for the method. To attain “Qualified” status, a laboratory must have completed training, the validation exercise, and passed





PHEP 12.4: Notification to Partners

Time for PHEP-funded laboratory to notify public health partners of **significant laboratory results**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: NYC Bio Only; Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start Time: Date and time PHEP-funded laboratory obtains a significant laboratory result

Stop Time: Date and time PHEP-funded laboratory completes notification of public health partners of significant laboratory results (i.e., time when last public health partner was notified, if partners were not simultaneously notified)



Why is this measure important?

Rapidly notifying public health partners of a significant laboratory result is a critical step in a public health response. Contacting public health partners and sharing information on positive or negative results allows the public health system to begin to prepare for an incident or adjust response efforts as needed



What other requirements are there for reporting measure data?

This performance measure applies to LRN-C laboratories Level 1 and 2.

Reporting is for incidents only. PHEP-funded laboratories that did not receive a significant laboratory result for a clinical specimen or a **nonclinical sample** will be able to indicate this when submitting performance measure data.

Note: This measure applies to both biological and chemical laboratories, but if the awardee's biological and chemical laboratories function as a single entity

(e.g., same laboratory director), the awardee would only report once for this measure.



What data must be reported?

- Total number of significant laboratory results for:
 - Clinical specimens (required)
 - Nonclinical samples (optional)
- Did the PHEP-funded laboratory notify public health partners of at least one significant laboratory result obtained from a clinical specimen? [Yes/No]
- If yes, provide the following information for each reported example of a notification of significant index test results obtained from a clinical specimen:
 - Date and time PHEP-funded laboratory obtained a significant laboratory result (Start time)
 - Date and time PHEP-funded laboratory completed notification of public health partners of significant laboratory results (i.e., time when last public health partner was notified, if partners were not simultaneously notified) (Stop time)
 - Did the PHEP-funded laboratory notify any of the appropriate partners of the significant laboratory results? [Yes/No]
 - Which partners did the PHEP-funded laboratory notify? [Select all that apply]
 - Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department



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- Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency
 - State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - Other partners, please specify and identify why they were notified [Text box]
- e. Which partners did the PHEP-funded laboratory notify within two hours? [Select all that apply]
- Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department
 - Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency
 - State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - Other partners, please specify and identify why they were notified [Text box]
- f. Which partners deemed appropriate for notification did the PHEP-funded laboratory not notify?
- Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department
 - Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency
 - State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - Other partners, please specify: [Text Box]
- g. Briefly describe why appropriate partners were not notified, either at all or within two hours [Text box].
- h. Does this incident represent the best demonstration of your agency's capability to notify partners of a significant lab result? [Yes/No]
- i. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of notification to partners [Select one]
- Context of the public health response – potential for substantial public health impact
 - Incident
 - Complexity of the demonstration/response – scale of the demonstration/response requiring significant laboratory resources (staff, resources, etc.)
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/demonstration available





- Other, please specify: [Text Box]
- j. Was this your quickest time? [Yes/No]
- k. Briefly describe the scenario or incident (if known), including name of substance(s) or agent(s), type of specimen, and other pertinent information, for this best demonstration. [Text box]
- 4. [*Optional Reporting Measure*] Did the PHEP-funded laboratory notify public health partners of at least one significant laboratory results obtained from a nonclinical sample? [Yes/No]
- 5. If yes, provide the following information for each reported example of a notification of significant index test results obtained from a nonclinical sample, please provide:
 - a. Time PHEP-funded laboratory obtained a significant laboratory result (Start time)
 - b. Time PHEP-funded laboratory completed notification of public health partners of significant laboratory results (i.e., time when last public health partner was notified, if partners were not simultaneously notified) (Stop time)
 - c. Did the PHEP-funded laboratory notify any of the appropriate partners of the significant laboratory results? [Yes/No]
 - d. Which partners did the PHEP-funded laboratory notify? [Select all that apply]
 - Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department
 - Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency
 - State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - e. Which partners did the PHEP-funded laboratory notify within two hours? [Select all that apply]
 - Other partners, please specify and identify why they were notified [Text box]
 - Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department
 - Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency
 - State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - Other partners, please specify and identify why they were notified [Text box]
 - f. Which partners deemed appropriate for notification did the PHEP-funded laboratory not notify?
 - Specimen submitter
 - State public health lab director
 - On-call or State epidemiologist
 - Health officer for state health department
 - Duty officer at CDC Emergency Operations Center
 - Other CDC point of contact (e.g., LRN, lab SME)
 - LHD
 - FBI
 - State homeland security or emergency management agency



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- State natural resources department or environmental health department
 - State law enforcement
 - Local law enforcement
 - Civil support team and/or first response team
 - Other partners, please specify: [Text Box]
- g. Briefly describe why appropriate partners were not notified, either at all or within two hours [Text box].
- h. Does this incident represent the best demonstration of your agency’s capability to notify partners? [Yes/No]
- i. Please select the primary/most significant reason why this exercise or incident was chosen as the best demonstration of notification to partners [Select one]
- Context of the public health response – potential for substantial public health impact
 - Incident
 - Complexity of the demonstration/response – scale of the demonstration/response requiring significant laboratory resources (staff, resources, etc.)
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/demonstration available
 - Other partners, please specify: [Text Box]
- j. Was this your quickest time? [Yes/No]
- k. Briefly describe the scenario or incident (if known), including name of substance(s) or agent(s), type of specimen, and other pertinent information, for this best demonstration. [Text box]

demonstration of a notification based on a test of a clinical specimen.

Nonclinical samples have been added for optional reporting for awardees that want to demonstrate performance in notifying public health partners of a significant result from a nonclinical sample. Samples can include rule-out requests.



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How is this measure operationalized?

Awardees are strongly encouraged to report data from multiple incidents. However, awardees that choose to submit data for this measure are required, at a minimum, to report data on their one best

PHEP 12.5: Proficiency Testing (LRN-C Additional Methods)

Proportion of LRN-C proficiency tests (additional methods) successfully passed by PHEP-funded laboratories

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: PAHPA Benchmark
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program



How is the measure calculated?

Numerator: Number of LRN-C additional methods successfully proficiency tested by the PHEP-funded laboratory

Denominator: Total number of LRN-C additional methods for which the PHEP-funded laboratory is qualified to test



Why is this measure important?

Recognition of a public health emergency requires accurate laboratory testing of samples to detect disease or potential exposure. Once a laboratory is qualified to test for certain biological or chemical agents, it is important to ensure that this qualification is maintained, and that the awardee preparedness office is aware of the laboratory’s testing capability. Additional methods build upon the foundation established by the core methods, providing modifications to core techniques which allow for laboratories to test for additional agents and thereby expand their testing capabilities.

With the exception of Reported Data Element 5, no new data collection will be required outside of the existing proficiency testing conducted or sponsored by CDC’s LRN-C. The intent is to ensure that awardee preparedness offices are aware of proficiency testing activities and capabilities and validate the information on an annual basis in the PHEP reporting system.



What other requirements are there for reporting measure data?

This performance measure is **REQUIRED** for LRN-C Level 1 laboratories. It is **OPTIONAL** for Level 2 laboratories.

Reported Data Elements 1-4 are collected internally by the CDC LRN-C program and are shared with DSLR. Awardees will submit information for Reported Data Element 5 in the PHEP reporting system.

Proficiency testing data must be validated by the awardee preparedness office in the PHEP reporting system.



What data must be reported?

1. Total number of LRN-C additional methods for which the PHEP-funded laboratory is qualified to test (denominator)
2. Number of LRN-C additional methods successfully proficiency tested by the PHEP-funded laboratory (numerator)
3. Total number of LRN-C additional methods in which the PHEP-funded laboratory has trained
4. Total number of LRN-C additional methods for which the PHEP-funded laboratory has been validated
5. If the PHEP-funded laboratory did not pass or participate in all LRN-C additional methods proficiency tests, please explain why and any remediation taken [Text box]



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How is this measure operationalized?

Proficiency testing in additional methods is routinely conducted by the LRN-C program office at CDC. Results from these tests will be shared with DSLR as part of PHEP performance measurement and monitoring.



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Response

PHEP 12.6: Proficiency Testing (LRN-C Core Methods)

Proportion of LRN-C proficiency tests (core methods) successfully passed by PHEP-funded laboratories

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: PAHPA Benchmark
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program



How is the measure calculated?

Numerator: Number of LRN-C core methods successfully proficiency tested by the PHEP-funded laboratory

Denominator: Total number of LRN-C core methods (9)

Level 1 laboratories. It is OPTIONAL for Level 2 laboratories.

Reported Data Elements 1-4 are collected internally by the CDC LRN-C program and are shared with DSLR. Awardees will submit information for Reported Data Element 5 in the PHEP reporting system.



Why is this measure important?

Recognition of a public health emergency requires accurate laboratory testing of samples to detect disease or potential exposure. Once a laboratory is qualified to test for certain biological or chemical agents, it is important to ensure both that this qualification is maintained, and that the awardee preparedness office is aware of the laboratory's testing capability. The core methods are significant as they offer new technical fundamentals in the methods that provide the foundation of LRN-C laboratory capabilities.

With the exception of Reported Data Element 5, no new data collection will be required outside of the existing proficiency testing conducted or sponsored by CDC's LRN-C. The intent is to ensure that awardee preparedness offices are aware of proficiency testing activities and capabilities and validate the information on an annual basis in the PHEP reporting system.

Proficiency testing data must be validated by the awardee preparedness office in the PHEP reporting system.



What data must be reported?

1. Number of LRN-C core methods successful proficiency tested by the PHEP-funded laboratory (numerator)
2. Total number of LRN-C core methods for which the PHEP-funded laboratory is qualified to test
3. Total number of LRN-C core methods in which the PHEP-funded laboratory has trained
4. Total number of LRN-C core methods for which the PHEP-funded laboratory has been validated
5. If the PHEP-funded laboratory did not pass or participate in all LRN-C core methods proficiency tests, please explain why and any remediation taken [Text box]



What other requirements are there for reporting measure data?

This performance measure is REQUIRED for LRN-C



How is this measure operationalized?

Proficiency testing in core methods is routinely conducted by the LRN-C program office at CDC. Results from these tests will be shared with DSLR as part of PHEP performance measurement and monitoring.

PHEP 12.7: Sample Collection, Packing, and Shipping (SCPaS)

Ability of PHEP-funded LRN-C laboratories to collect, package, and ship samples properly during an LRN exercise

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: PAHPA Benchmark
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program



How is the measure calculated?

Sample collection, packaging, and shipping (SCPaS) exercise results [Passed/did not pass]



Why is this measure important?

The proper collection, packaging, and shipping of specimens is important to ensure the integrity of the specimen and the safety of all those involved.

This annual exercise evaluates the ability of a laboratory to collect relevant samples for clinical chemical analysis and ship those samples in compliance with International Air Transport Association, U.S. Department of Transportation, and state regulations.

No new data collection will be required outside of the existing SCPaS exercise conducted by CDC’s LRN-C, but the intent is to ensure that awardee preparedness offices are aware of SCPaS activities and validate the information on an annual basis in the PHEP reporting system.



What other requirements are there for reporting measure data?

This is an annual LRN-C exercise.

Data will be collected for LRN-C laboratories of all levels (i.e., 1, 2 and 3).

At least one PHEP-funded laboratory for each awardee must participate annually and is expected to pass. Additional laboratories may participate if they choose. An awardee will be rated as “Passed” if at least one of their LRN-C laboratories participated and passed (e.g., if an awardee has one laboratory pass and another fail or not participate, the awardee will be rated as passed, since the awardee had at least one laboratory demonstrate the capability). If an awardee does not have at least one PHEP-funded laboratory participate in this exercise during the year, the awardee will be rated as “Did not pass.”



What data must be reported?

1. SCPaS results for each laboratory [Pass, did not pass, did not participate]
2. Name/location of all LRN-C laboratories
 - a. Level of lab (i.e., 1, 2, or 3)



How is this measure operationalized?

Data are collected internally by the CDC LRN-C program and are shared with DSLR.

SCPaS data must be validated in the PHEP reporting system by the awardee preparedness office.



PHEP 12.8: LRN Surge Capacity Exercise

Ability of each PHEP-funded LRN-C Level 1 laboratory to process and report results to CDC for 500 samples during the LRN Surge Capacity Exercise

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program



How is the measure calculated?

Start Time: Date and time of delivery of 500 samples to LRN-C Level 1 laboratory

Stop Time: Date and time result from last sample was reported to CDC



Why is this measure important?

This exercise demonstrates the ability of each Level 1 laboratory to test and report results for 500 samples (a total of 5000 samples for 10 LRN-C Level 1 laboratories) on a 24/7 basis as would be required by a large scale chemical incident.

Note: The 5,000 samples include approximately 4,000 unspiked and 1,000 spiked samples to mimic the expected exposed/unexposed ratio. The spiked samples are spiked at low-high levels with a minimum of three and a maximum of five different values. Each Level 1 laboratory receives approximately 80% unspiked and 20% spiked samples.

No new data collection will be required (outside of the existing data collected by CDC's LRN-C), but the intent is to ensure that awardee preparedness offices are aware of Surge Capacity Exercise results and validate the information on an annual basis in the PHEP reporting system.



What other requirements are there for reporting measure data?

Data will be collected for PHEP-funded LRN-C laboratories Level 1 only.



What data must be reported?

1. Date and time of delivery of 500 samples to LRN-C Level 1 laboratory (Start time)
2. Date and time result from last sample was reported to CDC (Stop time)
3. Name/location of all LRN-C laboratories
 - a. Level of lab (i.e., 1, 2, or 3)



How is this measure operationalized?

Data are collected internally by the CDC LRN-C program and are shared with DSLR.



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PHEP 12.9: Communication between PHEP-funded and Sentinel Clinical Laboratories

Time for **sentinel clinical laboratories** to acknowledge receipt of an **urgent message** from PHEP-funded LRN-B laboratory

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input checked="" type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Start time: Date and time PHEP-funded LRN-B laboratory sends urgent message to first sentinel clinical laboratory

Intermediate stop time: Date and time at least 50% of sentinel clinical laboratories acknowledged receipt of urgent message

Intermediate stop time: Date and time at least 90% of sentinel clinical laboratories acknowledged receipt of urgent message

Stop time: Date and time last sentinel clinical laboratory acknowledged receipt of urgent message

their one best demonstration of the ability of sentinel clinical laboratories to acknowledge receipt of an urgent message from the PHEP-funded laboratory. The demonstration must have occurred as part of one of the following:

- Drill
- Functional exercise (FE)
- Full-scale exercise (FSE)
- Incident
- Planned event



Why is this measure important?

Ensuring that PHEP-funded laboratories and the sentinel clinical laboratories are able to rapidly communicate important information with one another enhances their ability to recognize and respond to potential public health emergencies in a timely manner.



What other requirements are there for reporting measure data?

Awardees are strongly encouraged to report data from multiple drills or exercises and/or real-incidents. However, awardees that choose to report on this measure are required, at a minimum, to report data on



What data must be reported?

For each communication between the PHEP funded LRN-B laboratory and sentinel lab being reported:

1. Date and time PHEP-funded LRN-B laboratory sends urgent message to first sentinel clinical laboratory (Start time)
2. Date and time at least 50% of sentinel clinical laboratories acknowledged receipt of urgent message) (Intermediate stop time)
3. Date and time at least 90% of sentinel clinical laboratories acknowledged receipt of urgent message) (Intermediate stop time)
4. Date and time last sentinel clinical laboratory acknowledged receipt of urgent message) (Stop time)
5. Final percentage of sentinel clinical laboratories that acknowledged receipt of urgent message [%]
 - a. If 50%, 90%, or 100% of sentinel clinical laboratories did not acknowledge receipt of the urgent message:



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- i. Briefly describe, in general terms, key factors that account for less than 100% of sentinel clinical laboratories not acknowledging receipt of the urgent message. [Text box]
 - ii. What steps has the awardee taken to improve ability to send an urgent message and receive acknowledgement from sentinel clinical laboratories? [Text box]
6. Please specify the definition of sentinel clinical laboratory used in the awardee’s jurisdiction [Check one]
- LRN Joint Leadership Committee (JLC) (see definitions section)
 - Jurisdictionally defined (provide definition): [Text box]
 - a. Please describe any barriers to adopting the LRN JLC approved definition [Text box]
7. Number of sentinel clinical laboratories in the awardee’s jurisdiction
- a. Total
 - b. Advanced, if defined
 - c. Basic, if defined
8. Total number of operations-based exercises (drill, FE, or FSE only) testing communication between PHEP funded LRN-B laboratory and sentinel labs conducted between July 1, 2012 and June 30, 2013
9. Total number of incidents testing communication between the PHEP funded LRN-B laboratory and sentinel labs that occurred between July 1, 2012 and June 30, 2012
10. Method(s) PHEP-funded LRN-B laboratory used to send urgent message to sentinel clinical laboratories [Select all that apply]
- Cell phone
 - E-mail outside of rapid notification system
 - Fax
 - Rapid notification system (e.g. Health Alert Network)
 - Land-line telephone
 - Pager
 - Satellite communication system
 - Other, please specify: [Text Box]
11. Method(s) sentinel clinical laboratories used to acknowledge receipt of urgent message [Select all that apply]
- Cell phone
 - E-mail outside of rapid notification system
 - Fax
 - Rapid notification system (e.g., Health Alert Network)
 - Land-line telephone
 - Pager
 - Satellite communication system
 - Other, please specify: [Text Box]
12. Does this exercise or incident represent the best demonstration of the capability to communicate between PHEP-funded LRN-B laboratory and sentinel clinical laboratories? [Yes/No]
13. Please select the reason why this exercise or incident was chosen as the best demonstration of a communication between PHEP-funded LRN-B laboratory and sentinel clinical laboratories [Select the primary/most significant reason]
- Context of the public health response – potential for substantial public health impact
 - Incident
 - Complexity of the demonstration/response – scale of the demonstration/response requiring significant laboratory resources (staff, resources, etc.)
 - Duration of the demonstration/response
 - Required the mobilization of resources outside of the affected area
 - Quickest time
 - Only example/demonstration available
 - Other, please specify: [Text Box]
14. Was this your quickest time? [Yes/No]



How is this measure operationalized?

