Public Health Emergency Preparedness Cooperative Agreement

Budget Period 1
Performance Measure Specifications and Implementation Guidance
July 1, 2017 – June 30, 2018

Version 1

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BP1 Performance Measures Specifications and Implementation Guidance

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Introduction

The Applied Science and Evaluation Branch (ASEB) in the Division of State and Local Readiness (DSLR) in CDC's Office of Public Health Preparedness and Response (OPHPR) is responsible for developing and implementing a standardized set of relevant, feasible, and useful performance measures and other evaluation strategies as part of the PHEP cooperative agreement.

Evaluation is an ongoing process integral to a program's success. Awardee performance information provides CDC with critical information used to demonstrate accountability. By assessing how well this federal investment in preparedness has improved the nation's ability to prepare for, and respond to public health emergencies, CDC is able to report progress in the nation's public health preparedness. Performance measurement data is used to:

- Support **program improvement** and **technical assistance activities** 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

- Report **awardee accomplishments and performance** in publications such as CDC's National Snapshot of Public Health Preparedness (NSPHP)

Primer on Evaluation

This section provides basic information on evaluation concepts that can lay the foundation for effective performance measurement.

What is evaluation?

Evaluation can be thought of – in simple terms – as collecting, analyzing, and using data to make decisions.[1] **Program evaluation** entails collecting and analyzing data to make decisions about a program or aspects of a program, that is, a set of activities typically organized with specific structures and processes to accomplish a goal. Ideally, data are collected and analyzed systematically to determine how well a program is working and why (or why not).[2]

Various types of program evaluation can be conducted depending on the purpose of the evaluation. Table 1 shows two common types of program evaluation: *process* and *outcome* evaluation. Process evaluations provide a method to assess the extent to which, and how well, program activities have been implemented as well as determine the degree of fidelity to program requirements and objectives. Process evaluations can also focus on whether grant recipients have "done what they said they were going to do" and determine how well program activities have been performed.

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[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.

Outcome evaluations determine whether desired program results have been achieved, the extent to which program activities contributed to these results, and distal impacts within a population, system or other intended "target" for a program.

Table 1: Types of Evaluation

Process	- What resources or inputs are needed to meet program requirements? - What activities are being conducted? - How well are activities being conducted? - Do activities comply with program requirements? - Have awardees accomplished their stated objectives? - What outputs have been produced from the activities?
Outcome	- What results have been achieved from the program? - To what extent can results be tied to program objectives and activities? - What is the impact within a population, system or other target of a program, due (at least in part) to program activities?

Why do we conduct evaluations?

There are two primary reasons for conducting evaluations:

1. To facilitate program improvement or organizational learning
2. To demonstrate accountability to stakeholders, including funders

The ultimate goal of any evaluation effort is to improve how an activity works, not merely to prove that it was accomplished. Evaluation is ongoing—it is not an end product of a program. Midcourse findings from the evaluation help determine whether corrections are necessary during the project period. Evaluation findings are powerful decision-making tools when used to identify gaps and make necessary changes to activities, strategies, and budgets.

Collecting performance information is meaningless unless is used for ongoing improvements to the program. Program evaluation can help state, local, and territorial PHEP awardees benchmark themselves in key areas, against which they can assess improvement over time.

The U.S. Congress, federal oversight agencies, state and local legislatures, and taxpayers are increasingly interested in knowing what changes have occurred as a result of the PHEP investments and whether jurisdictions – and the country as a whole – are better prepared to respond to public health emergencies. As PHEP funds continue to decrease, the need to articulate PHEP successes and impact grows more urgent. Data gathered through program evaluation, including performance measurement, can enable state, local, and territorial PHEP awardees to respond to requests for information from various stakeholders and provide credible, meaningful evidence that PHEP investments are being used as intended to achieve desired outcomes.

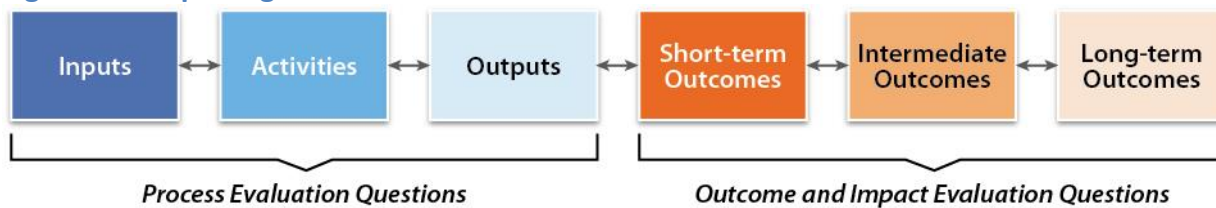**How does logic modeling assist in program evaluation?**

To evaluate a program, it is helpful to understand the relationships between program resources, activities, outputs, and outcomes. Logic modeling is one way to display these connections. Logic models identify and propose relationships between and among program resources, activities, outputs, and outcomes.

Logic Model Defined

A logic model is a visual "snapshot" of a program that communicates the intended relationship between program goals, activities, outputs, and intended outcomes. Logic models are an iterative tool useful for **planning and evaluation purposes**. Simply put, logic models graphically describe the theory—or logic—of how a program is supposed to work. The practical application of a logic model is to get everyone on the same page about the program and the approach the program will take to produce change.

Figure 1 provides a sample logic model followed by definitions of its components.

Figure 1: Sample Logic Model

Logic Model Components:

- **Inputs:** Resources that are required to support the program, including staff and volunteers, funding, guidance, policies, 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-term, intermediate, and long-term timeframes

Program 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 these measurement data is to facilitate 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 Public Health Service Act as amended by the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), the Government Performance and Results Act (GPRA), and the Healthy People 2020 Initiative. Data from these measures often are reported to requesting agencies and other entities, such as HHS, the White House Office of Management and Budget, and others. The data provide evidence that PHEP awardees are complying with funding requirements and demonstrating adequate performance in public health preparedness practice.

Other forms of accountability, which increasingly will be incorporated into PHEP measurement as the evidence base grows, relate to expectations, standards, and aspirational targets for performance in key areas deemed critical for public health preparedness and response. Finally, a number of PHEP measures are incorporated into the National Health Security Preparedness Index (NHSPI), which is a composite of indicators across the health security arena. More information on the NHSPI is available at **www.nhspi.org**.

How are PHEP measures developed?

DSLR uses the following performance measure development process.

1. Review literature, existing measures and existing federal requirements, statutes and initiatives.
2. Identify potential and verify existing points of measurement with subject matter experts (SMEs) and program representatives.
3. Confer with leadership to ensure the points of measurement aligns with priorities and goals of the program and meets the information needs of various end-users.
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. Draft new measures. Modify, retain or retire measures as appropriate.
7. Facilitate performance measure training and technical assistance.
8. Evaluate performance measures for face validity, utility, feasibility of data collection and burden.
9. Develop final measures, implementation guidance, and tools.
10. Review existing measures. Modify, retain or retire measures, as appropriate.

Additional forms of PHEP Performance Measurement
It is important to note that not every aspect of the PHEP program or the capabilities is amenable to performance measurement. Some aspects may be better evaluated through methods such as descriptive questionnaires, site visits, and document review, as well as through the use of evaluation tools, checklists and other methods, such as special studies.

Overview of PHEP Measures

The PHEP *Budget Period 1 Performance Measures Specifications and Implementation Guidance* categorizes performance measures according to the following types:

- **Core public health** – measures that assess performance in the health department's critical, routine, day-to-day activities such as laboratory services and public health surveillance.

- **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 that occur while conducting, demonstrating, or achieving a capability during an incident, planned event, or exercise including drills.