Not applicable



Pre-Incident

Core Public Health

Response

PHEP 12.10: Notification Drill associated with Proficiency Testing

Ability of PHEP-funded LRN-B reference laboratory to contact the CDC Emergency Operations Center within 2 hours during LRN notification drill

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-B Program



How is the measure calculated?

Notification drill results [Passed/did not pass/did not participate]



What data must be reported?

1. Notification drill results [Passed/did not pass/did not participate]
2. Month(s) drills were conducted



Why is this measure important?

LRN notification drills ensure that biological laboratories can contact the CDC Emergency Operations Center to report results to the watch staff and duty officers within 2 hours of obtaining a result. These drills are associated with participation in a specific proficiency test; laboratories that cannot participate in the test (e.g., they do not test for the agent in question, or are offline due to facility/equipment issues) are excluded from this drill.

No new data collection will be required (outside of the existing notification drill data collected by CDC’s LRN-B), but the intent is to ensure that awardee preparedness offices are aware of notification drill results and validate the information on an annual basis in the PHEP reporting system.

Performance target determined by the CDC LRN-B program



How is this measure operationalized?

Data will be collected by CDC’s LRN-B program and will be shared with DSLR. Notification drill data must be validated in the PHEP reporting system by the awardee’s preparedness office.



What other requirements are there for reporting measure data?

This performance measure is REQUIRED for all 50 state PHEP awardees as well as Los Angeles County, New York City, and Washington, D.C..



PHEP 12.11: Proficiency Testing (LRN-B)

Proportion of LRN-B proficiency tests successfully passed by PHEP-funded laboratories

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: PAHPA Benchmark
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-B Program



How is the measure calculated?

Numerator: Number of LRN-B proficiency tests successfully passed by PHEP-funded laboratory(s)

Denominator: Total number of LRN-B proficiency tests participated in by PHEP-funded laboratory(s)



Why is this measure important?

Recognition of a health emergency requires accurate laboratory testing of samples to detect disease or potential exposure. Once a laboratory is qualified to test for certain biological or chemical agents, it is important to ensure that this qualification is maintained, so that the CDC’s LRN and the awardee preparedness offices are aware of awardee testing capabilities.

With the exception of Reported Data Element 4, no new data collection will be required (outside of the existing proficiency testing conducted by CDC’s LRN-B or LRN-B sponsored proficiency tests), but the intent is to ensure that awardee preparedness offices are aware of proficiency testing activities and testing capabilities and validate the information on an annual basis in the PHEP reporting system.



What other requirements are there for reporting measure data?

This performance measure is REQUIRED for all 50 state PHEP awardees as well as Los Angeles County, New York City, and Washington, D.C..



What data must be reported?

1. Number of LRN-B proficiency tests participated in by the PHEP-funded laboratory (denominator)
2. Number of LRN-B proficiency tests successfully passed by the PHEP-funded laboratory during first attempt (numerator)
3. Number of LRN-B proficiency tests successfully passed by the PHEP-funded laboratory after remediation
4. If the PHEP-funded laboratory did not pass all LRN-B proficiency tests during first attempt, please explain why and the remediation taken [Text box]
5. Number of LRN-B proficiency tests participated in by all public health laboratories
6. Number of LRN-B proficiency tests successfully passed by all public health laboratories during first attempt
7. Number of PHEP-funded public health LRN-B laboratories.
8. Total number of public health LRN-B laboratories.



How is this measure operationalized?

Data are collected internally by the LRN-B program and will be shared with DSLR. Awardees will submit information for Reported Data Element 4. Proficiency testing data must be validated in the PHEP reporting system by the awardee’s preparedness office.

Please consult with the LRN-B program office or e-mail the LRN Helpdesk (LRN@cdc.gov) for specific questions about proficiency testing.



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PHEP 12.12: Sample Quality – First Responders

Percentage of LRN nonclinical samples received by the PHEP-funded LRN-B laboratory for confirmation or rule-out testing from **first responders** without any **adverse quality assurance events** (QA)

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of LRN nonclinical samples without any adverse QA events received at the PHEP-funded LRN-B laboratory for confirmation or rule-out testing from first responders

Denominator: Total number of LRN nonclinical samples received at the PHEP-funded LRN-B laboratory for confirmation or rule-out testing from first responders



Why is this measure important?

The proper collection, packaging, and shipping of samples is important to ensure the integrity of the sample and the safety of all those involved. Assessing the overall quality of samples from first responders will help ensure the effective and timely recognition of potential health emergencies. To complement the requirement for PHEP-funded laboratories to demonstrate PCPaS to CDC, this measure allows for a standardized evaluation of these practices by first responders.



What other requirements are there for reporting measure data?

Data are to be reported on the quality of LRN nonclinical samples received from first responders on a day-to-day basis (i.e., not via exercises). Only LRN nonclinical samples received from first responders (e.g., hazardous material team) within the awardee’s jurisdiction or a U.S. Territory (if applicable) may be included in this performance measure.



What data must be reported?

- Total number of LRN nonclinical samples received for confirmation or rule-out testing from first responders (denominator)
 - Number of samples from first responders within the awardee’s jurisdiction
 - Number of samples from first responders in a U.S. Territory (if applicable)
- Total number of LRN non-clinical samples for confirmation or rule-out testing without any adverse QA events received from (numerator)
 - First responders within the awardee’s jurisdiction
 - U.S. Territory (if applicable)
- Please specify definition of adverse QA event used in the awardee’s jurisdiction: [Select one]
 - Definition as written in Definitions of Key Terms section or
 - Jurisdictionally-defined. Please provide definition. [Text box]
- For those LRN nonclinical samples received from first responders within your jurisdiction that had adverse QA events:
 - What types of adverse QA events occurred? [Text box]
 - What steps has the awardee taken to address these adverse QA events? [Text box]
- For those LRN nonclinical samples received from first responders in U.S. Territories that had adverse QA events (if applicable):
 - What types of adverse QA events occurred? [Text box]





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- b. What steps have been taken to address any QA events from territorial submissions? [Text box]



How is this measure operationalized?

Not applicable



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Response

PHEP 12.13: Specimen Quality – Sentinel Clinical Laboratories

Percentage of LRN clinical specimens received by PHEP-funded LRN-B laboratory for confirmation or rule-out testing from sentinel clinical laboratories without any adverse QA events

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of LRN clinical specimens received by PHEP-funded LRN-B laboratory for confirmation or rule-out testing from sentinel clinical laboratories without any adverse QA events

Denominator: Total number of LRN clinical specimens received by PHEP-funded LRN-B laboratory for confirmation or rule-out testing from sentinel clinical laboratories



Why is this measure important?

The proper collection, packaging, and shipping of specimens is important to ensure the integrity of the specimen and the safety of all those involved. Assessing the overall quality of specimens received from sentinel clinical laboratories will help ensure the effective and timely recognition of potential public health emergencies.



What other requirements are there for reporting measure data?

All state-level, PHEP-funded LRN-B reference laboratories must participate in proficiency testing for this measure. Other awardees have the option to report these data, as applicable.

Data are to be reported on the quality of LRN clinical specimens received from sentinel clinical laboratories on a day-to-day basis (i.e., not via exercises). Only LRN clinical specimens received from sentinel clinical

laboratories and/or U.S. Territory health departments (if applicable) may be included in this performance measure.



What data must be reported?

- Total number of LRN clinical specimens received for confirmation or rule-out testing from sentinel clinical laboratories (denominator)
 - Number of specimens from sentinel clinical laboratories within the awardee’s jurisdiction
 - Number of **U.S. Territory health department specimens** (if applicable)
- Total number of LRN clinical specimens received from sentinel clinical laboratories for confirmation or rule-out testing without any adverse QA events (numerator)
 - Number of specimens from sentinel clinical laboratories within the awardee’s jurisdiction
 - Number of specimens from a U.S. Territory (if applicable)
- Please specify the definition of adverse QA event used in the awardee’s jurisdiction [Select one]
 - Definition as written in Definitions of Key Terms section or
 - Jurisdictionally-defined. Please provide definition. [Text box]
- For those LRN clinical specimens received from sentinel clinical laboratories within your jurisdiction that had adverse QA events:
 - What types of adverse QA events occurred? [Text box]
 - What steps has the awardee taken to address these adverse QA events? [Text box]





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5. For those LRN clinical specimens received from U.S. Territories that had adverse QA events (if applicable):
 - a. What types of adverse QA events occurred? [Text box]
 - b. What steps have been taken to address any QA events from territorial submissions? [Text box]



How is this measure operationalized?

Not applicable



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Response

PHEP 12.14: PFGE *E. coli*

Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet (PN) national database **within four working days** of receiving isolate at the PFGE laboratory

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Accountability: GPRA Measure
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC ELC Program and CDC PulseNet



How is the measure calculated?

Numerator: Number of results from PFGE sub-typing of *E. coli* O157:H7 isolates that were submitted to the PulseNet (PN) database within four **working days** of receipt at the PFGE laboratory.

Denominator: Total number of *E. coli* O157:H7 isolates for which the state performed PFGE subtyping

Target: 90%.



Why is this measure important?

Awardees need to be able to inform local, state, and national laboratorians and epidemiologists of disease occurrences in a timely manner to determine the extent and scope of potential outbreaks and to minimize the effects of these outbreaks.

Performing PFGE subtyping and submitting data results to the PulseNet electronic database in a timely manner indicates the public health laboratory's ability to subtype specific bacteria and share results quickly.



What other requirements are there for reporting measure data?

Data for this performance measure will be collected by the Epidemiology and Laboratory Capacity cooperative agreement program (from its awardees) as well as

extracted from the PulseNet national database, and shared with DSLR. PHEP awardees that allocate PHEP funding towards PFGE activities will be required to verify these data. Data from this measure, irrespective of PHEP funding, may be reported in CDC's State-by-State Public Health Preparedness Report. (<http://www.bt.cdc.gov/cdcpreparedness/pubs-links/>).



What data must be reported?

1. Number of *E. coli* O157:H7 isolates received by the *state public health laboratory*. (ELC*)
 - a. Of these, number of isolates sent to another laboratory (out of state) for PFGE sub-typing. (ELC)
2. Number of *E. coli* O157:H7 isolates for which the *PFGE laboratory* performed PFGE subtyping. (denominator) (ELC)
 - a. ELC grantees will self-report this number as the total number of isolates run with primary enzyme
3. Number of primary patterns from sub-typed isolates uploaded into the PulseNet national database (PN*)
 - a. Of these, number of primary patterns with a valid receive date (i.e., date received at the *PFGE laboratory*) (PN).
4. Number of results from PFGE sub-typing of *E. coli* O157:H7 isolates that were submitted to the PulseNet database within four working days of receipt at PFGE laboratory (numerator) (PN)





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5. If calculated percentage for this performance measure (determined by CDC PulseNet) < 90%, please describe barriers or challenges to meeting this target (90% of subtyping results submitted to PulseNet within four working days of receipt at PFGE laboratory)

* Reporting entity in parentheses (e.g., ELC, PN)



How is this measure operationalized?

Awardees should not count duplicates in the isolates they receive if they are not subtyped.

Isolates refers to reference or clinical isolates.



PHEP 12.15: PFGE *L. monocytogenes*

Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *Listeria monocytogenes* submitted to the PulseNet (PN) national database within four working days of receiving isolate at the PFGE laboratory

Measure Applies To :	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: CDC ELC Program and CDC PulseNet



How is the measure calculated?

Numerator: Number of results from PFGE sub-typing of *Listeria monocytogenes* isolates that were submitted to the PulseNet (PN) database within four working days of receipt at the PFGE laboratory.

Denominator: Total number of *Listeria monocytogenes* isolates for which the state performed PFGE subtyping

Target: 90%.



Why is this measure important?

Awardees need to be able to inform local, state, and national laboratorians and epidemiologists of disease occurrences in a timely manner to determine the extent and scope of potential outbreaks and to minimize the effects of these outbreaks.

Performing PFGE subtyping and submitting data results to the PulseNet electronic database in a timely manner indicates the public health laboratory’s ability to subtype specific bacteria and share results quickly.



What other requirements are there for reporting measure data?

Data for this performance measure will be collected by the Epidemiology and Laboratory Capacity cooperative agreement program (from its awardees) as well as

extracted from the PulseNet national database, and shared with DSLR. PHEP awardees that allocate PHEP funding towards PFGE activities will be required to verify these data. Data from this measure, irrespective of PHEP funding, may be reported in CDC’s State-by-State Public Health Preparedness Report. (<http://www.bt.cdc.gov/cdcpreparedness/pubs-links/>).



What data must be reported?

1. Number of *Listeria monocytogenes* isolates received by the *state public health laboratory*. (ELC*)
 - a. Of these, number of isolates sent to another laboratory (out of state) for PFGE sub-typing. (ELC*)
2. Number of *Listeria monocytogenes* isolates for which the *PFGE laboratory* performed PFGE subtyping. (denominator) (ELC)
 - a. ELC grantees will self-report this number as the total number of isolates run with primary enzyme
3. Number of primary patterns from sub-typed isolates uploaded into the PulseNet national database (PN*)
 - a. Of these, number of primary patterns with a valid receive date (i.e., date received at the *PFGE laboratory*) (PN).
4. Number of results from PFGE sub-typing of *Listeria monocytogenes* isolates that were submitted to the PulseNet database within four working days of receipt at PFGE laboratory (numerator) (PN)





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5. If calculated percentage for this performance measure (determined by CDC PulseNet) < 90%, please describe barriers or challenges to meeting this target (90% of subtyping results submitted to PulseNet within four working days of receipt at PFGE laboratory)

* Reporting entity in parentheses (e.g., ELC, PN)



How is this measure operationalized?

Awardees should not count duplicates in the isolates they receive if they are not subtyped.

Isolates refers to reference or clinical isolates.





Key Measurement Terms

Acknowledgement: An acknowledgement is a notified sentinel clinical laboratories confirm receipt of urgent message. Sentinel clinical laboratories can acknowledge receipt of the message through cell phone, e-mail outside of rapid notification system, fax, rapid notification system (e.g. Health Alert network), land-line telephone, pager, satellite communication system, or another method, including electronic lab reporting or LIMS systems in place. Method of acknowledgement can differ from method of notification.

Adverse quality assurance event: An adverse quality assurance event is any deviation from established and written policies and procedures for an ongoing mechanism that monitors, assesses, and, when indicated, corrects identified problems that could result in a negative or potentially negative outcome (as stated in the Clinical Laboratory Improvement Amendments (CLIA) sec. 493).

CDC EOC official: A CDC EOC official is a staff member of CDC's Emergency Operation Center (EOC) who initiates the 24/7 emergency contact drill, and receives confirmation of receipt from awardees' on-call epidemiologists and laboratorians.

Exercise types: Exercise types are additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at <https://hseep.dhs.gov/support/Volumel.pdf>

First responders: First responders are first trained professionals to arrive on scene for response efforts. Examples of first responders include firefighters (e.g., professional and volunteer), police officers, emergency medical services (EMS) personnel, and hazardous material teams

Nonclinical sample: Non-clinical samples exclude any human specimens. Examples of nonclinical samples include soils, water, powders, food, and animal products.

Notification: Notification is communication by the PHEP-funded laboratory (through phone, fax, e-mail or other methods) to public health partners indicating that it has obtained significant laboratory results from a clinical specimen or nonclinical sample.

Outside of normal business hours: Outside of normal business hours are those hours outside of which most business is conducted (i.e. non-working hours).

On-call epidemiologist: An on-call epidemiologist is personnel from the awardee epidemiology office or health department who has authority to act or process the notification from an on-call laboratorian.

On-call laboratorian: An on-call laboratorian are laboratory personnel who have authority to receive samples and ensure that testing can be conducted. Ensuring that testing can be conducted includes responsibilities such as assessing the need to initiate testing and / or contacting a properly trained laboratorian that can begin testing samples. This does not include security personnel that can only receive samples.

PHEP-funded laboratory: A PHEP-funded laboratory is an awardee-level laboratory that is partially or fully funded with PHEP funds – either directly from the awardee health department or via contract. Generally, measures that apply to LRN-B labs refer to the state public health laboratories – as well as the public health labs in Los Angeles County, New York City, and Washington, D.C. States with multiple state-level LRN-B reference labs should report data on all of them, as applicable, depending on whether the performance measure is self-report or reported through CDC's LRN (the latter may only collect data from a subset of all state labs). Measures that apply to LRN-C indicate what level of lab needs to report (i.e., Level 1, 2 and/or 3). Performance measures will specify which PHEP-funded laboratory(ies) should report data.

Public health designated official: The public health designated official is any individual in the public health agency who has the authority to take necessary action in the context of a public health response. A designated official may be the lab director, state or city health officer, state epidemiologists, emergency management official, or any other individual with such authority.