In addition to classification by measure type, each PHEP performance measure is reportable to CDC according to one of the following categories:

- **Annually required** applies to most core public health and response performance measures.
- Reportable **if PHEP funds are allocated** (directly or via contracts) to the associated capability (i.e., *any* amount of PHEP funding). This criterion typically applies to pre-incident planning measures. It also applies to select laboratory (core public health) measures.

> A single incident, planned event, or exercise may be used to collect data on multiple performance measures across capabilities.
>
> Awardees must identify the name and date of the incident, planned event, or exercise when reporting data for an applicable performance measure

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

Reporting Requirements for PHEP Performance Measures

Each measure in this document contains information on its specific reporting requirements. Summary requirements across all measures for Budget Period 1 (including which awardees are required to report and under what circumstances) can be found in **Appendix A**.

Table 2: Types of PHEP Measure and Reporting Criteria

Type of Measure	Reporting Criteria	Notes
Core Public Health	Annually required (primarily)	• Applies to most measures and tools for capabilities 12 and 13. • PHEP 12.14 and 12.15 are only required to be reported (i.e., verified) if PHEP funds are allocated towards pulsed-field gel electrophoresis (PFGE) activities (otherwise, no reporting required)
Pre-incident Planning	Report only if allocating PHEP funds toward the capability in the capability or contracts plan	• PHEP 15.1.
Response	Annually required	• Joint Measure J.1 (formerly HPP-PHEP 6.1) and J.2 (formerly HPP-PHEP 15.1) are annually required. These measures must be exercised annually, as prescribed in this guidance document, if no incident occurs.

**Please note: CDC may use performance measure data for public reporting, including but not limited to the annual CDC NSPHP. Awardees who provide no data or insufficient information for a given performance measure may be deemed *out of compliance* with PHEP reporting requirements. In addition, CDC may reflect awardee nonsubmission or insufficient submission of data in public reports and documents (including the NSPHP). Examples of nonreporting include not providing performance data that meet minimum requirements or reporting no data (e.g., stating that there were no incidents, drills, etc., to report) when data are required.

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Key Changes to PHEP Measures in the New Project Period

- The CP evaluation tool from capability 1 has been retired. Key components of that tool will be collected in the operational readiness review.

- Performance measure PHEP 3.1 has been retired. Key components from that measure including EOC site activation and staff assembly will be collected in the operational readiness review.

- Performance measure PHEP 5.1 has been retired. Awardees may continue to collect this information, but will not be required to report to CDC.

- Joint measures will continue to be collected in BP1. The names of the measures have changed from HPP-PHEP 6.1 to HPP-PHEP J.1 and from HPP-PHEP 15.1 to HPP-PHEP J.2 to reflect the revision of the HPP capabilities. The new HPP capabilities no longer align directly with PHEP capabilities so joint measures will no longer contain the capability number. In this document, guidance will be located with the public health preparedness capabilities where it has been in past guidance (the data collected for J.1 is still information sharing data, and for J.2 is still volunteer management data). Portions of information sharing and volunteer management will be also be collected in real time as applicable in the operational readiness review.

- Performance measure 13.1, *Disease Reporting*, has been adjusted slightly with respect to reporting on *E. coli* STEC. In addition to providing information on awardee-required reporting timeframe, CDC is collecting the total number of disease reports received by a public health agency within 7 days, in addition to awardee specific reporting timeframes. This will be divided by the total number of cases and will allow us to aggregate reporting across awardees for one of the required reported diseases.

Medical Countermeasure Operational Readiness Review

Beginning in 2014 (BP3 from prior project period) CDC implemented a new method to assess awardee- and local-level medical countermeasure dispensing, management, and distribution capabilities. The MCM Operational Readiness Review (ORR) builds upon the progress jurisdictions have made in MCM *planning* over the years by shifting the focus of assessment to both planning and *operational capability*. In addition to public health preparedness capabilities 8 and 9, capabilities 1, 3, 4, 6, 14 and 15 were included because elements of those capaiblities are necessary to support a medical countermeasure mission.

During the new project period (2017–2022), the planning and operational aspects of these capabilities will be reviewed more generally to assess progress across the PHEP program including but not exclusively to support MCM. Within these capabilities, there are opportunities to integrate efforts to meet both PHEP performance measures and ORR requirements simultaneously.

Data from the ORR will be used to identify planning and operational gaps for targeted technical assistance to advance medical countermeasure and overall PHEP readiness. Separate ORR guidance will accompany the release of the updated ORR.

Drills and Exercises
The ORR will house required drill and exercise data as required by CDC-RFA-TP17-1701.

A summary of the changes in PHEP performance measures from Budget Period 1 (BP1) through BP5 are listed in Table 3. Measures retained are in **bold type**. Measures 5.1 and 15.1, noted with the term "(Awardee)," are oriented toward all entities (awardee or local health department(s)) responsible for supporting capabilities 5 (fatality management) and 15 (volunteer management), respectively, in the awardee's jurisdiction.

Table 3: Summary of PHEP Performance Measure Modifications

Capability	PHEP Performance Measure	Retain for current Project Period	Retire after BP5 (previous project period)	Retire after BP2 (previous project period)	Retire after BP1 (previous project period)
1 Community Preparedness	1.1 Identification of Key Organizations				X
	1.2 Community Engagement in Risk Identification				X
	1.3 Community Engagement in Public Health Preparedness Activities				X
	1.4 Community Engagement in Recovery Planning				X
	Evaluation Tool		X		
2 Community Recovery	Evaluation Tool			X	
3 Emergency Operations Coordination	3.1 Staff Assembly		X		
	3.2 Incident Action Plan (IAP)			X	
	3.3 After Action Report (AAR) and Improvement Plan (IP)			X	
4 Emergency Public Information Warning	4.1 Public Message Dissemination				X
5 Fatality Management	5.1 Identify Role with Partners (Awardee)		X		
	5.2 Identify Role with Partners (LHDs)				X
6 Information Sharing	6.1 Share Epidemiological/Clinical Data (Awardee)			X	
	6.2 Share Epidemiological/Clinical Data (LHDs)				X
	HPP-PHEP J1 Information Sharing	X			
7 Mass Care	7.1 Define Role with Partners (Awardee)			X	
	7.2 Define Role with Partners (Local Health Departments)				X
	Evaluation Tool			X	

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Capability	PHEP Performance Measure	Retain for current Project Period	Retire after BP5 (previous project period)	Retire after BP2 (previous project period)	Retire after BP1 (previous project period)
8 Medical Countermeasure Dispensing	MCMDD Composite Score				X
9 Medical Materiel Management and Dispensing	MCMDD Composite Score				X
10 Medical Surge	N/A				
11 Non-pharmaceutical Interventions	11.1 Determine Role with Partners (Awardee)			X	
	11.2 Determine Role with Partners (LHDs)				X
	11.3 Develop NPI Recommendations with Partners			X	
	12.1 Laboratorian Reporting			X	
	12.2 24/7 Emergency Contact Drill (Bi-Directional)	X			
	12.3 LRN-C Emergency Response Exercise		X		
	12.4 Notification to Partners			X	
	12.5 Proficiency Testing (LRN-C Additional Methods)	X			
12 Public Health Laboratory Testing	**12.6 Proficiency Testing (LRN-C Core Methods)**	X			
	12.7 Sample Packing and Shipping Exercise (SPaSE)	X			
	12.8 LRN Surge Capacity Exercise				X
	12.9 Communication between PHEP-funded and Sentinel Clinical Laboratories			X	
	12.10 Notification Drill associated with Proficiency Testing				X
	12.11 Proficiency Testing (LRN-B)	X			
	12.12 Sample Quality - First Responders				X
	12.13 Specimen Quality - Sentinel Clinical Laboratories				X
	12.14 PFGE *E. coli*	X			
	12.15 PFGE *L. monocytogenes*	X			
13 Public Health Surveillance and Epidemiological Investigation	**13.1 Disease Reporting**	X			

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Capability	PHEP Performance Measure	Retain for current Project Period	Retire after BP5 (previous project period)	Retire after BP2 (previous project period)	Retire after BP1 (previous project period)
	13.2 Disease Control	X			
	13.3 Outbreak Investigation Reports				X
	13.4 Outbreak Reports with Minimal Elements				X
	13.5 Exposure Reports				X
	13.6 Exposure Reports with Minimal Elements				X
	14.1 Deployment Safety and Health (Awardee)			X	
14 Responder Safety and Health	14.2 Deployment Safety and Health (LHDs)				X
	14.3 Screening/Out-Processing			X	
	14.4 Responder Health Outcomes			X	
15 Volunteer Management	**15.1 Managing Volunteers (Awardee)**	X			
	15.2 Managing Volunteers (LHDs)				X
	HPP-PHEP J2 Volunteer Management	X			

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Document Organization

The chapters in the *Budget Period 5 Performance Measure Guidance and Specifications* consist of measures and evaluation tools for seven of the 15 public health preparedness capabilities found in CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011*.

The chapters are organized alphabetically and color-coded by capability. Each capability chapter follows this structure:

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

Table 4: Example Reporting Requirements Table

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☐ States	☐ Annual Requirement	☐ Incident	☐ Data Utilized By: (e.g. GPRA; ORR; NHSPI)
☐ Directly Funded Localities	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☐ Data Collected By: (e.g. CDC EOC; CDC LRN-C Program; CDC ELC Program; and CDC PulseNet)
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

Additional Information: This box is provided to give awardees additional information to help clarify reporting options, ORR tool alignment, and additional guidance if necessary.

Modified Table Elements

Annual Requirement – Annual reporting is required for most performance measures. If checked, report at the end of each BP. Additional details regarding what is required will be included in the box at the bottom of each PM Reporting Requirements Table. All *response* measures are now included in the category of "annual reporting." There is no longer a response check box. Response measures require reporting from an incident, exercise (including a drill) or planned event. See each response measure for specific details. One incident, exercise or planned event may be used for multiple performance measures, as applicable.

Please note: Failure to report required performance measure data may be deemed *out of compliance* by CDC and as a result, CDC may include failure to report as nonreporting in public documents (e.g., NSPHP, Annual Public Health Preparedness National Snapshot).

Data utilized by – In several cases, PHEP measures are used by other measurement tools or reported for accountability as part of GPRA, NHSPI, or the ORR. When this box is checked, these PHEP data are used as part of other measurement or reporting tools. Please note: This document identifies PHEP measures that have already been incorporated into the NHSPI. Several additional measures in this document, not currently marked as used by NHSPI, may be incorporated into future iterations of that index; those determinations will be made after publication of this BP1 performance measure guidance document.

If PHEP Funds allocated to the Capability or Contracts Plan – If awardees are allocating funds to the capability (or to a specifically stated activity, e.g., PFGE), reporting is required on the associated performance measure. Over the five-year cycle, building and sustaining jurisdictional capacity to address each capability is a goal of the PHEP funding. Once the capability has been addressed, CDC recommends continued use of the performance measure in subsequent budget periods to monitor progress and ensure sustainment of the capability.

PAHPRA Benchmark – An additional box has been added to reflect when a measure is used as a benchmark as required by PAHPRA.

Sections within a measure are indicated by icons (Figure 2) 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 must 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.

The **MCM ORR** icon indicates that the performance measure relates to the Operational Readiness Review (ORR).

Within the measures, key terms that appear in **bold** font are hyperlinked to a definition. To access the definition, press CTRL and click + on the text.

Italic font is used to indicate emphasis.

Bold italic font is used to emphasize select key terms.

Key Preparedness and Response Terms
The following are key terms found throughout this document.

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.

Full-scale exercise (FSE): A full-scale exercise is a multiagency, multijurisdictional 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 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. Characteristics of an FE include simulated deployment of resources and personnel and rapid problem solving. FEs are considered operations-based exercises.

Incident: For the purpose of PHEP performance measurement, an incident is any natural, technological or human-caused occurrence that requires specific mobilization and/or allocation of public health resources beyond routine, day-to-day activities. Incidents may range in size and duration, and may (but are not required to) involve partial or full activation of emergency operations (including incident command or an incident management structure), or declaration of a public health emergency.

Planned event: For the purpose of PHEP performance measurement, a planned event is a scheduled non-emergency occurrence (often a social event of some significance, such as a major sporting, political or other entertainment event) that entails planning and demonstration of capabilities. Planned events may range in size and duration, and may (but are not required to) involve partial or full activation of emergency operations (including incident command or an incident management structure).

Virtual assembly: The use of teleconference and/or Internet-based technology to convene two or more individuals in a real-time exchange of information to facilitate efficient decision-making. This can include, but is not limited to, teleconferencing, web-based meetings, and other types of online interactive systems and technologies in which voice and/or visual exchange of information is present. Virtual assembly does not include an active e-mail exchange with all parties or other types of time-delayed communications that do not allow for an immediate feedback / response discussion.

CAPABILITY-SPECIFIC
PERFORMANCE MEASURES

Capability 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**

The Community Preparedness Evaluation Tool was retired. Key aspects of information from this tool will be collected within the operational readiness review (ORR). CDC will collect data assessing readiness including how awardee and local CRI planning jurisdictions address vulnerable populations with functional and access needs. Refer to the previous project period guidance document for more information about this tool.

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Capability 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.

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**

The Community Recovery Evaluation Tool has been retired. Awardees may continue to use this tool for their own evaluation purposes. Key aspects of information from this tool will be collected within the operational readiness review (ORR). Refer to the previous project period guidance document for more information about this tool.

Capability 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 critical to public health emergency preparedness and response.

As part of the Incident Management (IM) concept, emergency operations coordination 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**

CDC will no longer use a performance measurement to assess this capability. Key aspects of information from this performance measure will be collected within the operational readiness review (ORR). Supplemental guidance for the operational readiness review will contain more information about reporting EOC activation and staff assembly. Reporting in the ORR will replace performance measure 3.1 staff assembly.

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Capability 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**

CDC will collect basic planning and operational components for this capability within the operational readiness review (ORR). Refer to the operational readiness review guidance document for more information.
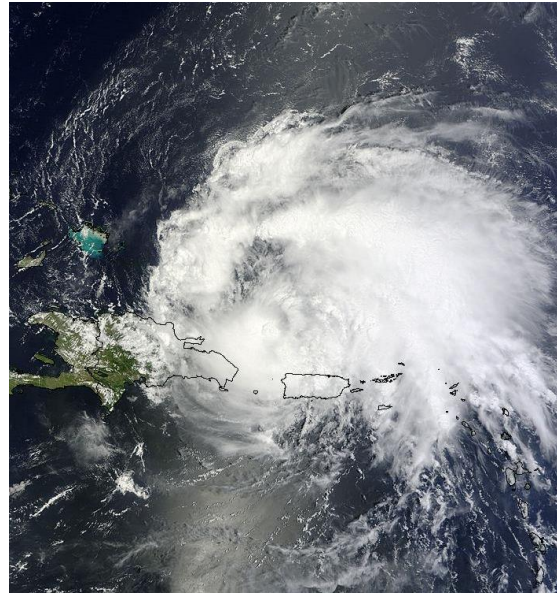
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Capability 5: Fatality Management

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 and related 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 planning measure is designed to encourage health departments to collaborate with emergency management, law enforcement, medical examiners, coroners, funeral directors, and other key partners to determine what role public health will play in managing significant numbers of fatalities – or in supporting the management of fatalities by other agencies. *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 its key partners, it has met the intent of this measure. Depending on its role, all elements within the measure may not be required to meet full capability based on awardee-determined role in fatality management.

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**

The fatality management performance measurement was retired. Awardees may continue to use this tool for their own evaluation purposes. Refer to the previous project period guidance document for more information about this tool.