Public health partners: Public health partners are any local, state, or federal agency, or healthcare provider, routinely involved in the public health response process – or otherwise involved due to the specific circumstances of an incident.

Report for duty at laboratory: To report for duty at laboratory is when an on-call laboratorian arrives at appropriate testing laboratory ready to receive specimens and can ensure that testing, packaging, and shipping, or referral, can begin.

Sentinel clinical laboratories: (as developed by CDC, the Association of Public Health Laboratories (APHL), and the American Society for Microbiology (ASM) and approved by the LRN Joint Leadership Committee- JLC): Sentinel clinical laboratories have the ability to perform routine assays of human specimens for the presence of microbial agents. Depending on the level of diagnostic testing, sentinel clinical laboratories should be characterized as advanced or basic. CDC recognizes the definition of Advanced and Basic Sentinel Laboratories as described by APHL in the document entitled “LRN Sentinel Laboratories: Clinical”. The document can be found at: http://www.aphl.org/aphlprograms/preparedness-and-response/Documents/LRN_Sentinel_Clinical.pdf

Significant laboratory results: Significant laboratory results are any result (i.e., positive or negative) obtained from testing a clinical specimen or nonclinical sample that requires notification to CDC and other key partners. Refer to the CDC/LRN Policy Statement on Notification of Officials of Significant Laboratory Results (LGE-00010) and agency-specific protocols. While no formal CDC/LRN notification policy exists for LRN-C laboratories, each state should maintain its own policy.

Submission of results within four working days: Submission of results within four working days is the target of this measure is the submission of PFGE subtyping results to PulseNet within four working days from the date that the PFGE laboratory has a pure culture of a viable organism with known identification.

Unannounced: Unannounced is when a notification with no advanced warning / notice.

Urgent message: An urgent message is a message that requires rapid acknowledgment from sentinel clinical laboratories. PHEP-funded laboratories should develop a message that is appropriate for their sentinel clinical laboratory network and are encouraged to explicitly request that sentinel clinical laboratories rapidly acknowledge receipt of the message.

U.S. Territory health department samples and specimens: U.S. Territory health department samples and specimens are samples and specimens received by awardee laboratories or first responders from American Samoa, Guam, Marshall Islands, Federated States of Micronesia, Northern Mariana Islands, Puerto Rico, Palau, and the Virgin Islands

Working days: Working days is equivalent to business days and includes every official working day. Working days do not include public holidays, regularly scheduled non-business days (e.g., Sunday), or furlough days.

13. Public Health Surveillance and Epidemiological Investigation

Introduction

This capability includes activities related to surveillance and detection of public health threats; conducting and documenting epidemiological investigations; and the recommendation or implementation of public health control measures. Case reporting is a prerequisite for an effective public health system and is an essential component of public health emergency preparedness. Timely reporting permits public health agencies to initiate investigations and recommend interventions, thereby protecting the health of the community. Conducting and documenting investigations with complete reports enables public health agencies to improve the quality of these investigations by ensuring that the incident is appropriately characterized, and that results and recommendations are documented and shared with decision makers.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Conduct Public Health Surveillance and Detection
2. Conduct Public Health and Epidemiological Investigation
3. Recommend, Monitor, and Analyze Mitigation Actions
4. Improve Public Health and Epidemiological Investigation Systems

Alignment of Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 13.1	●			
PHEP 13.2			●	
PHEP 13.3		●		
PHEP 13.4		●		
PHEP 13.5		●		
PHEP 13.6		●		

PHEP 13.1: Disease Reporting

Proportion of reports of selected reportable diseases received by a public health agency within the **awardee-required timeframe**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI, LAC	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of reports of selected reportable disease received by a public health agency within the awardee-required timeframe

Denominator: Number of reports of selected reportable disease received by a public health agency



Why is this measure important?

Case reporting of reportable infectious diseases is a prerequisite for an effective public health system. Timely reporting permits public health agencies to initiate investigations and recommend meaningful interventions, thereby protecting the health of individuals as well as the broader community.

The immediate intent of this performance measure is to capture the extent to which specific diseases of local and national public health significance are first reported to any level of the public health system (e.g., local, state, regional, county) from reporting entities (e.g., hospitals, labs, providers) within awardee-required timeframes.

The broader programmatic aim of this performance measure is to improve the timeliness of **disease reporting** by providers, hospitals, and laboratories to public health agencies as part of systematic program and process improvement for awardee and LHD surveillance programs

Note: The intent of this measure is not to capture the timeliness of disease “reporting” from LHDs to an awardee health department (or vice versa) or notification from an awardee to CDC.



What other requirements are there for reporting measure data?

This performance measure requires data collection from a sample of counties in the awardee’s jurisdiction. This sample is provided to awardees by CDC, and should be verified at the start of the budget period. See Appendix B for details. LHDs that receive reports of select cases of disease in these counties should report all necessary data for this measure to the awardee.

Awardees are required to report data on case reports with CDC notification dates between MMWR Week 32, 2012 (beginning Sunday, August 5, 2012) through MMWR Week 26, 2013 (ending June 29, 2013).

Awardees are required to provide data on the following diseases according to the specified case classification criteria noted in parentheses:

- Diseases associated with the following Category A agents:
 - Botulism (*Clostridium botulinum*), all types excluding infant botulism (confirmed)
 - Tularemia (*Francisella tularensis*) (confirmed and probable)
- *E. coli*, STEC (all reports)
- Hepatitis A, acute (confirmed)





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- Measles (confirmed)
- Meningococcal disease (*Neisseria meningitides*) (confirmed)

Awardees should calculate the numerator and denominator for this performance measure at the public health system level (i.e., to include reports first received by the awardee health department and reports first received by LHDs in pre-selected sample of counties). In other words, awardees should aggregate all reports first received by the awardee health department and by LHDs receiving case reports in the pre-selected sample of counties – excluding duplicate cases. Reports occurring in counties not included in the sample should be excluded from the numerator and denominator in reporting to CDC. Awardees should strongly consider collecting performance measures data from all counties/LHDs for program and surveillance improvement purposes.

Awardees should ensure counts exclude duplicate cases.

Awardees should exclude cases of disease from the numerator that are missing pertinent data (e.g., dates), which preclude definitive calculation of timeliness. These cases must be included in the denominator.



What data must be reported?

1. Total number of disease reports received (denominator). Please aggregate reports received by the awardee health department and by LHDs receiving reports in counties in the pre-selected sample; do not include reports from counties that were not included in the sample.
 - a. By disease
2. Total number of disease reports received within the awardee-required reporting timeframe (numerator). Please aggregate reports received by the awardee health department and by LHDs receiving reports in counties in the pre-selected sample; do not include reports from counties that were not included in the sample.
 - a. By disease
3. Do the awardee-required reporting timeframes differ for *providers* and *laboratories* for any of the selected diseases? [Yes/No] If NO, please skip to Question 6.

4. For each of the selected diseases, please indicate the awardee-required reporting timeframe for *providers* [Select one]
 - Immediately
 - 24 hours
 - 48 hours
 - 72 hours
 - 7 days
 - Other, please specify: [Text Box]
5. For each of the selected diseases, please indicate the awardee-required reporting timeframe for *laboratories* [Select one] – Please skip to Question 7.
 - Immediately
 - 24 hours
 - 48 hours
 - 72 hours
 - 7 days
 - Other, please specify: [Text Box]
6. For each of the selected diseases, please indicate the awardee-required reporting timeframe [Select one]
 - Immediately
 - 24 hours
 - 48 hours
 - 72 hours
 - 7 days
 - Other, please specify: [Text Box]
7. Case event date type selected for each disease [Select one]
 - Date of diagnosis – lab-confirmed
 - Date of diagnosis – presumptive/clinical
 - Date of laboratory report
 - Date of laboratory result
 - Date of specimen collection
8. Does the awardee health department have in place processes, procedures, etc., for periodic (e.g., annual) review of data related to timeliness of disease reporting for the purposes of program improvement? [Yes/No] – If No, skip to Question 10.
9. Please describe processes, procedures, etc., the awardee health department has in place for periodic (e.g., annual) review of data related to



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timeliness of disease reporting for the purposes of program improvement. [Text box]

- 10. Names of counties contributing data for this measure [Text box]
- 11. Number of LHDs reporting data for this measure
- 12. Total number of LHDs (from the reporting sample) that has a process, procedure, etc., in place for periodic (e.g., annual) review of data related to timeliness of reporting for the purposes of program improvement.
- 13. Please describe the key barriers to timely reporting of the select diseases for this performance measure by hospitals, providers and labs. [Text box]



How is this measure operationalized?

Case event dates – assessing timeliness of disease reporting by providers and labs: Time requirements for disease reporting by providers and labs to public health agencies are typically determined at the awardee level through statute or regulation (e.g., Providers should report measles within 24 hours to their LHD). For the purpose of this measure, awardees will need to determine the length of time between two specific case event dates noted for each case to determine whether a report was received within the required timeframe. Awardees may choose the first case event date type. The second case event date (and type) is always the date of first report to a public health agency.

Note: for each disease, awardees are encouraged to select the earliest case event that is feasible to collect from a program standpoint and subtract that from the date of first report to a public health agency. The result is a period of time that falls either within or outside the awardee-required reporting timeframe for a given disease. Once a case event date type is selected for a given disease, all cases of that disease must use that case event date type to calculate timeliness. For example, if presumptive diagnosis date is selected for measles, timeliness calculations for all measles cases must subtract date presumptive diagnosis date from first report to public health agency.

Case event date types – considerations for selection: With input from LHDs, awardees should select one case event date type for each disease prior to the start of the performance period. All health departments participating in data collection for this performance

measures should then uniformly use the same case event date for that disease.

Additional considerations for selecting a case event date type: Awardees may select different case event date types for each of the six diseases included in this performance measure. Awardees may also choose the same case event date type for multiple diseases. Although awardees have flexibility to determine which case event date type they will use for each disease, certain case event types may be less amenable for use for a given disease. Examples of questionable case event date types for specific diseases include date of presumptive diagnosis for hepatitis A or date of lab report, lab result, or lab-confirmed diagnosis for measles. Please see below for specific issues to consider regarding case event date types for *E. coli* and measles.

Category A agents: Category A agents can create situations that significantly impact community health. Most require broad public health preparedness efforts, such as enhanced surveillance and rapid public health response, particularly if used intentionally or found to be widespread. For this performance measure, awardees should report only for botulism and tularemia.

Date of diagnosis – presumptive/clinical: Selection of this case event date type presumes awardees (and LHDs) have or will have a standardized process and defined data field in place in their surveillance system(s) to capture this information. Awardees that have a generic date of diagnosis field on their case report forms or in their electronic disease surveillance systems should be sure they have clearly defined whether this field refers to presumptive/clinical or lab-confirmed diagnosis. Please see definitions section for more information.

E. coli (STEC), Hemolytic Uremic Syndrome (HUS) and case event date types: A small percentage of STEC cases result in an extremely serious condition known as HUS. Although these cases differ clinically from other STEC (which suggests using different case event date types for each), awardees are requested to choose only one case event date type for STEC and calculate timeliness against only that type.

First report to a public health agency: Awardees should use the time that a public health agency was first alerted to a case of selected disease whether by



phone, fax, online surveillance system, case report form, or another means of notification.

Low or zero incidence of disease: It is understood that in many jurisdictions (awardee and local), there may be few or no cases of certain diseases. Although there may be challenges in instituting program improvement processes on the basis of extremely low incidence diseases, the diseases selected for this performance measure are of significance nationally and require surveillance systems and processes for timely reporting irrespective of incidence rates. It should also be noted that reporting low or zero incidence of disease by awardees is not, in and of itself, a reflection of poor performance and will not be interpreted as such by CDC.

Measles – case event date type options: Due to the relative feasibility of recognizing and reporting suspected measles cases prior to lab confirmation, CDC recommends awardees select date of diagnosis – presumptive or Date of specimen collection for this disease.

Reporting timeframes – provider and lab differences: In some awardee jurisdictions, reporting timeframes for select diseases differ depending on whether reported by providers or labs. Awardees are requested to ensure that calculations of timeliness of reporting for each case of disease are compared against the appropriate required timeframe.

Note: for cases in which both a provider and a lab report the same case of disease, awardees should count the first instance of reporting the case for the purpose of this performance measure.

Simultaneous reporting to state and LHDs: In some instances, disease reports may be submitted to, or populate, local and state health department surveillance systems simultaneously. This should not impact total counts for this performance measure if duplicate cases are not included.



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PHEP 13.2: Disease Control

Proportion of reports of selected reportable diseases for which initial public health **control measure (s)** were initiated within the **appropriate timeframe**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities: Excludes CHI, LAC	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of reports of selected reportable diseases for which public health control measure(s) were initiated within an appropriate timeframe

Denominator: Number of reports of selected reportable diseases received by a public health agency



Why is this measure important?

Effective control measures and mitigation strategies are fundamental to the health of communities and populations by limiting the spread of disease and, as feasible, eliminating or reducing sources of infection.

The immediate intent of this performance measure is to capture the extent to which initial public health control measures are initiated within an appropriate timeframe following the first report of a selected disease (i.e., either probable or confirmed depending on what is appropriate in practice for that disease) received by a public health agency.

The broader programmatic aim of this measure is to improve the timeliness of appropriate interventions to limit the spread of disease in human populations and communities.



What other requirements are there for reporting measure data?

This performance measure requires data collection from a sample of counties in the awardee's jurisdiction. This sample is provided to awardees by CDC, and should be verified at the start of the budget period. See Appendix B for details. LHDs that receive reports of select cases of disease in these counties should report all necessary data for this measure to the awardee.

Awardees are required to report data on case reports with CDC notification dates between MMWR Week 32, 2012 (beginning Sunday, August 5, 2012) through MMWR Week 26, 2013 (ending June 29, 2013).

Awardees are required to provide data on the following diseases according to the specified case classification criteria noted in parentheses:

- Diseases associated with the following CDC Category A agents:
 - Botulism (*Clostridium botulinum*) , all types excluding infant botulism (confirmed)
 - Tularemia (*Francisella tularensis*) (confirmed and probable)
- *E. coli*, STEC (all reports)
- Hepatitis A, acute (confirmed)
- Measles (confirmed)
- Meningococcal disease (*N. meningitides*) (confirmed)



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Awardees should calculate the numerator and denominator for this performance measure:

- By disease

Awardees should ensure counts exclude duplicate cases.

Awardees should exclude cases of disease from the numerator that meet inclusion criteria but are missing pertinent data (i.e., dates), and include them in the denominator.



What data must be reported?

1. Total number of disease reports received (denominator). Please aggregate reports received by awardee health department *and* by LHDs receiving reports in counties in the pre-selected sample; *do not* include reports from counties that were not included in the sample.
 - a. By disease
2. Total number of reports for which a control measure was initiated within the appropriate timeframe (numerator)
 - a. By disease
 - i. By awardee health department
 - ii. By reporting LHDs (aggregated)
3. Does the awardee health department have in place processes, procedures, etc., for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement? [Yes/No] – If No, skip to Question 5.
4. Please describe processes, procedures, etc., the awardee health department has in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement. [Text box]
5. Names of counties contributing data for this measure [Text box]
6. Number of LHDs reporting data for this measure
7. Total number of reporting LHDs that has a process, procedure, etc., in place for periodic (e.g., annual) review of data related to timely initiation of public health control measures for the purposes of program improvement.
8. Please describe the key barriers faced by health departments in the timely control or mitigation of

the select diseases for this performance measure. [Text box]



How is this measure operationalized?

Assessing control measure timeliness: For a given case to count toward the numerator for the performance measure, awardees will need to compare case data with the Public Health Control Measures Table (see Appendix B) to determine whether a control measure(s) was initiated within the appropriate timeframe. Awardees should use the time that the first report of a selected disease (i.e., either probable or confirmed depending on what is appropriate in practice for that disease) was received by a public health agency as the start time for this performance measure. For example, a case report for meningococcal disease documenting prophylaxis or recommendations for prophylaxis of indicated contacts within 24 hours of receipt of the case *would count* toward the numerator for this performance measure. *Category A agents:* [see PHEP 13.1]

First report to a public health agency: [see PHEP 13.1]

Public health control measures and initiation: This performance measure focuses on the timely *initiation* of any one of a variety of public health control measures. Depending on the disease, measures range from identification (and removal, as feasible) of a source of infection, to immunization or prophylaxis of contacts, to exclusions from child care or food-handling. Awardees are given some latitude to determine which documented actions will count as an appropriate control measure, although in general the examples provided in the table of control measures (**Appendix D**) are meant to highlight the actions for each disease for which timeliness should be measured. Important points to note:

- This performance measure is meant to capture *initiation* of public health control measures, *not* completion.
- In general, the intent of this performance measure is *not* to capture the first phone call to a healthcare provider to discuss a case patient, unless that discussion entails recommendations and/or education regarding specific control measures (e.g., calling a parent and/or a day care center to exclude an



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infectious child from child care due to *E. coli* or hepatitis A would count).

- If a health department documents timely *initiation* of either (a) an appropriate control measure, (b) a *recommendation* for a control measure, (c) a decision *not* to initiate a control measure, or (c) *inability* to initiate a control measure despite an effort to do so, this will meet the intent of the measure and count toward the numerator.
- Awardees may wish to consider standardizing, with input from LHDs, an operational definition of initiation. Examples may include date of patient contact or date of interview, as long as these explicitly entail implementation or recommendation of control measures in addition to routine fact-finding.