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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 joint HPP-PHEP information sharing performance measure is designed to assess whether requests for information from the public health and medical lead to local partners are fulfilled in a timely manner.

Capability Functions

> **This PHEP 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
HPP-PHEP J.1			●

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HPP-PHEP J.1: Information Sharing

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

Measure Applies To :	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☑ **Incident**	☑ **Data Utilized By: MCM ORR**
☑ **Directly Funded Localities**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☑ **Exercise**	☑ **Data Collected By: HPP and/or PHEP (PERFORMS only)**
☑ **Territories or Freely Associated States**		☑ **Planned Event**	☐ PAHPRA Benchmark

Additional Information: Awardees are required to report twice for this measure. If you have zero or one data point to report, conduct exercises (including drills) or planned events to obtain two data points for this performance measure. Only information sharing related to an MCM incident or scenario (including an exercise or drill) will count towards the ORR, so ensure this is accomplished at least every other year. In alternate years, consider exercising information sharing related to non-MCM incidents and scenarios to test capability for sharing different types of EEI with different local partners.

How is the measure calculated?

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

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

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 public 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?

This measure requires submission of self-reported data. Data should be collected and reported by incident (or planned event or exercise).

Awardees are required to report at least two data points for this measure. One data point must reflect the awardee's best performance (highest percentage); the other must reflect performance which, based on a determination from the awardee, calls for focused quality improvement and – if applicable – technical assistance. Awardees are encouraged to submit data on additional incidents, planned events and exercises as well. There are no specific reporting requirements or parameters for these additional data points.

How does this measure align with the ORR?

MCM ORR

Information sharing is essential during responses to all emergencies and is particularly important to the facilitation of situational awareness and appropriate allocation of resources during an incident. There is an opportunity to work with partners to align EEI sharing processes for the HPP-PHEP J1 and MCM ORR by conducting an MCM-oriented exercise or drill every two years and on alternate years conducting an exercise or drill to share EEI for other hazards. Data from HPP-PHEP J.1 can apply directly to the ORR. Sharing POD or mass vaccine site data (e.g., throughout, open/set-up status) can be exercised as an alternative reporting option if no incidents occur during the budget period.

What data must be reported?

For each incident, exercise, or planned event reported for demonstration of the Information Sharing Capability, please enter the following information:		
1. Number of local partners that received a request for EEI (denominator)	*[Max 5 digits]*	
2. Number of local partners that reported requested EEI to the health and medical lead within the requested timeframe (numerator)	*[Max 5 digits]*	
Performance Measure: Percent of local partners that reported EEI to the health/medical lead within the requested timeframe (System calculated)	*[Percentage]*	%

3. The request for EEI occurred during a/an: *[Select one]*

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

4. Please identify the type of incident/exercise/planned event upon which the request for EEI was based.* *[Select only one, even if multiple hazards existed in one incident]*

☐ Extreme weather (e.g., heat wave, ice storm)   ☐ Biological hazard or disease, please specify
☐ Flooding   *[Max 100 characters]*
☐ Earthquake
☐ Hurricane/tropical storm   ☐ Radiation
☐ Hazardous material   ☐ Other, please specify *[Max 100 characters]*
☐ Fire
☐ Tornado

5. Was this incident/exercise/planned event MCM-related? *check to align with MCM ORR*   ☐ Yes
                                                                                                                                        ☐ No

6. Please provide the name and date of the incident/planned event/exercise.

   a. Name *[Max 100 characters]*   b. Date *[MM/DD/YYYY]*

7. This incident/planned event/exercise utlized or demonstrated one or more functions within the: *[Select one]*

☐ HPP Capability
☐ PHEP Capability
☐ Both HPP and PHEP Capabilities

8. Please state how many of each type(s) of local partners responded to the request. *[Max 5 digits for each type]*

Hospitals   Healthcare Organizations (HCOs)
Long-term care facilities   Local public health entities (LHDs, district or
Community health center   regional offices, etc.)

9. Did "other" types of local partners (not listed above) respond to the request? *[Maximum five "other" types]*

☐ Yes
☐ No

a., please describe other type #1.　　*[Max 100 characters]*

b., how many local partners of "other" type #1 responded to the request?　　*[Max 3 digits]*

c. Please describe other type #2.　　*[Max 100 characters]*

d. How many local partners of other type #2 responded to the request?　　*[Max 3 digits]*

e. Please describe other type #3.　　*[Max 100 characters]*

f. How many local partners of other type #3 responded to the request?　　*[Max 3 digits]*

g. Please describe other type #4.　　*[Max 100 characters]*

h. How many local partners of "other" type #4 responded to the request?　　*[Max 3 digits]*

i. Please describe other type #5.　　*[Max 100 characters]*

j. How many local partners of "other" type #5 responded to the request?　　*[Max 3 digits]*

10. Please identify the requesting entity (e.g., public 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 *[Max 100 characters]*

11. Please identify the types of EEI requested. *[Select all that apply]*

☐ Facility operating status
☐ Facility structural integrity
☐ The 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, absenteesim, etc.)
☐ POD/mass vaccine sites data (e.g., throughout, open/set-up status, etc.),
☐ Other, please specify *[Max 100 characters]*

12. Please identify the type of IT or other communication system used to request EEI from local partners. *[Select all that apply]*

☐ Telecommunication (e.g., cell phone, satellite phone, landline)
☐ E-mail
☐ Online/web interface (electronic bed or patient tracking, survery tools, WebEOC or similar, etc.)
☐ Health Alert Network
☐ Other, please specify *[Max 100 characters]*

13. Continuous Quality Improvement:

a. Were relevant corrective actions/improvement plans items from *prior responses* (including exercises, drills, etc.) related to information sharing incorporated into planning and/or response procedures before this incident/drill/planned event took place?

☐ Yes
☐ No
☐ Some

b. Have corrective actions/improvement plan items related to information sharing been identified as a result of this incident/drill?

☐ Yes
☐ No

i. Have they been implemented?

☐ Yes
☐ No
☐ Some

14. Please indicate any barriers to submitting requested EEI within the requested timeframe. *[Select all that apply]*

☐ Communication
☐ Equipment
☐ Funding
☐ Participation
☐ Policies/procedures
☐ Resource limitations
☐ Staffing
☐ Time constraints
☐ Training
☐ Other, please specify
☐ None

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15. [Optional] Please provide any additional clarifying, contextual, or other information *[Max 1,000 characters]*

NOTE: When completed with reporting of all incidents for Performance Measure HPP-PHEP J.1, PERFORMS will prompt the user to address two additional questions: 1) Which of the incidents was the awardee's best performance and 2) which incident is being used to focus on quality improvement or technical assistance.

How is this measure operationalized?

This measure intends to capture information on the communication of incident-specific public health/medical EEIs. Determination of which EEIs are to be requested or collected during a response, as well as which local entities should report the information and the timeframe in which the information should be reported, and should be based on established plans, protocols and procedures. These are ultimately at the discretion of the incident commander or designee.

If large volumes of EEI are collected in an incident, it is the responsibility of the awardee to determine which of this information was "essential" – and therefore able to count towards the numerator and denominator – for this performance measure.

Key Measurement Terms

Essential Elements of Information (EEI): Essential elements of information are discrete types of reportable public health or healthcare-related incident-specific knowledge communicated or received concerning a particular fact or circumstance, 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 period of time for receiving requested EEI (e.g., operational period, set time to meet special request, e.g., 1500 hours).

Capability 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 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.

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**

PHEP 7.1 and the Mass Care Evaluation Tool have been retired. Awardees may continue to use this measure and tool for their own evaluation purposes, but CDC will not collect these data. Refer to the BP2 (2013-2014) performance measures guidance document for more information about this measure and the evaluation tool.

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Capability 8 and 9: Medical Countermeasure Dispensing and Medical Materiel Management and Distribution

Introduction

Following an emergency, effective care cannot be delivered without available staff and appropriate countermeasures. Accordingly, managing the distribution of and access to and administration of countermeasures while assuring the safety and health of key personnel are important priorities for preparedness and continuity of operations. PHEP funding plays an important role in medical countermeasure planning, procuring and dispensing MCMs for the community.

Operational Readiness Review (ORR)

The Operational Readiness Review (ORR) will be used to assess Capabilities 8 and 9 (and related elements from other capabilities). The ORR replaced the Technical Assistance Review and the Medical Countermeasures Distribution and Dispensing Composite Score. Refer to the FOA and operational readiness review supplemental guidance for information about other requirements related to capabilities 8 and 9, including information on the jurisdictional data sheets (JDS), drills, exercises, POD and RSS checklist requirements.

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Capability 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**
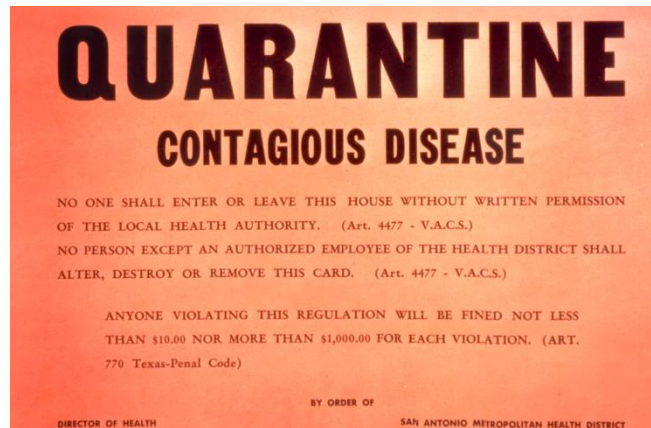
At present there are no CDC-defined performance measures for this capability.

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Capability 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.

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**

PHEP 11.1 and 11.3 have been retired. Awardees may continue to use these measures for their own evaluation purposes, but CDC will not collect these data. Refer to BP2 (2013-2014) performance measures guidance document for more information about these measures.
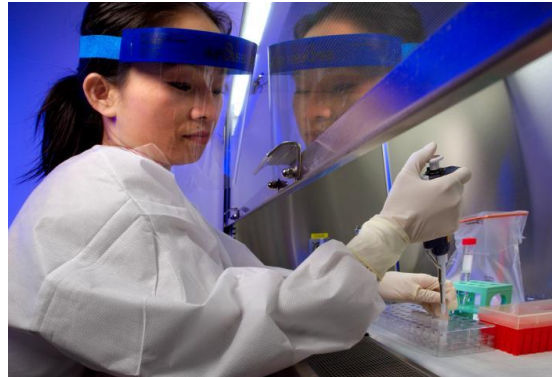
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Capability 12: Public Health Laboratory Testing

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, a number of measures utilized by the Laboratory Response Network (LRN-B and LRN-C) have been incorporated as PHEP performance measures. Although not encompassing all 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 12.2				●	
PHEP 12.5			●		
PHEP 12.6			●		
PHEP 12.7		●			
PHEP 12.11			●		
PHEP 12.14					●
PHEP 12.15					●

*Note: The performance measures for Capability 12 use data collected primarily from other CDC sources. Once the data is provided to DSLR, awardees are asked to confirm the data. No templates are provided for Capability 12 performance measures because direct self-report (i.e., manual entry) of data to DSLR is not required.

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

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

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☐ Data Utilized By
☑ **Directly Funded Localities: Excludes Chicago**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☑ **Data Collected By: CDC EOC**
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

How is the measure calculated?

*Start Time***:** Date and time that CDC EOC staff first dialed the contact number for the on-call laboratorian or epidemiologist, depending on drill direction.

*Stop Time***:** Date and time that on-call laboratorian or epidemiologist (depending on drill direction) contacted 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 ensuring good communication between laboratory and epidemiology staff and in fostering improvements in communication response gaps revealed by exercises and incidents.

The purpose of the 24/7 Emergency Contact Drill is to ensure a timely and effective response to incidents of public health significance by promoting rapid communication between a jurisdiction's on-call epidemiologist and on-call laboratorian (and vice versa). The measure is *not intended to adhere to, or assess, CDC's emergency notification protocol to state public health labs or state epidemiologists*. Although conducted by the CDC Emergency Operations Center (EOC), the drill is not an EOC or LRN measure of performance; it is strictly a PHEP performance 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 EOC and shared with the Division of State and Local Readiness (DSLR).

Awardees are expected to maintain updated contact information for their jurisdiction's on-call LRN-B laboratorian, on-call LRN-C laboratorian, and on-call epidemiologist as described in **Appendix B**.

CDC staff may contact the awardee at any time during the budget period to verify contact information for on-call (and alternate on-call) contact information for LRN-B/LRN-C laboratorians and/or epidemiologists.

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What data must be reported?

Data for this measure is collected by CDC EOC. Additional data may be collected by DSLR as part of technical assistance and overall program improvement (e.g., factors accounting for not meeting the performance target or communication barriers).

How is this measure operationalized?

Please refer to **Appendix B** for details on how this measure is operationalized.

BP5 drill direction for awardees with separate biological and chemical laboratories:

Drill #1: CDC EOC→LRN-C→EPI→CDC EOC

Drill #2: CDC EOC→EPI→LRN-B→CDC EOC

BP5 drill direction for awardees with joint biological and chemical laboratories:

Drill #1: CDC EOC→LRN-B/C→EPI→CDC EOC

Drill #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 laboratory; the term "EPI" refers to the awardee's on-call epidemiologist.

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 refer to Appendix B for an overview of pre-drill, drill, and post-drill activities, including what PHEP directors can do to ensure drill success (e.g., how to update contact information for the on-call laboratorian and on-call epidemiologist contact information).

Pre-Incident

Core Public Health

Response

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

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

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☑ **Data Utilized By: NHSPI**
☑ **Directly Funded Localities: Excludes Chicago**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☑ **Data Collected By: CDC LRN-C Program**
☐ Territories or Freely Associated States	☐ If Emergency Response Required Use of this Capability, Regardless of Funding	☐ Planned Event	☑ **PAHPRA Benchmark**

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

Laboratories must pass/qualify on 90% of the methods tested.

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. 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.

A key objective 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 measure is required for awardees with Level 1 laboratories; it is optional for awardees with Level 2 laboratories.

Data Elements 1-2 are collected internally by the CDC LRN-C program and are shared with DSLR. Awardees will submit information for Data Elements 3-4 in PERFORMS.

Proficiency testing data must be validated by the awardee preparedness office in PERFORMS.

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Pre-Incident

Core Public Health

Response

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 successful proficiency tested by the PHEP-funded laboratory (numerator)
3. Please indicate any barriers to passing or participating in proficiency testing. [Select all that apply]
    - ☐ Communication
    - ☐ Equipment
    - ☐ Funding
    - ☐ Participation
    - ☐ Policies/procedures
    - ☐ Resource limitations
    - ☐ Staffing
    - ☐ Time constraints
    - ☐ Training
    - ☐ Other, please specify
    - ☐ None
4. [Optional] Please provide any additional clarifying, contextual or other information.

Pre-Incident

Core Public Health

Response

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

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

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☑ **Data Utilized By: NHSPI**
☑ **Directly Funded Localities: Excludes Chicago**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☑ **Data Collected By: CDC LRN-C Program**
☐ Territories or Freely Associated States	☐ If Emergency Response Required Use of this Capability, Regardless of Funding	☐ Planned Event	☑ **PAHPRA Benchmark**

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 for which the PHEP-funded laboratory is qualified to test

Laboratories must pass/qualify on 90% of the methods tested.

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.

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 measure is required for awardees with Level 1 or Level 2 laboratories.