Key Measurement Terms for Public Health Surveillance

Appropriate timeframe: An appropriate timeframe is a timeframe for intervention(s) or control measures with meaningful public health relevance. Although individual cases may vary in practice, appropriate timeframes for each of the six selected diseases have been standardized for the purpose of this performance measure.

Awardee-required timeframe: The awardee-required timeframe is a jurisdictionally-mandated timeframe either by law or regulation for healthcare providers to report

Case: Awardees should provide aggregate data solely on cases that meet the classification criteria for each disease described below (e.g., meningococcal disease: confirmed cases only). These criteria meet CDC's most recent Morbidity and Mortality Weekly Report (MMWR) print criteria for each disease. Due to the provisional nature of some case data and the likelihood of eventual rule-outs of some cases, it is understood that case counts may change following awardee reporting for this performance measure. Awardees are not required to reconcile this performance measure data to their final National Notifiable Disease Surveillance System (NNDSS) data. Provisional case counts for this performance measure are acceptable.

Case event date types: Case events mark the occurrence of specific clinical or laboratory activities or milestones that, in the context of the Disease Reporting performance measure, serve as the "start time" (measured via the "case event date") against which timeliness of reporting for cases of disease can be calculated. There are five options for case event date types, all defined below. Awardees may utilize only one type of case event date for all cases of a given disease, but are free to use that same type for multiple diseases (e.g., Date of diagnosis-lab confirmed for Hepatitis A and *E. coli* (STEC)). Please see the Additional Guidance section of the SURV – Disease Reporting performance measure for further instructions and recommendations regarding *E. coli* and measles.

- **Date of diagnosis – lab-confirmed:** Date of medical determination of a disease state following confirmation of the presence of an organism or toxin (e.g., positive blood or stool culture, antigen test, botulinum toxin test, etc.) or physiological effects (e.g., presence or increase in antibodies associated with a disease, etc.) from laboratory testing. This refers to definitive, as opposed to preliminary, laboratory results.
- **Date of diagnosis – presumptive/clinical:** Date of medical determination indicating suspected presence of a particular disease for which initial interventions can be initiated and/or further testing undertaken. By definition, a presumptive diagnosis has not (yet) been confirmed. Instead, this type of diagnosis may be based on empirical observations by a clinician, patient histories, establishment of epidemiological linkages, preliminary laboratory findings (e.g. Gram's stain), or special diagnostic procedures (e.g. using an EMG test on a person with suspected botulism).
- **Date of laboratory report:** Date that first positive laboratory test result is either posted or communicated to appropriate clinical or organizational entity (i.e., a provider, not the public health agency). The report date can refer to communication of preliminary (if applicable or necessary) or confirmed lab results.
- **Date of laboratory result:** Date that a test, assay or other procedure is first determined to be either positive for the existence of an organism or otherwise significantly indicative of a relevant disease state.
- **Date of specimen collection:** Date that a clinical specimen is collected for analysis and/or testing. Specimen collection generally refers to the collection of blood, feces, or cerebrospinal fluid.

Immediate reporting timeframe: Immediate reporting is within 12 standard (i.e., not business) hours. If health departments do not capture dates and times of specific case events, they may consider cases as immediately reported if the selected case event date and date of first report to a health department occur on the same date.

Initiation of a control measure: Initiation of a control measure refers to the first substantive activity by public health staff to prevent or control the spread of disease. Please see the Additional Guidance section of the SURV – Disease Control performance measure for more information regarding activities that constitute initiation and examples of control measures. Examples may also be found in Appendix B.

Reporting of selected disease: Reporting of a selected disease is an initial communication by a hospital, lab, or provider to report a suspected or confirmed case of disease, or positive test result, either to an awardee health department (including its local, regional or branch offices in centralized states) or autonomous LHDs participating in the data collection effort for this performance measure. Please note, by definition, awardees should not count cases of disease reported to the awardee (e.g., state health department) from an LHD.

PHEP 13.3: Outbreak Investigation Reports

Percentage of **infectious disease outbreak investigations** that generate reports

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of infectious disease outbreak **investigation reports** generated

Denominator: Number of infectious disease outbreaks investigated

- The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report
- Completed investigations for which a draft investigation report has not yet been finalized or approved.
- Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown.



Why is this measure important?

The immediate intent of this measure is to capture the ability of awardees and LHDs to document epidemiological investigations of infectious disease outbreaks.

The broader programmatic aim of this measure is to improve the ability of health departments to conduct epidemiological investigations of infectious disease outbreaks by appropriately documenting and reporting on investigation activities and findings.

Awardees should calculate a numerator and denominator for this performance measure:

- At the awardee level and
- For LHDs reporting on outbreaks in the pre-selected sample of counties. Please see the Additional Guidance section for further instructions.



What other requirements are there for reporting measure data?

Awardees are required to report summary data generated from real infectious disease outbreak investigations and investigation reports only (i.e., not drills or exercises). This sample is provided to awardees by CDC, and should be verified at the start of the budget period. See Appendix B for details.

Draft reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:



What data must be reported?

Questions 1 through 6 refer to *awardee-level* investigation activities only (i.e., no data from LHDs reporting on outbreaks in the pre-selected sample of counties should be included in these responses).

1. Total number of infectious disease outbreaks reported to the awardee by all sources
2. Total number of infectious disease outbreak investigations in which the awardee
 - a. *led* the investigation – solely or as part of a **joint investigation** (denominator for awardee metric)
 - b. *supported* any LHD investigation (irrespective of whether LHD is in reporting sample)



- c. supported any other type of joint investigation (i.e., *not* supporting an LHD; this may include supporting CDC or another state)
- 3. The total number of infectious disease outbreak investigations for which *a report was generated*
 - a. in which the *awardee led* the investigation (numerator for awardee metric)
 - b. in which the awardee supported *any LHD investigation* and contributed to the investigation report
 - c. in which the awardee supported *any other type* of joint investigation and contributed to the investigation report (i.e., *not* supporting an LHD; this may include supporting CDC or another state)
- 4. Rank the key factors that accounted for the awardee health department *not* conducting investigations of infectious disease outbreaks. [Rank only those that apply]
 - Interagency collaboration and coordination challenges (i.e., between a health department and another government agency or department)
 - Intraagency collaboration and coordination challenges (i.e., within the health department)
 - Insufficient resources (e.g., funding, staffing, time): If selected, please describe, to extent feasible, how this impacted awardee’s ability to investigate outbreaks. (e.g., numbers or types of outbreaks not investigated) [text box]
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Policy decision not to investigate certain types of infectious disease outbreaks (e.g., norovirus): please elaborate. [Text box]
 - Other, please specify: [Text Box]
- 5. Does the awardee health department have in place processes, procedures, etc., for review of its epidemiological investigations of infectious disease outbreaks for the purposes of program improvement? [Yes/No]
- 6. What type(s) of processes, procedures, etc., does the awardee health department have in place for review of its epidemiological investigations of infectious disease outbreaks for the purposes of program improvement? [Select all that apply]
 - Periodic or annual reviews
 - Episodic reviews or hotwashes
 - After-action reports

- No procedure in place
- Other, please specify: [Text Box]

The following questions (7-13) refer to the LHDs reporting data from the pre-selected sample of counties. Specifically, these questions concern outbreak investigations led by health departments within this sample, without any support from the awardee or federal agencies.

- 7. The total number of infectious disease outbreaks occurring within the sample of pre-selected counties
- 8. The total number of infectious disease outbreak investigations *led by LHDs reporting on outbreaks in the pre-selected sample of counties* (denominator for local metric)
- 9. The total number of infectious disease outbreak investigations for which a report was generated (LHD must have *led* the investigation) (numerator for local metric)
- 10. What were the most frequent factors that accounted for *not* investigating infectious disease outbreaks among the sample of LHDs reporting data for this performance measure? [Select all that apply]
 - Interagency collaboration and coordination challenges (i.e., between a health department and another government agency or department)
 - Intraagency collaboration and coordination challenges (i.e., within a health department)
 - Insufficient resources (e.g., funding, staffing, time)
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Policy decision not to investigate certain types of infectious disease outbreaks (e.g., norovirus): please elaborate. [Text box]
 - Other, please specify: [Text Box]
- 11. Names of counties contributing data for this measure [Text box]
- 12. Number of LHDs reporting data for this measure
- 13. Please identify the total number of LHDs (from the reporting sample) that has a process, procedure, etc., in place for review of epidemiological investigations of infectious disease outbreaks for the purposes of program improvement. Examples can include, but are not limited to, periodic or annual reviews, hotwashes, after-action reports



How is this measure operationalized?

Infectious disease outbreak reporting: Only reported outbreaks, which should include notifiable disease cases and clusters – and might include other unusual cases – should be included in this performance measure. Food-borne outbreaks should be included here.

Note: HIV, STDs, and tuberculosis are not included in this definition.

Investigation: For the purpose of these performance measures, initial investigative activity of a more preliminary or exploratory character that results in either a decision not to investigate further or referral to another agency without further significant involvement by the health department, should not count as an investigation. Referrals to other agencies that do entail further significant involvement by the health department should count as an investigation. Investigations that take place across reporting periods for this performance measure may, at the awardees discretion, be included in the denominator for the following reporting period.

Sample of LHDs: [See Reporting Requirements]



PHEP 13.4: Outbreak Reports with Minimal Elements

Percentage of infectious disease outbreak investigation reports that contain all **minimal elements**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of infectious disease outbreak investigation reports containing all minimal elements

Denominator: Number of infectious disease outbreak reports generated

- The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report
- Completed investigations for which a draft investigation report has not yet been finalized or approved.
- Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown.



Why is this measure important?

The immediate intent of this measure is to capture the ability of awardees and LHDs to document epidemiological investigations of infectious disease outbreaks with complete reports (i.e., reports that contain a set of minimal elements).

The broader programmatic aim of this measure is to improve the quality of epidemiological investigations reports by ensuring that awardee and LHDs appropriately characterize and investigate the incident, document results and recommendations, and share these data as appropriate with decision makers.

Awardees should calculate a numerator and denominator for this performance measure:

- At the awardee level and
- For LHDs reporting on outbreaks in the pre-selected sample of counties. Please see the Additional Guidance section for further instructions.

Awardees may be asked to provide information on counties or LHDs reporting data for this measure.



What other requirements are there for reporting measure data?

Awardees are required to report summary data generated from real infectious disease outbreak investigations and investigation reports only (i.e., not drills or exercises). This sample is provided to awardees by CDC, and should be verified at the start of the budget period. See Appendix B for details.

Draft reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:



What data must be reported?

1. The total number of infectious disease outbreak investigations for which a report was generated
 - a. in which the awardee led the investigation (denominator for awardee metric)
 - b. in which the awardee supported any LHD investigation and contributed to writing the investigation report (irrespective of whether LHD is in reporting sample)
 - c. in which the awardee supported any other type of joint investigation and contributed to writing the investigation report (i.e., not



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- supporting an LHD; this may include CDC or another state)
- 2. Total number of infectious disease outbreak reports containing all minimal elements
 - a. in which the awardee led the investigation (numerator for awardee metric)
 - b. in which the awardee supported any LHD investigation and contributed to writing the investigation report (irrespective of whether the LHD is in reporting sample)
 - c. in which the awardee supported any other type of joint investigation and contributed to writing the investigation report (i.e., not supporting an LHD; this may include CDC or another state)
- 3. For the reports identified above that do not contain all of the minimal elements, please identify the elements that were most frequently missing [Select all that apply]
 - Context/background
 - Initiation of investigation
 - Investigation methods
 - Investigation findings/results
 - Discussion and/or conclusions
 - Recommendations
 - Key investigators and/or report authors
 - a. Briefly explain why this element(s) was most frequently missing. [Text box]

- Discussion and/or conclusions
- Recommendations
- Key investigators and/or report authors
 - a. Briefly explain why this element(s) was most frequently missing. [Text box]
- 7. Names of counties contributing data for this measure [Text box]
- 8. Number of LHDs reporting data for this measure



How is this measure operationalized?

Minimal Elements: [See Key Measurement Terms for a detailed description of the seven Minimal Elements] Health departments reporting on this performance measure should determine whether investigation reports include all of the seven minimal elements. Report elements do not have to be labeled exactly as shown below but should, if applicable, contain all of the content (bullets) within each element, as described. In some instances, some content (bullets) may appear under another minimal element (e.g., population affected may be reported in the results section of the report and not in context/background). This is acceptable for the purpose of calculating a numerator for this measure.

The following questions refer to the group of LHDs reporting data for this performance measure. Specifically, these questions concern outbreak investigations, led by an LHD, in counties from the pre-selected sample, without any support from the awardee or federal agencies.

- 4. The total number of infectious disease outbreak investigations for which a report was generated (LHD must have led the investigation) (denominator for local metric)
- 5. The total number of infectious disease outbreak investigation reports containing all minimal elements (numerator for local metric)
- 6. For the reports identified above that do not contain all of the minimal elements, please identify the elements that were most frequently missing. [Select all that apply]
 - Context/background
 - Initiation of investigation
 - Investigation methods
 - Investigation findings/results



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PHEP 13.5: Exposure Reports

Percentage of epidemiological investigations of **acute environmental exposures** that generate reports

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of epidemiological investigation reports of acute environmental exposures generated

Denominator: Number of epidemiological investigations of acute environmental exposures



Why is this measure important?

The immediate intent of this measure is to capture awardees' ability to document epidemiological investigations of the human health impacts of acute environmental exposures of public health significance. For awardee health departments that do not conduct these investigations, the intent is to ensure the awardee is aware of these exposures, investigations, and investigation reports to be able to act upon, learn from, or refer to them as appropriate.

The broader programmatic aim of this measure is to improve the ability of health departments to conduct epidemiological investigations of acute environmental exposures by appropriately documenting and reporting on investigation activities and findings.



What other requirements are there for reporting measure data?

Awardees are required to report summary data generated from real epidemiological investigations of acute environmental exposure and investigation reports only (i.e., not drills or exercises).

Draft investigation reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:

- The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report
- Completed investigations for which a draft investigation report has not yet been finalized or approved
- Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown

Awardees should calculate the numerator and denominator for this performance measure at the awardee level only. Submission of LHD data is not required for this performance measure.

Awardees that do not conduct epidemiological investigations of acute environmental exposures of public health significance are expected to have access to information from other jurisdictional partners pertaining to these investigations and the reports generated from them for the purpose of reporting for this performance measure.

Awardees that do not conduct epidemiological investigations of acute environmental exposures of public health significance are not required to provide information for Reported Data Elements #6 or #7.



What data must be reported?

1. Is the awardee health department responsible for conducting epidemiological investigations of acute environmental exposure incidents of public health significance, in either a lead or a **supporting role**? [Yes/No] – If yes, proceed to #2. If no, please answer Questions 1a. through 1e. in reference to your jurisdiction before continuing to #2.
 - a. Which agency (or agencies) outside the health department is responsible for conducting epidemiological investigations of acute environmental exposures? [Text box]
 - b. Is the awardee health department typically notified of epidemiological investigations of acute environmental exposures conducted by that agency? [Yes/No]
 - c. Does the awardee health department typically receive investigation reports documenting epidemiological investigations of acute environmental exposures conducted by that agency? [Yes/No]
 - d. What barriers, if any, does the awardee health department face in being notified of acute environmental exposure incidents of public health significance, epidemiological investigations of these exposures, and/or receiving investigation reports from that agency? [Text box]
 - e. What steps, if any, has the awardee health department taken to address these barriers? [Text box]
2. Total number of acute environmental exposure incidents of public health significance that occurred in the awardees’ jurisdiction.
3. Total number of epidemiological investigations of acute environmental exposures in which
 - a. the awardee led the investigation – solely or as part of a joint investigation (denominator)
 - b. the awardee supported another agency’s investigation [Proceed to #4, below]
 - c. Another agency conducted the epidemiological investigation (s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with no role in these investigations)
4. If the awardee assumes a supporting role in the epidemiological investigation of acute environmental exposure(s), please identify the types of organizations that the awardee health department supports. [Select all that apply]

- LHD
 - State environmental health agency
 - State occupational safety and health agency
 - State department of natural resources
 - State law enforcement agency
 - Hazardous materials agency
 - Other, please specify: [Text Box]
5. Total number of investigations for which a report was generated in which
 - a. the awardee led the investigation – solely or as part of a joint investigation (numerator)
 - b. the awardee supported another agency’s investigation and contributed to writing the investigation report
 - c. another agency conducted the epidemiological investigation(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with no role in these investigations)

Note: Data elements 6 and 7 apply only to awardees with a lead or supporting epidemiological investigation role for acute environmental exposures.

6. Rank the key factors that account for the awardee health department not conducting epidemiological investigations of acute environmental exposures (this question refers exclusively to acute environmental exposures for which it is the general policy and/or usual practice of the awardee to investigate). [Rank only those that apply]
 - Interagency collaboration and coordination challenges (i.e., between a health department and another government agency or department)
 - Intraagency collaboration and coordination challenges (i.e., within the health department)
 - Insufficient resources (e.g., funding, staffing, time)
 - Major or unexpected shifts in priorities due to emergent events, changes in mission or organization, etc.
 - Other, please specify: [Text Box]
7. What type(s) of processes, procedures, etc., does the awardee health department have in place for review of its epidemiological investigations of acute environmental exposures for the purposes of program improvement? [Select all that apply]
 - Periodic or annual reviews





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- Episodic reviews or hotwashes
- After-action reports
- No procedure in place
- Other, please specify: [Text Box]



How is this measure operationalized?

Please see **Appendix E** for a table of acute environmental exposure inclusion/exclusion criteria.

Food-borne outbreaks: Food-borne outbreaks should not be reported in this performance measure; these should be reported in the EI- Outbreak Investigation Reports performance measure.



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PHEP 13.6: Exposure Reports with Minimal Elements

Percentage of epidemiological investigation reports of acute environmental exposures that contain all minimum elements

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of epidemiological investigation reports of acute environmental exposures containing all minimal elements

Denominator: Number of epidemiological investigation reports of acute environmental exposures generated

- Awardee health departments that are not responsible for conducting epidemiological investigations of the human health impact(s) of acute environmental exposures of public health significance

Awardees are required to report summary data generated from real epidemiological investigations of acute environmental exposures and investigation reports only (i.e., not drills or exercises).



Why is this measure important?

The primary intent of this measure is to capture awardees' ability to document epidemiological investigations of acute environmental exposures of public health significance with complete reports (i.e., reports that contain a complete set of minimal elements). For awardee health departments that do not conduct these epidemiological investigations, the intent is to ensure the awardee is aware of these acute environmental exposures, investigations and investigation reports in order to be able to act upon, learn from or refer to them as appropriate.

The broader programmatic aim of this measure is to improve the quality of epidemiological investigation reports by ensuring that awardee health departments appropriately characterize and investigate the incident, document results and recommendations, and share these data as appropriate with decision makers.

Draft investigation reports are acceptable for inclusion in the numerator for this measure under select circumstances, including:

- The completion of an investigation near the end of the reporting period for this performance measure, with insufficient time to complete an investigation report
- Completed investigations for which a draft investigation report has not yet been finalized or approved
- Long-term or ongoing investigations for which the timeline for completion of a final investigation report is unknown

Awardees should calculate the numerator and denominator for this performance measure at the awardee level only. Submission of LHD data is not required for this performance measure.



What other requirements are there for reporting measure data?

Reporting for this performance measure is **REQUIRED** for all awardees, **EXCEPT FOR:**



What data must be reported?

1. Is the awardee health department responsible, in either a lead or supporting role, for conducting epidemiological investigations of the human



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health impact(s) of acute environmental exposures of public health significance? [Yes/No] If yes, proceed to question #2. If no, all following data elements are optional.

2. The total number of epidemiological investigations of acute environmental exposures for which a report was generated in which
 - a. the awardee led the investigation – solely or as part of a joint investigation (denominator)
 - b. the awardee supported another agency’s investigation
 - c. Another agency conducted the epidemiological investigation(s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with no role in these investigations) [optional reporting]
3. Total number of epidemiological investigation reports of acute environmental exposures containing all minimal elements in which
 - a. the awardee led the investigation (numerator)
 - b. the awardee supported another agency’s investigation and contributed to writing the investigation report
 - c. Another agency conducted the epidemiological investigation (s) of an acute environmental exposures, but reported the investigation to the awardee (for awardees with no role in these investigations) [optional reporting]
4. For the reports identified above that do not contain all of the minimal elements, please identify the minimal elements that were most frequently missing. [Select all that apply]
 - Context/background
 - Initiation of investigation
 - Investigation methods
 - Investigation findings/results
 - Discussion and/or conclusions
 - Recommendations
 - Key investigators and/or report authors
 - a. Briefly explain why this element(s) was most frequently missing. [Text box]

Minimal Elements: [See Key Measurement Terms for a detailed description of the seven Minimal Elements] Health departments reporting on this performance measure should determine whether investigation reports include all of the seven minimal elements. Report elements do not have to be labeled exactly as shown below, but should, if applicable, contain all of the content (bullets) within each element, as described. In some instances, some content (bullets) may appear under another minimal element, below (e.g., population affected may be reported in the results section of the report, and not in context/background). This is acceptable for the purpose of calculating a numerator for this measure.



How is this measure operationalized?

Food-borne outbreaks: Food-borne outbreaks should not be reported in this performance measure; these should be reported in the Outbreak Reports with Minimal Elements performance measure (PHEP 13.4).



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Key Measurement Terms for Epidemiological Investigation

Acute environmental exposure: An acute environmental exposure is a discrete, sudden, and/or generally unexpected exposure to a non-infectious agent that could potentially cause adverse symptoms, conditions, illness, or disease in a human population within either an immediate or relatively short timeframe. Please see the Special Notes section below and Table 1.20 for further guidance on the types of exposures that these performance measures are designed to capture

Incident of public health significance: An incident of public health significance is a discrete, sudden, and/or generally unexpected real event marked by human exposure to a toxic, poisonous, or otherwise harmful noninfectious agent for which (a) acute and immediate adverse symptoms, conditions, illness, or disease can feasibly be expected, and (b) additional exposure beyond the initial exposure case can feasibly be anticipated.

Infectious disease outbreak: An infectious disease outbreak is an increase in the number of observed cases (over expected) of a given disease or illness of public health importance caused by a specific infectious agent. Please see the Additional Guidance sections of the EI – Outbreak Investigation Reports and EI – Outbreak Investigation Reports with Minimal Elements performance measures for more information regarding reported/non-reported outbreaks and food-borne outbreaks.

Investigation: An investigation is the systematic collection and analysis of facts or data to determine the scope of an incident and the cause(s) of illness as well as identify a means of intervention or prevention strategy. In general, the term refers to systematic investigative activity beyond that required for routine follow-up and basic documentation (e.g., of single cases). It may (but is not required to) call for the allocation of additional organizational resources such as staff, funding, etc. Example activities include, but are not limited to, site visits, field assessments, case finding, record reviews, and lab testing. The term refers explicitly to epidemiological investigations in the context of the outbreak and acute environmental exposure EI performance measures. The term does not refer to an environmental health assessment or regulatory-related investigation. There is no expectation by CDC that all outbreaks or documented exposures shall lead to epidemiological investigations.

Investigation report: An investigation report is the written or electronic documentation describing the event, methods of investigation (e.g., lab, epidemiological, and statistical methods), findings, recommendations, etc., produced as a result of an epidemiological investigation of an infectious disease outbreak or acute environmental exposure(s). Although in practice elements of a report vary, generally all should contain each of seven main “minimal elements” (see below). Further, while reports are often generated in traditional “report” style, other formats can be included for the purpose of this performance measure. Examples include memoranda, e-mails, written correspondence, templates, forms, etc.

Joint investigation: A joint investigation is any investigation involving the awardee and at least one other agency. Awardees can lead or support joint investigations. Examples include investigations conducted by both the awardee and CDC or investigations conducted by multiple agencies (e.g., the awardee, CDC, and an LHD).

Minimal elements: Minimal elements are a core set of elements that are necessary for an investigation report to be considered complete. Generally, all sub bullets relevant to an infectious disease outbreak or acute environmental exposure investigation, below, must be part of a report for it to be considered complete. Sub-bullets not relevant to a given type of investigation (infectious disease or acute environmental exposure) are not required. Recognizing that investigation reports take various forms, and are presented in various ways, these elements do not have to be in the exact format laid out below. Please see the Additional Guidance sections of the EI – Outbreak Reports with Minimal Elements and EI – Exposure Reports with Minimal Elements performance measures for further information.

- Context/background – Information that helps to characterize the incident, including:
 - Population affected (e.g., estimated number of persons exposed and number of persons ill)
 - Location (e.g., setting or venue)
 - Geographical area(s) involved
 - Suspected or known etiology



- Initiation of investigation – Information regarding receipt of notification and initiation of the investigation, including:
 - Date and time initial notification was received by the agency
 - Date and time investigation was initiated by the agency
- Investigation methods – Epidemiological or other investigative methods employed, including:
 - Any initial investigative activity (e.g., verified laboratory results)
 - Data collection and analysis methods (e.g., case-finding, cohort/case-control studies, environmental investigation or testing, etc.)
 - Tools that were relevant to the investigation (e.g., epidemic curves, attack rate tables, questionnaires)
 - Case definitions (as applicable)
 - Exposure assessments and classification (as applicable)
 - Reviewing reports developed by first responders, lab testing of environmental media, reviews of environmental testing records, industrial hygiene assessments, questionnaires
- Investigation findings/results – All pertinent investigation results, including:
 - Epidemiological results
 - Laboratory results (as applicable)
 - Clinical findings (as applicable)
 - Other analytic findings (as applicable)
- Discussion and/or conclusions – Analysis and interpretation of the investigation results, and/or any conclusions drawn as a result of performing the investigation. In certain instances, a conclusions section without a discussion section may be sufficient (this is left to awardees' discretion).
- Recommendations for controlling disease and/or preventing/mitigating exposure – Specific control measures or other interventions recommended for controlling the spread of disease or preventing future outbreaks and/or for preventing/mitigating the effects of an acute environmental exposure.
- Key investigators and/or report authors – Names and titles are critical to ensure that lines of communication with partners, clinicians and other stakeholders can be established.

Supporting role (in an investigation): A supporting role is technical assistance or consultation provided by the awardee health department to an LHD or other agency. The term generally does not refer to routine involvement by a state public health laboratory in support of a local investigation or to aid in establishing a diagnosis (e.g., to conduct rule-out or confirmation testing). In some awardee jurisdictions, support in an investigation occurs as a function of an outbreak crossing jurisdictional lines; in others, it may be initiated upon request from a single, typically local level agency. See above: Joint investigation

14. Responder Safety and Health

Introduction

The Responder Safety and Health capability refers to the ability to protect public health agency staff responding to an incident by identifying safety and health risks, providing medical countermeasures and/or personal protective equipment, facilitating risk-specific training, and monitoring responder health. Implementing these activities enables health departments to assure that public health responders are medically fit, appropriately trained, and monitored for potential adverse health effects, if needed.

The Responder Safety and Health pre-incident process measure gauges the extent to which health departments have deployment safety and health programs for public health responders in place. The first response measure determines whether public health responders received health screening before and after deployment – so that medical readiness and any adverse health effects as a result of the deployment can be determined. The second response measure provides health outcome data for deployed public health responders (i.e., injuries, illnesses, exposures and fatalities) to enable health departments to address health and safety concerns and continually improve their deployment safety and health programs.



Capability Functions

This capability consists of the ability to perform the following functions:

1. Identify responder safety and health risks
2. Identify safety and personal protective needs
3. Coordinate with partners to facilitate risk-specific safety and health training
4. Monitor responder safety and health actions

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 14.1	●		●	●
PHEP 14.2	●		●	●
PHEP 14.3				●
PHEP 14.4				●

PHEP 14.1: Deployment Safety and Health Program (Awardee)

The awardee health department has a **deployment** safety and health program in place for **public health responders** [Yes/No]

Awardees should only report on this measure (PHEP 14.1) if public health-related support of responder safety and health is or will be a role carried out at the awardee level. If public health-related support of responder safety and health is an LHD responsibility, awardees should report on PHEP 14.2. If public health-related support of responder safety and health is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

A deployment safety and health program includes all of the following elements:

- Meet medical requirements prior to deployment
- Receive **risk-specific training** (e.g., on hazard awareness and recognition, communication of potential personal risks, and proper PPE use) prior to and, if necessary, at the time of an incident
- Receive exposure, mental/behavioral health, and medical **monitoring** during and after an incident (if necessary)
- Have access to needed **Personal Protective Equipment (PPE)** or countermeasures

they are monitored for medical and mental/behavioral health sequelae post-incident, if necessary.

The immediate intent of this measure is to assess the extent to which health departments have in place processes, procedures and other elements necessary to determine responders' basic medical **readiness**, provide or assure training appropriate to the specific hazards faced in a response, and provide or assure access to needed personal protective equipment/medical countermeasures. Additionally, this measure is intended to ensure that health departments have a process in place to provide or assure the provision of medical, mental/behavioral health, and exposure monitoring for public health responders, if warranted.

The broader programmatic aim of this measure is to provide for, or assure, the safety and health of deployed public health responders through proper screening, training, and monitoring.



Why is this measure important?

Implementing an effective deployment safety and health program is an important mechanism for health departments to prepare public health responders adequately for deployment assignments and assure



What other requirements are there for reporting measure data?

Not applicable



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What data must be reported?

1. For which of the following items does the health department have operational plans, processes and procedures in place to ensure the health and safety of public health responders? [Select all that apply]
 - Ensuring responders meet medical requirements prior to deployment
 - Providing or assuring risk-specific training (e.g., on hazard awareness and recognition, communication of potential personal risks, and proper PPE use) prior to and, if necessary, at the time of an incident
 - Providing or assuring exposure, mental/behavioral health, and medical monitoring during and after an incident (if necessary)
 - Providing or ensuring access to needed PPE or countermeasures
2. If one or more items are unchecked, briefly explain why and identify any relevant challenges/barriers to achieving any remaining items. [Text box]
3. Please identify the hazards/risks on which the elements of the awardee health department’s deployment safety and health program are based. [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane/tropical Storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
4. How does the awardee health department ensure that public health responders meet medical requirements prior to deployment? (e.g., e-mail to responders, basic health screening) [Text box]
5. Does the awardee health department screen its staff responder pool on a routine basis? (Yes/No) If “yes”, how often? [Select one]
 - More frequently than annually
 - Annually
 - Less frequently than annually
6. Please identify the types of training that the awardee provides or assures public health responders receive. [Select all that apply]
 - Safety Awareness (e.g., driving hazard awareness, environmental conditions, disaster zone safety, personal protective equipment)
 - Communications (e.g., hazard communications, health and safety plan, standard operating guide/procedures, mobile communications)
 - Self-Care/Buddy Care (e.g., physical, medical, emotional)
 - Organization (e.g., Incident Command System, National Incident Management System)
 - Decontamination (e.g., chemical, biological, gross, equipment)
 - Hazard Characteristics (e.g., debris from tornados, vector-borne illness following floods, chemical/toxic substance exposure, radiation)
7. Which entity provides:
 - a. Medical monitoring for public health responders, if needed? [Select one]
 - Awardee health department
 - Other, please specify: [Text Box]
 - None
 - b. Mental/behavioral health monitoring for public health responders, if needed? [Select one]
 - Awardee health department
 - Other, please specify: [Text Box]
 - None
 - c. Exposure monitoring for public health responders, if needed? [Select one]
 - Awardee health department
 - Other, please specify: [Text Box]
 - None
8. Which of the following elements does the awardee health department ensure for its public health volunteer responders (not paid staff)? [Select all that apply]



- Ensuring responders meet medical requirements prior to deployment
 - Providing or assuring risk-specific training (e.g., on hazard awareness and recognition, communication of potential personal risks, and proper PPE use) prior to and, if necessary, at the time of an incident
 - Providing or assuring exposure, mental/behavioral health, and medical monitoring during and after an incident (if necessary)
 - Providing or ensuring access to needed PPE or countermeasures
9. Has the health department identified subject matter experts that can be used by public health staff to make recommendations to the safety officer during emergency operations? [Yes/No]

(c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



How is this measure operationalized?

Health departments are encouraged to base the elements of their responder safety and health programs on relevant hazards/risks identified in existing (or, as appropriate, new) jurisdictional hazard and risk assessments.

Either direct provision by a health department, or assurance (e.g., through partner agencies, third-party organizations, contractors, etc.) of health screening, risk-specific training, health monitoring, and PPE for public health responders meets the intent of this measure.

Ensuring that public health responders meet medical requirements/screening for medical readiness prior to deployment could include identifying any pre-existing medical and psychiatric conditions, current medical concerns, changes in medical history, immunization status, functional and access needs, and any need for additional training. A comprehensive physical or medical examination of responders prior to deployment is not a requirement of this measure. Public health agencies have flexibility to use a variety of methods (e.g., e-mail, phone call, in-person meeting) to ascertain whether public health responders meet medical requirements.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or



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PHEP 14.2: Deployment Safety and Health Program (LHDs)

Proportion of PHEP-funded LHDs that have a deployment safety and health program in place for public health responders

Awardees should only report on this measure (PHEP 14.2) if public health-related support of responder safety and health is or will be a role carried out at the awardee level. If public health-related support of responder safety and health is an LHD responsibility, awardees should report on PHEP 14.1. If public health-related support of responder safety and health is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that have a deployment safety and health program in place for public health responders that ensure all of the elements below

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Responder Safety & Health activities

A deployment safety and health program includes all of the following elements:

- Meet medical requirements prior to deployment
- Receive risk-specific training (e.g., on hazard awareness and recognition, communication of potential personal risks, and proper PPE use) prior to and, if necessary, at the time of an incident
- Receive exposure, mental/behavioral health, and medical monitoring during and after an incident (if necessary)
- Have access to needed personal protective equipment (PPE) or countermeasures



Why is this measure important?

Implementing an effective deployment safety and health program is an important mechanism for health departments to prepare public health responders adequately for deployment assignments and assure they are monitored for medical and mental/behavioral health sequelae post-incident, if necessary.

The immediate intent of this measure is to assess the extent to which health departments have in place processes, procedures and other elements necessary to determine responders' basic medical readiness, provide or assure training appropriate to the specific hazards faced in a response, and provide or assure access to needed personal protective equipment/medical countermeasures. Additionally, this measure is intended to ensure that health departments have a process in place to provide or assure the provision of medical, mental/behavioral health, and exposure monitoring for public health responders, if warranted.

The broader programmatic aim of this measure is to provide for, or assure, the safety and health of deployed public health responders through proper screening, training, and monitoring.