Data Elements 1-2 are collected internally by the CDC LRN-C program and are shared with DSLR. Awardees will submit information for Data Elements 3-4 in PERFORMS.

Proficiency testing data must be validated by the awardee preparedness office in PERFORMS

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 (denominator)
3. Please indicate any barriers to passing or participating in proficiency testing. [Select all that apply]

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☐   Communication

☐   Equipment

☐   Funding

☐   Participation

☐   Policies/procedures

☐   Resource limitations

☐   Staffing

☐   Time constraints

☐   Training

☐   Other, please specify

☐   None

4. [Optional] Please provide any additional clarifying, contextual or other information.

PHEP 12.7: Specimen Packaging and Shipping Exercise (SPaSE)

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

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☑ **Data Utilized By: NHSPI**
☑ **Directly Funded Localities: Excludes Chicago**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☑ **Exercise**	☑ **Data Collected By: CDC LRN-C Program**
☐ Territories or Freely Associated States	☐ Optional	☐ Planned Event	☑ **PAHPRA Benchmark**

How is the measure calculated?

Specimen packaging and shipping exercise (SPaSE) results, per laboratory: Passed/Did not pass/Did not participate

An awardee will be rated as "Passed" if at least one LRN-C laboratory in the jurisdiction participated and passed. If an applicable awardee does not have at least one PHEP-funded laboratory participate in this exercise during the year; or no participating laboratory receives a score of at least 90% during this year, the awardee will be rated as "Did not pass."

Why is this measure important?

The proper 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 package and ship patient specimens in compliance with International Air Transport Association, U.S. Department of Transportation, and state regulations.

What other requirements are there for reporting measure data?

This measure applies to LRN-C levels 1, 2 and 3.

At least one PHEP-funded laboratory within an applicable awardee jurisdiction must participate annually. Additional laboratories may participate if they choose.

Data elements 1 and 2 are reported by the LRN-C program and shared with DSLR. Awardees should report data elements 3 and 4 in PERFORMS. SCPaS data must be validated in PERFORMS by the awardee preparedness office.

What data must be reported?

1. Specimen Packaging and Shipping Exercise (SPaSE) 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)
3. Please indicate any barriers to successful sample collection, packing, and shipping. [Select all that apply]

   ☐ Communication

☐ Equipment

☐ Funding

☐ Participation

☐ Policies/procedures

☐ Resource limitations

☐ Staffing

☐ Time constraints

☐ Training

☐ Other, please specify

☐ None

4. [Optional] Please provide any additional clarifying, contextual or other information.

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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:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☑ **Data Utilized By: NHSPI**
☑ **Directly Funded Localities: Excludes Chicago**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☑ **Data Collected By: CDC LRN-B Program**
☐ Territories or Freely Associated States		☐ Planned Event	☑ **PAHPRA Benchmark**

How is the measure calculated?

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

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

Laboratory cannot fail more than one PT challenge

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 so that the CDC's LRN and the awardee preparedness offices are aware of awardee testing capabilities.

What other requirements are there for reporting measure data?

Data elements 1-6 will be collected by the LRN-B program and shared with DSLR. Awardees should report data elements 7 and 8 in PERFORMS. Awardees must validate performance measure data on an annual basis in PERFORMS.

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 remediation proficiency tests successfully passed by the PHEP-funded laboratory
4. Number of LRN-B proficiency tests participated in by all public health laboratories
5. Number of LRN-B proficiency tests successfully passed by all public health laboratories during first attempt
6. Total number of public health LRN-B laboratories.
7. Please indicate any barriers to participation and/or passing LRN-B proficiency testing. [Select all that apply]

   ☐ Communication

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☐ Equipment

☐ Funding

☐ Participation

☐ Policies/procedures

☐ Resource limitations

☐ Staffing

☐ Time constraints

☐ Training

☐ Other, please specify

☐ None

8. [Optional] Please provide any additional clarifying, contextual, or other information.

How is this measure operationalized?

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 12.14: PFGE *E. coli*

Percentage of pulsed field gel electrophoresis (PFGE) sub-typing 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:	Data May Be Taken From:	Other Considerations:
☑ **States**	☐ Annual Requirement	☐ Incident	☑ **Data Utilized By: GPRA**
☑ **Directly Funded Localities: Excludes Chicago**	☑ **If PHEP Funds Allocated to the Capability or Contracts Plan (for PFGE activities)**	☐ Exercise	☑ **Data Collected By: CDC ELC Program and CDC PulseNet**
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

How is the measure calculated?

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

Denominator: Total number of primary patterns from sub-typed *E. coli* O157:H7 human isolates uploaded into the PulseNet national database.

Performance 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 NSPHP. *The reporting period for this performance measure is Calendar Year (CY) 2017.*

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What data must be reported?

1. Number of *E. coli* O157:H7 human isolates received by the *state public health laboratory.* (ELC*)
   a. Of these, number of human isolates sent to another laboratory (out of state) for PFGE sub-typing. (ELC)
2. Number of primary patterns from sub-typed human isolates uploaded into the PulseNet national database (PN*) (denominator)
   a. Of these, the number of primary patterns with a valid 'receive date' (i.e., date received at the *PFGE laboratory*) (PN).
3. Number of results from PFGE sub-typing of *E. coli* O157:H7 human isolates that were submitted to the PulseNet database within four working days of receipt at PFGE laboratory (numerator) (PN).
4. If calculated percentage for this performance measure (determined by CDC PulseNet) < 90 percent, please describe barriers or challenges to meeting this target (90 percent 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 human isolates they receive if they are not sub-typed.
Human isolates refers to reference or clinical human isolates.

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PHEP 12.15: PFGE *L. monocytogenes*

Percentage of pulsed field gel electrophoresis (PFGE) sub-typing 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:	Data May Be Taken From:	Other Considerations:
☑ **States**	☐ Annual Requirement	☐ Incident	☐ Data Utilized By
☑ **Directly Funded Localities: Excludes Chicago**	☑ **If PHEP Funds Allocated to the Capability or Contracts Plan (for PFGE activities)**	☐ Exercise	☑ **Data Collected By: CDC ELC Program and CDC PulseNet**
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

How is the measure calculated?

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

Denominator: Total number of primary patterns from sub-typed *Listeria monocytogenes* human isolates uploaded into the PulseNet national database.

Performance 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 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 NSPHP. ***The reporting period for this performance measure is Calendar Year (CY) 2017***.

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What data must be reported?

1. Number of *Listeria monocytogenes* human isolates received by the *state public health laboratory.* (ELC*)
   a. Of these, number of human isolates sent to another laboratory (out of state) for PFGE sub-typing. (ELC*
2. Number of primary patterns from sub-typed human isolates uploaded into the PulseNet national database (PN*) (denominator)
   a. Of these, the number of primary patterns with a valid 'receive date' (i.e., date received at the *PFGE laboratory*) (PN).
3. Number of results from PFGE sub-typing of *Listeria monocytogenes* human isolates that were submitted to the PulseNet database within four working days of receipt at PFGE laboratory (numerator) (PN)
4. If calculated percentage for this performance measure (determined by CDC PulseNet) < 90%, please describe barriers or challenges to meeting this target (90%of sub-typing 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 human isolates they receive if they are not sub-typed. Human isolates refers to reference or clinical human isolates.

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Key Measurement Terms

Notification: Notification related to the 24/7 Emergency Contact Drill (PHEP 12.2) refers to a chain of communication between the CDC EOC, an on-call laboratorian and an on-call epidemiologist (or vice versa), depending on the direction of the drill. Notification always concludes with a communication back to the CDC EOC. Refer to Appendix B for more information.

Outside of normal business hours: Outside of normal business hours are those times of the day outside of which most business is conducted (e.g., non-working hours, evenings, weekends, legal holidays, etc.).

On-call epidemiologist: An on-call epidemiologist is the person 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 is the person from the laboratory who has 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.