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What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

- Number of LHDs that receive PHEP funds (directly or through contracts) to implement Responder Safety & Health activities (denominator)
- Number of LHDs that receive PHEP funds (directly or through contracts) to implement Responder Safety & Health activities that have a deployment safety and health program in place for public health responders as defined in the measure specifications (numerator)
- For those LHDs that receive PHEP funds (directly or through contracts) to implement Responder Safety & Health activities that have not addressed all four elements, please identify the:
 - *Minimum* number of elements that LHDs have addressed
 - *Maximum* number of elements that LHDs have addressed

(Please see data element 4, below, for a list of the four elements)
- For which of the following items are operational plans, processes and procedures most frequently missing across LHDs that receive PHEP funds (directly or through contracts) to implement Responder Safety & Health activities? [Select all that apply]
 - Ensuring responders meet medical requirements prior to deployment
 - Providing or assuring risk-specific training (e.g., on hazard awareness and recognition, communication of potential personal risks, and proper PPE use) prior to and, if necessary, at the time of an incident
 - Providing or assuring exposure, mental/behavioral health, and medical monitoring during and after an incident (if necessary)
 - Providing or ensuring access to needed PPE or countermeasures
- Briefly describe successes cited by LHDs in developing responder safety and health programs. [Text box]

- Briefly describe the most frequent challenges or barriers faced by LHDs in planning for, or building out, the items missing in their deployment safety and health programs. [Text box]



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for responder safety and health activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

Health departments are encouraged to base the elements of their responder safety and health programs on relevant hazards/risks identified in existing (or, as appropriate, new) jurisdictional hazard and risk assessments.

Either direct provision by a health department, or assurance (e.g., through partner agencies, third-party organizations, contractors, etc.) of health screening, risk-specific training, health monitoring, and PPE for public health responders meets the intent of this measure.

Ensuring that public health responders meet medical requirements/screening for medical readiness prior to deployment could include identifying any pre-existing medical and psychiatric conditions, current medical concerns, changes in medical history, immunization status, functional and access needs, and any need for additional training. A comprehensive physical or medical examination of responders prior to deployment is not a requirement of this measure. Public health agencies have flexibility to use a variety of methods (e.g., e-mail, phone call, in-person meeting) to ascertain whether public health responders meet medical requirements.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state



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government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state's direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



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PHEP 14.3: Screening/Out-Processing

Proportion of deployed public health responders screened for medical readiness prior to deployment and out-processed post-deployment

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability:
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding *	<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

* For BP1 only: Awardees who have had an incident, exercise or planned event involving deployment of responders by Dec. 31, 2012, must report this measure at mid-year



How is the measure calculated?

Numerator: Number of deployed public health responders screened for medical readiness prior to deployment and out-processed post-deployment

Denominator: Number of public health responders deployed



Why is this measure important?

Screening for medical readiness prior to deployment is important to ensure that public health responders are fit for duty. Similarly, out-processing is imperative to identify any injuries, illnesses, or exposures incurred by public health responders as a result of deployment so that public health responders receive follow-up monitoring and care, if needed.

The immediate intent of this measure is to capture the extent to which public health responders are screened/assessed, before and after they are deployed, for basic medical fitness as well as for exposure, illness or injury incurred as a result of the response.

The broader programmatic aims of the measure are (1) to improve the likelihood that health departments assign public health responders deployment roles for which they are medically fit, and (2) to increase health department awareness of any injuries, illnesses, or exposures incurred by public health responders so that

they can initiate or assure appropriate medical, mental/behavioral health, and/or exposure monitoring.



What other requirements are there for reporting measure data?

Awardees should report the numerator and denominator of this measure *by incident, planned event or exercise* at state, regional or local level.

For the purposes of reporting, awardees should include *at least two* incidents/exercises/planned events.



What data must be reported?

1. Number of public health responders deployed (denominator)
2. Number of deployed public health responders screened for medical readiness prior to deployment and out-processed post-deployment (numerator)
3. Number of deployed public health responders only screened for medical readiness prior to deployment (not out-processed post-deployment)
4. Number of deployed public health responders only out-processed post-deployment (not screened for medical readiness prior to deployment)
5. Which entity is reporting on this measure? [Select one]
 - Awardee health department



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- LHD
- 6. Were responders screened as part of a drill, functional exercise, full-scale exercise, planned event, or incident? [Select one]
 - Drill
 - Functional exercise
 - Full-scale exercise
 - Planned event
 - Incident
- 7. Please provide the name and date of the incident/planned event/exercise [Text box]
- 8. Please identify and describe the incident. [Select one]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane-/tropical Storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text Box]
 - Radiation
 - Other, please specify: [Text Box]
- 9. Briefly describe key challenges or barriers to providing screenings for medical readiness to deployed public health responders prior to deployment. [Text box]
- 10. Briefly describe key challenges or barriers to providing out-processing assessments for deployed public health responders. [Text box]
- 11. Was there a determination that additional post-incident surveillance or monitoring of deployed public health responders was needed? [Yes/No]
 - If yes, please briefly describe how these public health responders were/will be monitored. [Text box]
- 12. What challenges or barriers have been/are expected to be experienced in providing or assuring post-incident monitoring of deployed responders? [Text box]

deployment could include identifying any pre-existing medical and psychiatric conditions, current medical concerns, changes in medical history, immunization status, functional and access needs, and any need for additional training. A comprehensive physical or medical examination of responders prior to deployment is not a requirement of this measure. Public health agencies have flexibility to use a variety of methods (e.g., e-mail, phone call, in-person meeting) to ascertain whether public health responders meet medical requirements.



How is this measure operationalized?

Ensuring that public health responders meet medical requirements/screening for medical readiness prior to



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PHEP 14.4: Responder Health Outcomes

Percentage of public health responders who were injured, ill, exposed, or killed as a result of deployment during an incident

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By



How is the measure calculated?

Numerator: Number of public health responders who were injured, ill, exposed, or killed as a result of deployment during an incident

Denominator: Number of public health responders deployed

This is an aggregate measure across public health incidents involving responder deployment.



Why is this measure important?

Responder injuries, illnesses, exposures, and fatalities are often preventable. Responder health outcome data represent a critical information category useful to address immediate operational safety and health concerns (during a response) as well as identify broader programmatic factors for which corrective actions can be developed and implemented (post-incident).

The immediate intent of this measure is to capture the extent to which deployed public health responders are injured, ill, exposed, or killed as a result of deployment during an incident. Annual tracking of these data is an essential component of a broader strategy to assess the extent to which health departments are conducting assurance and monitoring of the health and safety of deployed responders.

The broader programmatic aim of the measure is continuous quality improvement for deployment health and safety programs. Data collected through

this measure are meant to enable health departments to identify and implement strategies to address the root cause(s) of injuries, illnesses, exposures, or fatalities, with a particular emphasis on the implementation of appropriate medical screening, targeted training, or monitoring during and/or after an incident, if needed.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of public health responders deployed (denominator)
2. Number of public health responders who were injured, ill, exposed, or killed as a result of deployment during an incident (numerator) *Note: Please do not double-count responders. If a responder experienced more than one of these health outcomes as a result of deployment, please report the responder in the category that corresponds with the most serious health outcome.*
 - a. Number of responders with documented exposures
 - b. Number of responders with documented illnesses
 - c. Number of responders with documented injuries
 - d. Number of responder fatalities
3. Please identify the data source(s) used for the collection of data related to injury, fatality, illness, or exposure [Select all that apply]





- ICS form (e.g., 200 and 209)
 - OSHA form (e.g., 300 and 301)
 - Other, please specify: [Text Box]
4. Please describe key challenges or barriers to the collection of data related to injury, fatality, illness, or exposures for deployed responders. [Text box]
 5. Please identify the number and types of incidents on which these data are based. [Text box]
 6. Please identify and describe any hazards/risks to which deployed public health responders were exposed during these incidents. [Select all that apply]
 - Extreme temperatures (e.g., hot or cold)
 - Structural (e.g., building) instability
 - Fire
 - Contaminated food/water
 - Respiratory hazards (e.g. dust, smoke, mold)
 - Chemical/hazardous materials
 - Communicable diseases
 - Debris
 - Noise
 - Animal bites
 - Radiological hazard
 - Social unrest/violence
 - Human remains
 - Other, please specify: [Text Box]
 - None
 7. How many incidents required the use of medical countermeasures and/or PPE?
 - a. In how many incidents requiring the use of medical countermeasures and/or PPE were they provided?
 8. Please identify and describe any injuries, illnesses, or exposures sustained by deployed public health responders that were noted as a result of these incidents. [Text box]
 9. Please identify the most important contributing factors to exposures, injuries, and/or illnesses sustained by public health responders. [Select all that apply]
 - Public health responders were not medically fit to deploy
 - Public health responders lacked appropriate training
 - PPE/medical countermeasure recommendation was untimely (e.g., too late)
 - PPE/medical countermeasure recommendation did not address full range of applicable hazards
 - Necessary PPE/medical countermeasure was not available
 - Public health responders did not use PPE/medical countermeasures
 - Public health responders used PPE improperly
 - Other, please specify (examples may include: fatigue, behavioral issues (e.g., drugs/alcohol), sleep deprivation, negligence) [Text box]
 10. Please identify any corrective actions identified and progress on addressing those corrective actions. [Text box]
 11. Has a “registry” and/or similar tracking system been developed and/or utilized (by the awardee or a partner agency) for monitoring public health responders, particularly for long-term or chronic health effects? [Yes/No]
 - a. If yes, please describe this system and its implementation [Text box]



How is this measure operationalized?

Awardee health departments should report aggregate data on all non-routine incidents. Examples of non-routine incidents can include, but are not limited to:

- Presence of life-threatening circumstances
- Declaration of a disaster/public health emergency

Inclusion criteria for injury, exposure, or illness include, but are not limited to:

- Filing of a worker’s compensation claim
- Responder fatality
- Documented exposure to a harmful radiological, chemical, or biological agent
- Provision of medical assistance beyond first aid
- Scores on mental/behavioral health assessments exceed a certain threshold (if conducted)

Data sources may include, but are not limited to, Incident Command System (ICS) Forms 201 and 209, the OSHA 300 log or equivalent employer injury log, and data from the Emergency Responder Health Monitoring and Surveillance (ERHMS) system or its equivalent.



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Key Measurement Terms

Deployment: Deployment is defined as physical assignment of public health responders to non-routine incident sites or relevant support locations (e.g., warehouses, distribution centers, PODs, etc.). Generally, headquarters, the EOC, and similar locations are not considered part of responder deployment for the purpose of this measure. Routine fieldwork, for example, restaurant inspections, investigations of common or relatively low-threat outbreaks, mold or lead inspections, etc., is excluded for this measure.

Incident-specific role: An incident-specific role is a role by a key partner based on a specific hazard (e.g., flooding, pandemic flu, radiation) The intent of delineating this term is to ensure that reporting health departments only include in this measure those key partners deemed necessary for the specific hazard(s) in question

Medical requirements/readiness (for deployment): Medical requirements/readiness refers to an acceptable level of physical, medical and mental/behavioral well-being, or health, appropriate for an individual responder's deployment. For the purpose of this measure, this threshold should be determined by or within each jurisdiction. Awardees are encouraged to work with their occupational health units and other partners to determine appropriate thresholds and definitions of medical readiness for responders.

Monitoring: Monitoring refers to the ongoing and systematic collection, analysis, interpretation, and dissemination of health-related data associated with an individual responder's injury, illness and/or exposure incurred during an incident. Monitoring is distinct from – and often follows from – a basic out-processing assessment, in which public health responders are assessed for injury, illness or exposure immediately following their deployment.

Personal Protective Equipment (PPE): Please refer to CDC's Public Health Preparedness Capabilities: National Standards for State and Local Planning (March 2011) document, page 129, Resource Element E1. It describes Level D basic safety equipment and references OSHA and CDC guidelines for PPE in clinical / healthcare settings.

Public health responders: Public health responders refer to public health agency staff deployed by public health agencies to support incidents with public health/medical missions.

Risk-specific training: Risk-specific training includes pre-incident training (e.g., on concepts such as hazard awareness and recognition, self-care, and proper PPE use) and site-specific training (e.g., on specific topics or problems that arise after the arrival of public health responders at an incident site, including immediate exposure risks, safety hazards, etc.).

15. Volunteer Management

Introduction

Volunteer management includes coordinating, notifying, dispatching, and demobilizing volunteers to support a public health agency’s response to an incident of public health significance. Public health and medical volunteers enable the public health and healthcare systems to surge and meet the elevated needs of an event or incident and therefore coordinated management is crucial.



The Volunteer Management pre-incident process measure gauges the extent to which health departments have developed plans, processes, and procedures to manage volunteers, including receiving, confirming credentials, providing training, and tracking.

The Volunteer Management response measure assesses the health and medical lead’s ability to meet requests for volunteers from response entities in a timely manner.

Capability Functions

This capability consists of the ability to perform the following functions:

1. Coordinate volunteers
2. Notify volunteers
3. Organize, assemble, and dispatch volunteers
4. Demobilize volunteers

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
PHEP 15.1	●	●		
PHEP 15.2	●	●		
HPP-PHEP 15.1			●	●

PHEP 15.1: Managing Volunteers (Awardee)

The awardee health department has plans, processes and procedures in place to manage **volunteers** supporting a public health or medical incident [Yes/No]

Awardees should only report on this measure (PHEP 15.1) if public health-related support of volunteer management is or will be a role carried out at the awardee level. If public health-related support of volunteer management is an LHD responsibility, awardees should report on PHEP 15.2. If public health-related support of volunteer management is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

A plan, process, and/or procedure to manage volunteers includes all of the following elements:

- Receiving volunteers
- Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers
- Confirming volunteer credentials
- Assigning roles and responsibilities to volunteers
- Providing Just-in-Time Training for volunteers
- **Tracking volunteers**
- **Out-processing** volunteers



Why is this measure important?

The immediate intent of this measure is to ensure that the public health/medical lead has the plans, processes and/or procedures in place to be able to manage volunteers during each phase of a response.

The broader programmatic intent of this measure is to ensure that the health/medical lead is able to

efficiently and effectively utilize and incorporate public health/medical volunteers in an incident.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Which of the following elements have been addressed by the awardee health department as a part of pre-incident planning? [Select all that apply]
 - Receiving volunteers
 - Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers
 - Confirming volunteer credentials
 - Assigning roles and responsibilities to volunteers
 - Providing just-in-time training for volunteers
 - Tracking volunteers





- Out-processing volunteers
- 2. Please briefly describe key barriers associated with plans, processes, and procedures to manage volunteers supporting a public health or medical incident. [Text box]



How is this measure operationalized?

Awardees are encouraged to utilize resources/competencies available through key partners to meet the intent of this measure as long as the plans, processes and procedures are clearly articulated.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



PHEP 15.2: Managing Volunteers (LHDs)

Proportion of PHEP-funded LHDs that have plans, processes and procedures in place to manage volunteers supporting a public health or medical incident

Awardees should only report on this measure (PHEP 15.2) if public health-related support of volunteer management is or will be a role carried out at the local level. If public health-related support of volunteer management is an awardee health department responsibility, awardees should report on PHEP 15.1. If public health-related support of volunteer management is a responsibility of the awardee and LHDs, report on both measures.

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan *	<input type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input type="checkbox"/> Data Collected By

** BP1 EXCEPTION: Mid-Year Reporting Required in BP1 for Baseline Data, Irrespective of Funding*



How is the measure calculated?

Numerator: Number of LHDs, receiving PHEP funds directly or through contracts, that have plans, processes, and procedures in place to manage volunteers

Denominator: Number of LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities

The following elements are required for inclusion in the numerator:

- Receiving volunteers
- Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers
- Confirming volunteer credentials
- Assigning roles and responsibilities to volunteers
- Providing Just in Time Training for volunteers
- Tracking volunteers
- Out-processing volunteers



Why is this measure important?

The immediate intent of this measure is to ensure that the public health/medical lead has the plans, systems and processes in place to be able to manage volunteers during each phase of a response.

The broader programmatic intent of this measure is to ensure that the public health/medical lead is able to efficiently and effectively utilize and incorporate public health/medical volunteers in an incident.



What other requirements are there for reporting measure data?

Not applicable



What data must be reported?

1. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities (denominator)
2. Number of LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities that have plans, processes,



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and/or procedures in place to manage volunteers supporting a public health/medical incident (numerator)

3. For those LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities that have not addressed all seven elements, please identify the *minimum* number that they have addressed. *(Please see data element 5, below, for a list of the seven elements)*
4. For those LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities that have not addressed all seven elements, please identify the *maximum* number that they have addressed. *(Please see data element 5, below, for a list of the seven elements)*
5. For those LHDs that receive PHEP funds (directly or through contracts) to implement Volunteer Management activities that have not addressed all seven elements, please identify the elements that are most frequently missing [Select all that apply]
 - Receiving volunteers
 - Determining volunteer affiliation, including procedures for integrating or referring non-registered and spontaneous volunteers
 - Confirming volunteer credentials
 - Assigning roles and responsibilities
 - Providing Just in Time Training for volunteers
 - Tracking volunteers
 - Out-processing volunteers
6. Please briefly describe the most frequent barriers or challenges cited by LHDs to manage volunteers supporting a public health or medical incident. [Text box]

the plans, processes and procedures are clearly articulated.

Awardees have the option of reporting *pre-incident planning measures* at (a) at the awardee-level, (b) as a proportion of PHEP-funded LHDs at the local level, or (c) both. This flexibility is provided to awardees to ensure that variability in jurisdictional governance structures and the organization of public health activity (e.g., in counties vs. districts vs. regions vs. the state) across PHEP awardees is able to be captured. In jurisdictions in which there are no LHDs (e.g., in most territories and freely associated states and a few states), awardees should report at the awardee level only. In jurisdictions in which LHDs are units of state government, CDC encourages the awardee to report the proportion metric as appropriate, since those organizations are recognized as LHDs (albeit units of state government) by NACCHO. *Importantly, the denominator of the local proportion metric should include only those LHDs that the awardee has funded (via contracts OR via a centralized state’s direct funding or support) to do work in the capability in question.* In jurisdictions in which both the state health department and LHDs undertake various planning and response roles, reporting of both metrics (the awardee-level “yes/no” and the local level proportion metric) is required.



How is this measure operationalized?

LHDs to be included (in the denominator) for this measure include only those that receive PHEP funds (directly or via contract) for volunteer management activities. The pre-selected sample of counties provided to the awardee by CDC does *not* apply to this measure.

Awardees are encouraged to utilize resources/competencies available through key local partners to meet the intent of this measure as long as



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HPP-PHEP 15.1: Volunteer Management

Proportion of volunteers **deployed** to support a public health/medical incident within an **appropriate timeframe**

Measure Applies To:	Circumstances for Reporting:	For Response Only:	Other Considerations:
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Reporting	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Optional
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input type="checkbox"/> Accountability
<input checked="" type="checkbox"/> Territories or Freely Associated States	<input checked="" type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding *	<input checked="" type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> Data Collected By: HPP and/or PHEP

* *Mid-Year and End-of-Year Reporting Required, Irrespective of Funding*



How is the measure calculated?

Numerator: Number of volunteers deployed to support a public health/medical incident within an appropriate timeframe

Denominator: Number of volunteers **requested** to deploy in support of a public health/medical incident within an appropriate timeframe

- Reporting for this measure is required annually.
- Reporting for this measure is required at mid-year and end-of-year for BP1.
- Awardees may report the numerator and denominator of this measure *by incident, planned event or exercise* at the state, sub-state regional or local level.
- For the purposes of reporting, awardees should include at least two incidents/exercises/planned events. Across all incidents/exercises/planned events reported, HPP and PHEP Volunteer Management capabilities must each be utilized or demonstrated at least once.



Why is this measure important?

The immediate intent of this measure is to assess the timeliness of implementing key stages of volunteer management – from receipt of request, to activation of volunteers, to deployment – in order to determine key bottlenecks and chokepoints which inhibit timely deployment of volunteers.

The broader programmatic intent of this measure is to ensure that the health/medical lead meets requests for volunteers in a timely manner.

This measure is NOT intended to assess routine or day-to-day volunteer activities in healthcare organizations.



What data must be reported?

For each incident/planned event/exercise reported on, please provide the following information.

1. The request for volunteers occurred during a: [Select one]
 - Incident
 - Full Scale Exercise
 - Functional Exercise
 - Drill
 - Planned event
2. This incident/planned event/exercise utilized or demonstrated one or more function(s) within the: [Select one]
 - HPP Volunteer Management Capability



What other requirements are there for reporting measure data?

- Reporting for this measure is required for all awardees.





- PHEP Volunteer Management Capability
- Both HPP and PHEP
- 3. The type of incident/exercise/planned event upon which the request for volunteers was based: [Select all that apply]
 - Extreme weather (e.g., heat wave, ice storm)
 - Flooding
 - Earthquake
 - Hurricane / Tropical Storm
 - Hazardous Material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify: [Text box]
 - Radiation
 - Other, please specify: [Text box]
- 4. The name and date of the incident/planned event/exercise [Text box]
- 5. The date/time when request for volunteers was received by health/medical lead.
- 6. The number of volunteers requested to deploy from the originating requestor (denominator)
- 7. The entity that made the original request for volunteers: [Select one]
 - Local health department
 - State health department
 - Healthcare organization
 - Healthcare coalition
 - Other, please specify: [Text box]
- 8. The date/time when volunteers were requested to arrive at staging area or on scene by health/medical lead
- 9. The requested location for the deployment: [Select one]
 - Staging/assembly area(s) (not actual incident site)
 - Hospital(s)
 - Shelter(s)
 - POD(s)
 - Alternate care site(s)
 - Other, please specify: [Text box]
- 10. The number of volunteers who were notified to deploy (i.e., “activated”)

- 11. The date/time when the last volunteer was notified to deploy (i.e., “activated”)
- 12. The number of volunteers who arrived at staging area/on scene within requested timeframe (numerator).
Of these:
 - a. Number of deployed volunteers registered in ESAR-VHP
 - b. Number of deployed volunteers registered in other systems
- 13. Date/time that last volunteer arrived at staging area/on scene within requested timeframe.
- 14. Barriers/challenges to deploying volunteers to support a public health/medical incident within requested timeframe. [Text box]



How is this measure operationalized?

This measure can also be found in the HPP BP1 Healthcare Systems Preparedness: Performance Measures Specifications and Implementation Guidance.

NOTE: The “start time” for this measure refers to the date/time that the health/medical lead at the local, regional, or state level receives a request for volunteers. The “stop time” for this measure refers to the time that the last requested volunteer arrives at a staging area or on scene, but no later than the requested timeframe.

Awardees are encouraged to report on 1 **long running** and 1 **acute incident** during the budget period, if possible. The awardee may also report on 2 long running or 2 acute incidents as an option. If neither of these is possible, reporting on 2 exercises or planned events is permissible.

Reporting of joint measures: HPP and PHEP programs should coordinate data collection and reporting for joint performance measures. Preferably, data should be reported on incidents, planned events and exercises that involve volunteer management across the public health and healthcare systems. However, flexibility is provided to HPP and PHEP awardees to determine the types of incidents, events, etc., to which this measure will be applied.



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Key Measurement Terms

Acute incident: An acute incident refers to an incident in which response activities do not exceed 96 hours.

Appropriate timeframe: Timeframe in which volunteers are requested to report for duty.

Deploy: Deployment is defined as the movement of activated volunteers to a staging area or assigned mission location such as the scene of an incident, planned event or exercise.

Long running incident: A long running incident refers to an incident in which response activities are underway beyond 96 hours.

Out-processing volunteers: Out-processing volunteers refers to the return of equipment, operational debriefing, and any transfer of command or responsibilities.

Request: A request is a formal application to ask for volunteers, typically by local response entities, to the health and medical lead at the local, regional or state level

Tracking volunteers: Tracking volunteers refers to the process, plans or procedures to capture volunteer activities, roles, locations, etc.

Volunteers: Volunteers are individuals supporting the public health/medical incident, including public health, medical and non-medical professionals (e.g., from the ESAR-VHP system, Medical Reserve Corps, health department, etc.)

APPENDICES



Appendix A: Alignment of Capabilities, Performance Measures and Reporting Requirements

Note: Supersedes Appendix 9 of the BP1 Funding Opportunity Announcement (CDC-RFA-TP12-1201)

Capability and Measure	Function Alignment	Applies To			Reporting Criteria ¹			Comments Optional, Accountability, Exclusions
		States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded ²	Report if Response	
Community Preparedness								
PHEP 1.1	2	X	X	X	X			
PHEP 1.2	1	X	X	X	X			
PHEP 1.3	4	X	X	X	X			
PHEP 1.4	2	X	X	X	X			
Community Recovery								
Eval. Tool	1, 2	X	X	X			X	
Emergency Operations Coordination								
PHEP 3.1	2	X	X	X	X			GPRA Measure
PHEP 3.2	3	X	X	X			X	Optional
PHEP 3.3	5	X	X	X	X			HP2020 Measure
Emergency Public Information and Warning								
PHEP 4.1	5	X	X	X	X			HP2020 Measure
Fatality Management								
PHEP 5.1	1	X	X	X		X		
PHEP 5.2	1	X				X		
Information Sharing								
PHEP 6.1	1, 3	X	X	X		X		
PHEP 6.2	1, 3	X				X		
HPP-PHEP 6.1	3	X	X	X			X ³	
Mass Care								
PHEP 7.1	1	X	X	X		X		
PHEP 7.2	1	X				X		
Eval. Tool	ALL	X	X	X			X	
Medical Surge								
<i>See Information Sharing</i>								

¹ Unless otherwise noted, measures and evaluation tools are required to be reported at End-of-Year.

² **BP1 EXCEPTION: Mid-Year Reporting Required (applies to all "Report if PHEP-Funded" measures except PHEP 12.14 and 12.15)**

³ **Mid- and End-of-Year Reporting Required**

Capability and Measure	Function Alignment	Applies To			Reporting Criteria ¹			Comments Optional, Accountability, Exclusions
		States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded ²	Report if Response	
Medical Countermeasure Dispensing								
MCMDD Composite	ALL	X	X	X	X			
Medical Materiel Management and Distribution								
MCMDD Composite	ALL	X	X	X	X			
Non Pharmaceutical Interventions								
PHEP 11.1	1	X	X	X		X		
PHEP 11.2	1	X				X		
PHEP 11.3	1, 2, 3	X	X	X			X ⁴	
Public Health Laboratory Testing								
PHEP 12.1	1	X	X		X			Optional, Excludes CHI
PHEP 12.2	4	X	X		X			Excludes CHI
PHEP 12.3	3	X	X		X			Levels 1 and 2 Required; Excludes CHI
PHEP 12.4	5	X	X		X			NYC Bio Only, Excludes CHI
PHEP 12.5	3	X	X		X			PAHPA Benchmark, Level 1 Required, Level 2 Optional; Excludes CHI
PHEP 12.6	3	X	X		X			PAHPA Benchmark, Levels 1 and 2 Required; Excludes CHI
PHEP 12.7	2	X	X		X			PAHPA Benchmark, Excludes CHI
PHEP 12.8	3	X	X		X			Level 1 Only, Excludes CHI
PHEP 12.9	1	X			X			Optional
PHEP 12.10	5	X	X		X			Excludes CHI
PHEP 12.11	3	X	X		X			PAHPA Benchmark, Excludes CHI
PHEP 12.12	2	X			X			

⁴ For BP1 only: Awardees who have had an incident involving NPI by Dec. 31, 2012, must report this measure at mid-year

Capability and Measure	Function Alignment	Applies To			Reporting Criteria ¹			Comments Optional, Accountability, Exclusions
		States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded ²	Report if Response	
PHEP 12.13	2	X			X			
PHEP 12.14	5	X	X			X		GPRA Measure Excludes CHI
PHEP 12.15	5	X	X			X		Excludes CHI
Public Health Surveillance and Epidemiologic Investigation								
PHEP 13.1	1	X	X		X			Excludes CHI, LAC
PHEP 13.2	3	X	X		X			Excludes CHI, LAC
PHEP 13.3	2	X	X	X	X			
PHEP 13.4	2	X	X	X	X			
PHEP 13.5	2	X	X	X	X			
PHEP 13.6	2	X	X	X	X			
Responder Safety and Health								
PHEP 14.1	1, 3, 4	X	X	X		X		
PHEP 14.2	1, 3, 4	X				X		
PHEP 14.3	4	X	X	X			X ⁵	
PHEP 14.4	4	X	X	X	X			
Volunteer Management								
PHEP 15.1	1, 2	X	X	X		X		
PHEP 15.2	1, 2	X				X		
HPP-PHEP 15.1	3, 4	X	X	X			X ⁶	

⁵ For BP1 only: Awardees who have had an incident, exercise or planned event involving deployment of responders by Dec. 31, 2012, must report this measure at mid-year

⁶ **Mid- and End-of-Year Reporting Required**

Appendix B: Sample Selection Strategy

Following is an overview of the sampling strategy for the Capability 1 (Community Preparedness) and Capability 13 (Public Health Surveillance & Epidemiological Investigations) performance measures.

To facilitate reporting of select performance measure data in Budget Period 1 (BP1), CDC has selected a random, stratified sample of counties in each of the 50 states. This is the same sample as utilized and provided to awardees in BP 11 – including awardee-requested substitutions approved by CDC. Lists of these counties will again be provided to state PHEP awardees, who will be asked to confirm that they will continue collecting data from the same counties in BP1 and/or submit county substitution requests to CDC. For the Capability 1 measures, awardees are requested to collect data from the largest health department in each selected county. For the Capability 13 measures, awardees are requested to collect case, outbreak and exposure data from each selected county, irrespective of which local health department reports or has primary responsibility for the case. If activity for Capability 1 or Capability 13 is undertaken at a regional or district level, and county-level data collection is infeasible, awardees may collect and report regional-level data instead (the region should include at least one of the sampled counties).

*The sampling strategy is utilized only for Capability 1 and Capability 13 measures (i.e., PHEP 1.1 through 1.4 and PHEP 13.1 through 13.4 – it does not apply to 13.5 and 13.6, which are awardee-level measures only). It is **not** utilized for any other measures, including new measures (e.g., Mass Care, Responder Safety and Health, etc.) introduced in BP1.*

Rationale and Methodology for the Sampling Strategy

Sampling permits awardees to aggregate data from a select subset of reporting entities as opposed to all of them, thereby reducing the burden of aggregation and reporting on them. While awardees are *encouraged* to collect data from all their health departments, sampling ensures that they are not required to compile, aggregate, and report this volume of data to CDC. Sampling also benefits CDC by preventing the agency from having to analyze aggregated data from nearly 3,000 health departments.

In developing the sampling strategy, CDC weighed a number of options. CDC initially planned on using the National Association of County and City Health Officials' (NACCHO) list of local health departments (LHDs) from which to draw a sample. Initially, CDC focused on sampling from the universe of LHDs, only to find that states with a high number of health departments would shoulder a disproportionate burden in reporting performance measure data. A technical consideration was also at play, namely, the idea of a “representative sample” of LHDs, particularly if such a sample was to be drawn on a state-by-state basis. Although a complex, multistage, stratified sample would have allowed comparisons within and across states in terms of local capabilities as well as provided a national estimate, it was decided that this type of sample would be too resource intensive to implement.

After significant internal deliberations and external vetting, CDC decided to *use counties as the population unit* from which to select the local sample.

Sampling Strategy – Details and Method

For the Capability 1 and Capability 13 measures, the objective of the local sampling strategy is efficiency. The intent is to capture a population large enough to generate analyzable local data while minimizing the number of LHDs that would need to collect and report data for this measure. One additional objective is to include in the sample at least one health department that serves large, medium-large, medium-small, and

small populations. Finally, to minimize burden and complexity, CDC's intent was to generate a single sample for all performance measures that required using a sample of LHDs. While admittedly not truly representative of the local health agencies in a state, the approach outlined below should provide sufficient information on LHDs while minimizing the data collection burden.

Once the decision was made to use counties as the sampling frame, the task was to create the most efficient sample given the parameters noted above. To do so, CDC devised the following methodology:

1. A medical officer reviewed the MMWR *Summary of Notifiable Diseases, United States, 2009* and, for every state, identified the reportable infectious diseases that typically **may** lead to an investigation and report.
2. For every state, CDC ranked the counties by population size, from largest to smallest.
3. CDC then calculated the proportion of a state's population residing in each county and applied that proportion to the total number of notifiable diseases (as modified by step 1 above) in each state, thus giving a rough estimate of how many cases of notifiable diseases might occur in each county.¹
4. For every state, CDC then created quartiles from the population-ranked counties.
5. After experimenting with a number of population thresholds (i.e., the percent of the state's population that would need to be included in the sample to expect a reasonable number of reportable illnesses), it was decided that CDC would need to select enough counties to capture at least 25% of a state's population.²
6. Starting with the quartile that contained the largest counties, CDC selected the first county in each quartile (i.e., the largest county in the quartile) until the population threshold of 25% or greater was met.
7. In some cases, the largest county exceeded 25% of a state's population. In such a case, a county from the remaining three quartiles was selected to ensure representation from all county sizes.
8. In this way, the 25% population threshold was obtained most efficiently, while maintaining representation from each quartile.
9. Generally, this process led to 8-12 counties being selected from each state.
10. As noted above, for the Capability 13 performance measures, it does not matter if one or more LHDs operate in the county. If that county is selected for the sample, the data are aggregated up with the other counties in the sample, irrespective of exactly which LHD had primary responsibility for a case.

CDC has determined that the same sample of counties can be used for both the Capability 1 and Capability 13 performance measures. There is, however, one important difference: because one county could have multiple LHDs the potential burden could be substantial, especially in counties with several LHDs. Therefore, if two or more health departments serve the same county, CDC asks that the awardee report Capability 1 performance measure data from only the *largest* LHD in that county. Conversely, if a regional entity covers the county that was selected; the awardee is asked to provide data on the Capability 1 performance measures for that regional entity.

¹ CDC recognizes that the assumption that cases are equally distributed across a state based on the size of the county is not realistic. However, this simplifying assumption was necessary to draw the sample as expeditiously as possible.

² For example, to capture 50% of the population would require an increase of approximately 150% of counties while yielding only 65% more cases. This population threshold was considered inefficient for all but two states (in those two states, the addition of one county yielded a significant increase in cases).

Substitution Policy

Awardees may choose to substitute one county for another – or one region or district in lieu of a single county – if it makes sense programmatically to do so. Awardees must make substitution requests to their Project Officer. The Project Officer will submit the request to the chiefs of the Program Services Branch and Applied Science and Evaluation Branch for review. Both branch chiefs must approve the substitution. Substitutions must meet the following criteria: the “new” county must fall within the specific quartile as the initial county; the 25 % population threshold (for all sampled counties, in total) must still be met. Exceptions to these criteria can be made with branch chief approval.