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

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

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Capability 13: Public Health Surveillance and Epidemiological Investigation

Introduction

This capability includes activities related to surveillance and the detection of public health threats 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.

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			●	

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PHEP 13.1: Disease Reporting

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

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☐ Data Utilized By
☑ **Directly Funded Localities: Excludes Chicago and Los Angeles County**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☐ Data Collected By
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

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 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 health department 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?

Awardees should report jurisdictionwide (e.g., statewide) performance measure data for PHEP 13.1. Awardees that are unable to report jurisdictionwide performance measure data should report as much as feasible and indicate the percentage of the jurisdictional population covered by these data.

Awardees are required to report data on case reports with CDC notification dates between MMWR Week 27, 2017 (beginning Sunday, July 9, 2017) through MMWR Week 26, 2018 (ending Saturday, June 30, 2018).

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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:
  - o Botulism (*Clostridium botulinum*), all types excluding infant botulism (confirmed)
  - o Tularemia (*Francisella tularensis*) (confirmed and probable)
- *E. coli,* STEC (confirmed)
- Hepatitis A, acute (confirmed)
- Measles (confirmed)
- Meningococcal disease (*Neisseria meningitides*) (confirmed)

Awardees have the *option* to provide data on:

- Salmonellosis (confirmed), all types excluding Typhoid Fever (*Salmonella enterica* serovar Typhi)
- Up to three additional diseases of interest in the awardee jurisdiction (e.g., Shigella, Pertussis, etc.)

Awardees should calculate the numerator and denominator for this performance measure at the public health system level (i.e., to reflect how disease reporting actually occurs in the awardee's jurisdiction, irrespective of whether reporting first comes through the state or local level).

Awardees should ensure counts exclude duplicate cases.

Awardees must 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.

For each disease reported in 13.1 and 13.2, please ensure that the total number of disease reports received by the public health agency (the denominators) are the same.

New Reporting Requirement

E. coli, STEC reporting requirements include an additional component for measure 13.1. In addition to reporting based on jurisdictional reporting time requirements, CDC is now collecting the total number of reports received by a public health agency within 7 days. This will now serve as the numerator to create the percentage of reports received within 7 days. This will be a new performance measure that can be aggregated across all awardees. Continue submitting information on awardee-defined reporting period as well. This information is still of interest to key CDC stakeholders.

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What data must be reported?

Data Elements	
1. Total number of disease reports received by a public health agency for **Botulism** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Botulism** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Botulism** (confirmed) received by a public health agency within the awardee-required timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Botulism** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Botulism**?	☐ <25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Botulism**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *Max 100 characters]*

e. For **Botulism**, please indicate the awardee-required reporting timeframe for *laboratories*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *Max 100 characters]*

f. Case event date type for **Botulism**
- ☐ Date of diagnosis – lab-confirmed
- ☐ Date of diagnosis – presumptive/clinical
- ☐ Date of laboratory report
- ☐ Date of laboratory result
- ☐ Date of specimen collection

2. Total number of disease reports received by a public health agency for **Tularemia** (confirmed and probable) (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Tularemia** (confirmed and probable) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Tularemia** (confirmed and probable) received by a public health agency within the awardee-required timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Tularemia** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No

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2. Total number of disease reports received by a public health agency for **Tularemia** (confirmed and probable) (denominator).

[Max 4 digits]

(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Tularemia**?

☐ ≤25%
☐ 26-50%
☐ 51-75%
☐ 76-99%

d. For **Tularemia**, please indicate the awardee-required reporting timeframe for *providers*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *Max 100 characters]*

e. For **Tularemia**, please indicate the awardee-required reporting timeframe for *laboratories*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *Max 100 characters]*

f. Case event date type for **Tularemia**
☐ Date of diagnosis – lab-confirmed
☐ Date of diagnosis – presumptive/clinical
☐ Date of laboratory report
☐ Date of laboratory result
☐ Date of specimen collection

3. Total number of disease reports received by a public health agency for *E. coli*, **STEC** (confirmed) (denominator).

[Max 4 digits]

   a. Total number of disease reports received by a public health agency within 7 days (numerator):

[Max 4 digits]

   b. Percentage of reports of *E. coli*, **STEC** (confirmed) received by a public health agency within 7 days: *[System calculated]*

c. Are the values reported in the denominator and numerator for *E. coli*, **STEC** drawn from surveillance and disease reporting covering the entire jurisdiction?

☐ Yes
☐ No

(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for *E. coli*, **STEC**?

☐ ≤25%
☐ 26-50%
☐ 51-75%
☐ 76-99%

d. For *E. coli*, **STEC**, please indicate the awardee-required reporting timeframe for *providers*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *[Max 100 characters]*

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e. For *E. coli*, **STEC**, please indicate the awardee-required reporting timeframe for *laboratories*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

f. Case event date type for *E. coli*, **STEC**
- [ ] Date of diagnosis – lab-confirmed
- [ ] Date of diagnosis – presumptive/clinical
- [ ] Date of laboratory report
- [ ] Date of laboratory result
- [ ] Date of specimen collection

4. Total number of disease reports received by a public health agency for **Hepatitis A, acute** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Hepatitis A, acute** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Hepatitis A, acute** (confirmed) received by a public health agency within the awardee-required timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Hepatitis A, acute** drawn from surveillance and disease reporting covering the entire jurisdiction?	[ ] Yes [ ] No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Hepatitis A, acute**?	[ ] ≤25% [ ] 26-50% [ ] 51-75% [ ] 76-99%

d. For **Hepatitis A, acute**, please indicate the awardee-required reporting timeframe for *providers*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

e. For **Hepatitis A, acute**, please indicate the awardee-required reporting timeframe for *laboratories*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

f. Case event date type for **Hepatitis A, acute**
- [ ] Date of diagnosis – lab-confirmed
- [ ] Date of diagnosis – presumptive/clinical
- [ ] Date of laboratory report
- [ ] Date of laboratory result
- [ ] Date of specimen collection

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5. Total number of disease reports received by a public health agency for **Measles** (confirmed) (denominator).	*[Max 4 digits]*

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a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Measles** (confirmed) (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Measles** (confirmed) received by a public health agency within the awardee-required timeframe   *[System calculated]*

c. Are the values reported in the denominator and numerator for **Measles** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Measles**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Measles**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

e. For **Measles**, please indicate the awardee-required reporting timeframe for *laboratories*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

f. Case event date type for **Measles**
- ☐ Date of diagnosis – lab-confirmed
- ☐ Date of diagnosis – presumptive/clinical
- ☐ Date of laboratory report
- ☐ Date of laboratory result
- ☐ Date of specimen collection

6. Total number of disease reports received by a public health agency for **Meningococcal Disease** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Meningococcal Disease** (confirmed) (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Meningococcal Disease** (confirmed) received by a public health agency within the awardee-required timeframe   *[System calculated]*

c. Are the values reported in the denominator and numerator for **Meningococcal Disease** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Meningococcal Disease**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Meningococcal Disease**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours

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☐ 7 Days
☐ Other, please specify   *[Max 100 characters]*

e. For **Meningococcal Disease**, please indicate the awardee-required reporting timeframe for *laboratories*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *[Max 100 characters]*

f. Case event date type for **Meningococcal Disease**
☐ Date of diagnosis – lab-confirmed
☐ Date of diagnosis – presumptive/clinical
☐ Date of laboratory report
☐ Date of laboratory result
☐ Date of specimen collection