Special Consideration for Certain Jurisdictions

Los Angeles County, Chicago, New York City and Washington, DC: The sampling strategy does not apply to directly funded localities. For the Capability 13 performance measures, report all cases as described in the Performance Measure Guidance; for the Capability 1 performance measure, report all efforts to build partnerships as described in the Performance Measure Guidance.

U.S. territories and freely associated states: (American Samoa, Guam, U.S. Virgin Islands, Northern Mariana Islands, Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and Republic of Palau). For Capability 1 and Capability 13 performance measures, report data as described in the Performance Measure Guidance. PHEP measures 13.1 and 13.2 do not apply to these awardees.

Appendix C: PHEP 12.2: 24/7 Emergency Contact Drill Overview

Importance of this Drill to Public Health Emergency Program (PHEP) Awardees:

Timely communication between on-call epidemiologists and laboratorians (and vice versa) is critical for effective public health emergency response. As stewards of PHEP funds, the PHEP Director plays a crucial role in assuring good communication between laboratory and epidemiology staff, and for fostering improvements in communication in response to gaps revealed by exercises and real incidents.

Measure Purpose:

The purpose of PHEP 12.2: 24/7 Emergency Contact Drill is to ensure a timely and effective response to incidents of public health significance by promoting rapid communication between the epidemiologist and the laboratorian. The measure is **not intended to adhere to or assess an awardee's emergency notification protocol**. Although conducted by the CDC Emergency Operations Center (EOC), the drill is not an EOC or LRN measure; it is strictly a PHEP measure. It does not replace or substitute any other CDC drill (e.g., LRN notification drill).

Measure Details:

PHEP 12.2: 24/7 Emergency Contact Drill is associated with Capability 12: Public Health Laboratory Testing, Function 4: Support Public Health Investigations, and can occur at any time during a Budget Period (BP). Since the 24/7 drill is **unannounced and bi-directional**, two drills are held per budget period; one in each "direction." In "Direction 1" the on-call *laboratorian* is contacted first by the CDC EOC. In "Direction 2" the on-call *epidemiologist* is contacted first by the CDC EOC. Drills will be conducted between 8PM and 11PM (awardee local time) over a 5-7 day period. The order of the drills may vary (e.g. Direction 2 of a drill cycle may be conducted before Direction 1 of the cycle). During PHEP BP1 (July 1, 2012-June 30, 2013) and thereafter, the drills will be conducted in the following manner:

Drill Directions for Awardees with Separate Biological and Chemical Laboratories

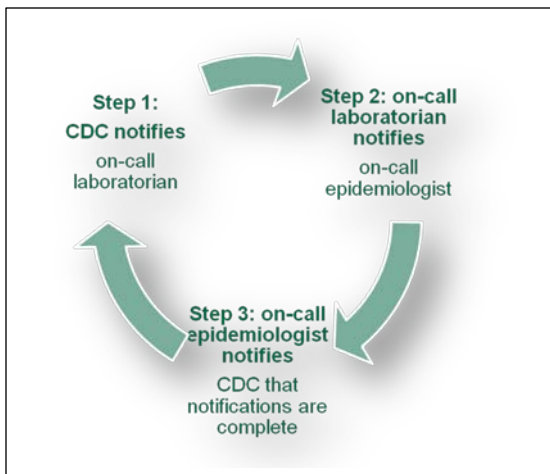
BP2 and BP4 drill direction:

Direction 1: CDC EOC → LRN-B → EPI → CDC EOC
 Direction 2: CDC EOC → EPI → LRN-C → CDC EOC

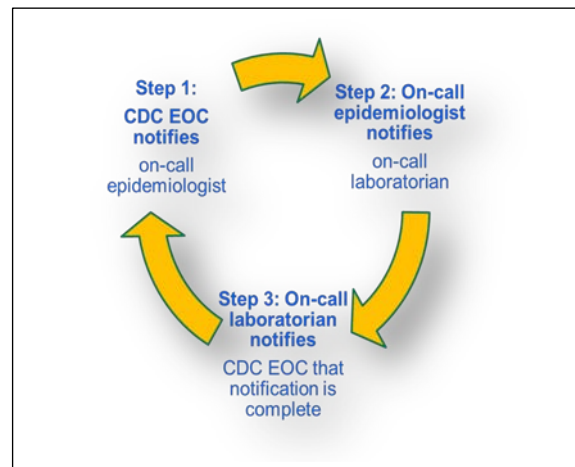
BP1 and BP3 drill direction:

Direction 1: CDC EOC → LRN-C → EPI → CDC EOC
 Direction 2: CDC EOC → EPI → LRN-B → CDC EOC

Drill Direction 1:



Drill Direction 2:



Drill Directions for Awardees with Joint Biological and Chemical Laboratories

BP1-BP4 drill direction:

Direction 1: CDC EOC → LRN-B/C → EPI → CDC EOC
 Direction 2: CDC EOC → EPI → LRN-B/C → CDC EOC

The time to complete the drill is measured using a Start and Stop Time (**Performance Target is 45 minutes**).

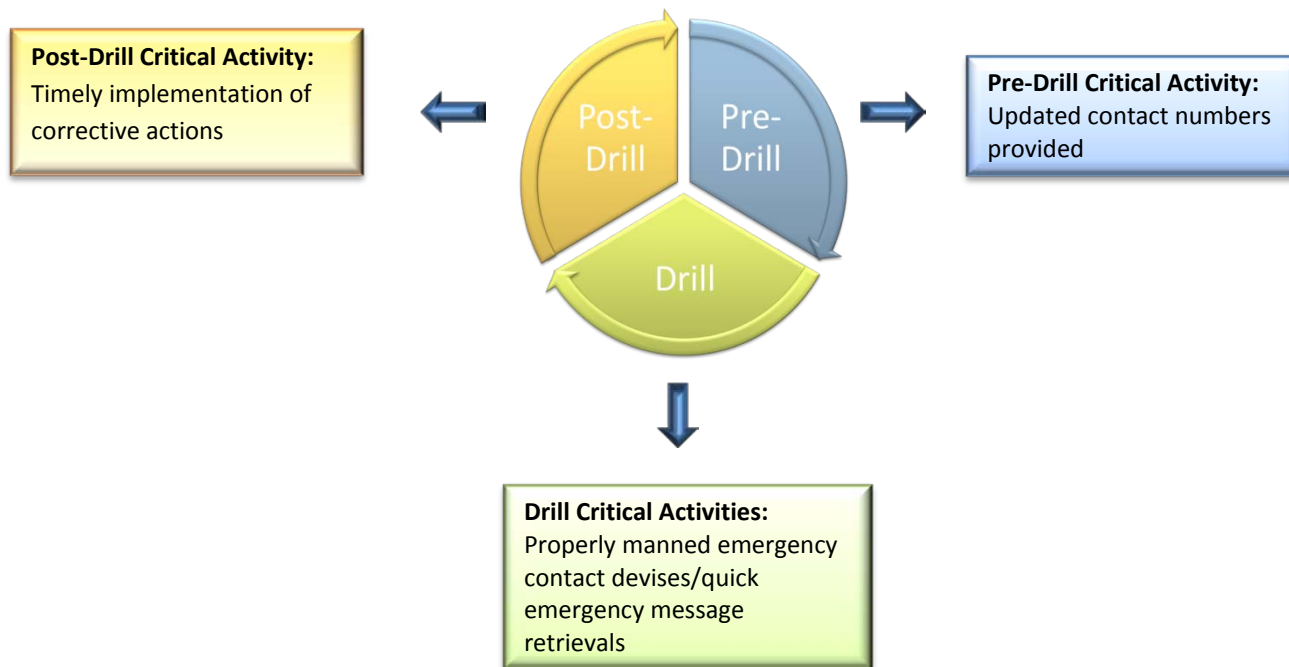
Start Time: Date/time that the CDC EOC initiates contact to the on-call laboratorian or epidemiologist, depending on drill direction.

Stop Time: Date/time the on-call laboratorian or epidemiologist (depending on drill direction) notifies the CDC EOC that the drill notification cycle is complete.

Drill Process:

The 24/7 Emergency Contact Drill is composed of three major segments—pre-drill, drill, and post drill. Each segment is comprised of various activities which must be completed in order to ensure the successful completion of the 24/7 drill. Failure to complete a critical activity within each drill segment may result in pitfalls that may prevent the awardee either from successfully completing the drill or completing it within the 45-minute time target. The critical activities for each drill segment are identified in the diagram below.

24/7 Drill Segments and Critical Activities for Drill Success



Pre-Drill Activities:

In order to complete this drill successfully, two sets of tasks need to be completed.

First, in order for the CDC EOC to initiate the drill, it must have the correct contact information for either the on-call laboratorian or the on-call epidemiologist, depending on the drill direction. The PHEP Director should ensure that the CDC EOC uses the correct information by: (a) providing the DSLR Project Officer with up-to-date contact information to reach the on-call epidemiologist, and (b) ensuring that the state LRN director (bio and chem) keeps updated contact information on file with the CDC LRN program (here: <https://lrnb.cdc.gov>). The CDC EOC will obtain updated contact information from these two sources prior to each drill. If no updated information is provided by the PHEP director or LRN director, the CDC EOC will utilize the information it has on hand. PHEP Directors are strongly encouraged to ensure that *primary* and *alternate* contact numbers for on-call laboratorians and on-call epidemiologists are provided to CDC. Contact numbers should grant expedient after-hours access to the on-call laboratorian or epidemiologist.

Second, PHEP Directors should ensure that the on-call laboratorians and on-call epidemiologists have each other's contact information. Remember, CDC EOC only *initiates* the drill; it is up to the on-call laboratorian or on-call epidemiologist to complete the drill by calling the other person, who must then call the CDC EOC. It is the PHEP program's responsibility to ensure that lines of communication are identified and clear, and contact information between these two key entities (lab and epidemiology) known.

Drill Activities:

1. Depending on the drill direction, the DSLR Applied Science and Evaluation Branch (ASEB) will request most recent on-call laboratorian and epidemiologist contact numbers either from the CDC LRN office or PHEP awardee Project Officers.
2. Using the updated on-call contact information, ASEB will generate a data collection spreadsheet for the CDC EOC Watch Officers to use.
3. CDC EOC Watch Officers will use the data collection spreadsheet and a call script to conduct the drill calls. If the primary contact that is listed cannot be reached, the CDC EOC Watch Officers will leave a message and wait 15 minutes for the primary contact to call back before calling the alternate – if one is provided.
4. CDC EOC Watch Officers will record drill start and stop times as well as the names and contact numbers of the on-call laboratorian and epidemiologist participating in the drill.
5. The CDC EOC will conduct drill calls between the hours of 8PM and 11PM, awardee time, over a 5-7 day period.
6. All drill data collected by the CDC EOC will be given to ASEB for analysis and dissemination.

Post-Drill Activities:

- The CDC DSLR Applied Science and Evaluation Branch (ASEB) populates drill notification forms with awardees' drill completion time, drill date, and names and contact phone numbers of the participating epidemiologist and laboratorian.
- Awardees that do not complete the drill cycle will receive drill notifications with an "Incomplete" as their drill time and are to state the challenges, barriers and/or root causes preventing them from completing the drill – as well as proposed corrective actions. Root causes, corrective actions, and the corrective action implementation timeframe should be provided to ASEB and the awardee's Project Officer within 30 calendar days of drill notification receipt.
- Awardee notification forms will report "Not Specified" if participant and/or contact number was not obtained by EOC during the drill.
- ASEB sends a copy of each awardee's drill notification to its Project Officer for dissemination to the awardee.
- Awardees are expected to confirm receipt of the email and notify the lab director of the participating lab of the drill results. Awardees are to consult with the labs during the drill verification process to ensure accuracy of drill results.
- Each awardee will be assigned an ASEB drill representative to assist in the verification process.
- ASEB Drill Representatives and PHEP Project Officers will follow up with PHEP awardees to verify the initial results before preparing a final report.
- Results of the BP11 drills will be used to encourage improvement within awardee jurisdictions as well as drill execution by CDC staff.

PHEP Directors Ensuring Success:

- Form and maintain close working relationships with participating biological and chemical lab directors.
- Work with their biological and chemical lab programs to ensure the CDC LRN program has up-to-date contact numbers.
- Ensure that Project Officers have up-to-date on-call epidemiologist contact information.
- Notify participating lab directors of the drill performance time and verify drill results.
- Provide root cause and corrective actions for "incomplete" or "not specified" drill times within 30 days of receipt of drill performance notification.
- Work with CDC Project Officer and lab director (biological and/or chemical) to implement strategies to improve communication cycle.

Appendix D: Examples of Public Health Control Measures for the Selected Six Diseases

Disease agent	Example control measures	Initiation timeframe
Botulism	Identification of potentially exposed individuals Identification / recovery of suspected source of infection, as applicable	Within 24 hours of initial case identification
<i>E. coli</i> (STEC)	Contact tracing Education: contacts as applicable Exclusions: child care, food handling as applicable	Within 3 days of initial case identification
Hepatitis A, Acute	Contact tracing Education: contacts Immunization (active/passive) administered or recommended to contacts, as appropriate	Within 1 week of initial case identification
Measles	Contact tracing Education: contacts Immunization (active/passive) administered or recommended for susceptible individuals Isolation: confirmed cases	Within 24 hours of initial case identification
Meningococcal Disease	Contact tracing Education: contacts Prophylaxis administered or recommended for susceptible individuals	Within 24 hours of initial case identification
Tularemia	Identification of potentially exposed individuals Identification of source of infection, as applicable	Within 48 hours Within 48 hours of initial case identification



Appendix E: Inclusion and Exclusion Criteria for Acute Environmental Exposures

Inclusion criteria	Exclusion criteria
<p>Incidents that directly impact human health immediately or with a short latency period (< 1 week) in which the signs and symptoms of acute toxicity are present or anticipated. These could include respiratory (e.g., constricted airway, shortness of breath), dermatological (e.g., itching, burning, redness of the skin), gastrointestinal (e.g., nausea, vomiting), and neurologic (e.g., disorientation, seizures) effects.</p> <p>Incidents in which two or more persons are ill with signs/symptoms of acute toxicity, are exposed, or a combination of both.</p> <p>Examples could include:</p> <ul style="list-style-type: none"> ▪ Organophosphate exposures ▪ Substantial heavy metal exposure, such as children playing with mercury <p>Any poisoning that is considered non-medicinal, unintentional, or to be of unknown etiology.</p>	<p>Exposures, including sustained or repeated low-level exposures, that result in diseases and conditions with long latencies such as:</p> <ul style="list-style-type: none"> ▪ Cancers ▪ Disorders of organ systems, or ▪ Long-term neurological, behavioral and/or developmental disabilities. (e.g., reports of abnormal blood levels of lead).
<p>Incidents necessitating contact tracing, such as for secondary exposures or for tracking the movement or spread of toxic substances away from the incident site. Examples include:</p> <ul style="list-style-type: none"> ▪ Persons exposed to pesticides in the field having residual amounts in their clothing, leading to exposure and illness to EMS and emergency department healthcare workers. ▪ A person with traces of mercury driving his vehicle back to his home resulting in the contamination of both vehicle and domicile. 	<p>Incidents related to occupational hazards involving only those in the workplace setting.²¹ This can include incidents that occurred at a non-occupational setting (e.g. a hazardous waste spill on a public road) with either no direct impact on human health or impact only to persons directly working with the hazardous materials (e.g. workers).</p>
<p>Acute exposure incidents that lead to the activation of the public health agency’s department operations center (DOC) or the jurisdiction’s emergency operations center (EOC), the formation of a task force, or the assignment of personnel to</p>	<p>Incidents that fall under the purview or jurisdiction of another state and/or federal agency for which the public health agency has no definable role.</p>

¹ Possible exception: incidents in an occupational setting that are large or widespread enough to affect populations outside the work setting.



Inclusion criteria	Exclusion criteria
another agency’s DOC or EOC.	
<p>Incidents that are suspected or proven to be intentional, malicious, or criminal.²</p> <p>Any large-scale or disaster incident in which public health agencies have a defined or prominent role in the response. Examples include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Conflagrations ▪ Explosions leading to the release of hazardous or toxic substances ▪ “Natural disasters” including but not limited to hurricanes, earthquakes, tornadoes, etc. 	<p>Exposures or injuries related to light, noise or transfers of energy other than radiation.</p> <p>Ongoing incidents with a low level of exposure. These can include issues surrounding air quality and concerns about water quality such as taste and odor problems, presence of low levels of contaminants that can be chemical (e.g. nitrates), microbiological (e.g. coliforms), or biotoxic (e.g., decaying harmful algae), etc.</p>
<p>Any incident involving an acute illness or disease state that has either the significance or interest to the public health agency to initiate an investigation. The presumed cause(s) can be either identified substances known to have adverse health effects or unknown substances yet to be identified and linked to that incident.</p>	<p>Incidents for which an investigation is deemed neither warranted nor appropriate, or for which site visits are made only to assess a setting for regulatory violations, gaps in proper procedures, or for mitigation or educational purposes.</p>
	<p>Clusters of chronic diseases or exacerbated medical conditions (e.g., cancer or asthma, respectively).</p>

²A notable exception includes incidents involving the transport or delivery of an alleged biological agent or toxin (white powder) which are deemed **non-credible** (hoax). If such an incident occurs and non-credibility **cannot** be established (e.g., a false-positive preliminary test), leading to the initiation of a public health response, then such incidents should be included. An example of the latter is the evacuation of the New York governor’s Manhattan offices in October 2001 due to a positive preliminary test for anthrax.