Optional Disease Reporting

7. Would you like to report data on **Salmonellosis** (confirmed)?
☐ Yes
☐ No

8. Total number of disease reports received by a public health agency for **Salmonellosis** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Salmonellosis** (confirmed) (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Salmonellosis** (confirmed) received by a public health agency within the awardee-required timeframe   *[System calculated]*

c. Are the values reported in the denominator and numerator for **Salmonellosis** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Salmonellosis**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Salmonellosis**, please indicate the awardee-required reporting timeframe for *providers*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *[Max 100 characters]*

e. For **Salmonellosis**, please indicate the awardee-required reporting timeframe for *laboratories*.
☐ Immediately
☐ 24 Hours
☐ 48 Hours
☐ 72 Hours
☐ 7 Days
☐ Other, please specify   *[Max 100 characters]*

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d. For **Salmonellosis**, please indicate the awardee-required reporting timeframe for *providers*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

f. Case event date type for **Salmonellosis**
- [ ] Date of diagnosis – lab-confirmed
- [ ] Date of diagnosis – presumptive/clinical
- [ ] Date of laboratory report
- [ ] Date of laboratory result
- [ ] Date of specimen collection

Additional Disease(s) of interest to awardee

9. Would you like to report data on other diseases (up to 3)? This is optional.
- [ ] Yes
- [ ] No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 1**.
[max 100 characters]

10. Total number of disease reports received by a public health agency for **Disease 1** (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Disease 1** (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Disease 1** received by a public health agency within the awardee-required timeframe
[System calculated]

c. Are the values reported in the denominator and numerator for **Disease 1** drawn from surveillance and disease reporting covering the entire jurisdiction?	[ ] Yes [ ] No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 1**?	[ ] <25% [ ] 26-50% [ ] 51-75% [ ] 76-99%

d. For **Disease 1**, please indicate the awardee-required reporting timeframe for *providers*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

e. For **Disease 1**, please indicate the awardee-required reporting timeframe for *laboratories*.
- [ ] Immediately
- [ ] 24 Hours
- [ ] 48 Hours
- [ ] 72 Hours
- [ ] 7 Days
- [ ] Other, please specify   *[Max 100 characters]*

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d. For **Disease 1**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

f. Case event date type for **Disease 1**
- ☐ Date of diagnosis – lab-confirmed
- ☐ Date of diagnosis – presumptive/clinical
- ☐ Date of laboratory report
- ☐ Date of laboratory result
- ☐ Date of specimen collection

11. Would you like to report data on a second disease? This disease will be referred to as **Disease 2**.
- ☐ Yes
- ☐ No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 2**.
   [Max 100 characters]

12. Total number of disease reports received by a public health agency for **Disease 2** (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Disease 2** (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Disease 2** received by a public health agency within the awardee-required timeframe *[System calculated]* Note: Displayed as a percentage in PERFORMS	
c. Are the values reported in the denominator and numerator for **Disease 2** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 2**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Disease 2**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

e. For **Disease 2**, please indicate the awardee-required reporting timeframe for *laboratories*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

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f. Case event date type for **Disease 2**
- ☐ Date of diagnosis – lab-confirmed
- ☐ Date of diagnosis – presumptive/clinical
- ☐ Date of laboratory report
- ☐ Date of laboratory result
- ☐ Date of specimen collection

13. Would you like to report data on a third disease? This disease will be referred to as **Disease 3**.
- ☐ Yes
- ☐ No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 3**.
   [max 100 characters]

14. Total number of disease reports received by a public health agency for **Disease 3** (denominator).	*[Max 4 digits]*
a. Total number of disease reports received by a public health agency within the awardee-required reporting timeframe for **Disease 3** (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Disease 3** received by a public health agency within the awardee-required timeframe
   [System calculated] Note: Displayed as a percentage in PERFORMS

c. Are the values reported in the denominator and numerator for **Disease 3** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 3**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

d. For **Disease 3**, please indicate the awardee-required reporting timeframe for *providers*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

e. For **Disease 3**, please indicate the awardee-required reporting timeframe for *laboratories*.
- ☐ Immediately
- ☐ 24 Hours
- ☐ 48 Hours
- ☐ 72 Hours
- ☐ 7 Days
- ☐ Other, please specify   *[Max 100 characters]*

f. Case event date type for **Disease 3**
- ☐ Date of diagnosis – lab-confirmed
- ☐ Date of diagnosis – presumptive/clinical
- ☐ Date of laboratory report
- ☐ Date of laboratory result
- ☐ Date of specimen collection

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15. Has the awardee health department reviewed disease reports and related information for the purposes of improving disease reporting between providers, laboratories and the public health system?	☐ Yes ☐ No
a. Has the awardee health department identified corrective actions to improve disease reporting between providers, laboratories and the public health system?	☐ Yes ☐ No
b. Has it implemented them?	☐ Yes ☐ Some ☐ No

16. Please indicate any barriers to timely disease reporting. *[Select all that apply]*

☐ Communication   ☐ Staffing
☐ Equipment   ☐ Time constraints
☐ Funding   ☐ Training
☐ Participation   ☐ Other, please specify
☐ Policies/procedures   ☐ None
☐ Resource limitations

17. *[Optional]* Please provide any additional clarifying, contextual or other information.
          [Max 1000 characters]

How is this measure operationalized?

Assessing timeliness: Timeliness should be based on calendar days (including weekends and holidays), not business days.

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 the health department). 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, reportable Category A agents include 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: In many jurisdictions there may be few or no cases of certain diseases. Although low incidence rates may create challenges for instituting program improvement, the selected diseases are significant nationally and require surveillance systems and processes for timely reporting. CDC will not interpret denominators with a value of zero as poor performance.

Measles – case event date type options: Due to the 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.

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PHEP 13.2: Disease Control

Percentage 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:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☐ Incident	☐ Data Utilized By
☑ **Directly Funded Localities: Excludes Chicago and Los Angeles County**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☐ Exercise	☐ Data Collected By
☐ Territories or Freely Associated States		☐ Planned Event	☐ PAHPRA Benchmark

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?

Awardees should report jurisdictionwide (e.g., statewide) performance measure data for PHEP 13.2. Awardees that are unable to report jurisdictionwide performance measure data should report as much data as feasible and indicate the percentage of the jurisdictional population covered by these data.

Awardees are required to report data on case reports with CDC notification dates between MMWR Week 27, 2016 (beginning Sunday, July 3, 2016) through MMWR Week 26, 2017 (ending Saturday, July 1, 2017).

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

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- 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 (confirmed)
- Hepatitis A, acute (confirmed)
- Measles (confirmed)
- Meningococcal disease (*N. meningitides*) (confirmed)

Awardees have the *option* to provide data on:

- Salmonellosis (confirmed), all types <u>excluding</u> Typhoid Fever (*Salmonella enterica* serovar Typhi)
- Up to 3 additional diseases of interest in the awardee jurisdiction (e.g., Shigella, Pertussis, etc.) (Awardees must provide their own target timeframe(s) for initiation of control measures for these diseases.

Awardees should calculate the numerator and denominator for this performance measure by disease, and 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.

For each disease reported here and in 13.1, please ensure that the total number of disease reports received by the public health agency (the denominators) are the same in 13.1 and 13.2.

What data must be reported?

Data Elements	
1. Total number of disease reports received by a public health agency for **Botulism** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Botulism** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Botulism** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Botulism** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Botulism**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%
2. Total number of disease reports received by a public health agency for **Tularemia** (confirmed and probable) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Tularemia** (confirmed and probable) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Tularemia** (confirmed and probable) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Tularemia** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No

Data Elements	
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Tularemia**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%
3. Total number of disease reports received by a public health agency for *E. coli*, **STEC** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for *E. coli*, **STEC** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of *E. coli*, **STEC** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **E. Coli, STEC** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **E. Coli, STEC**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%
4. Total number of disease reports received by a public health agency for **Hepatitis A, acute** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Hepatitis A, acute** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Hepatitis A, acute** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Hepatitis A, acute** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Hepatitis A, acute**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%
5. Total number of disease reports received by a public health agency for **Measles** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Measles** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Measles** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Measles** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Measles**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%
6. Total number of disease reports received by a public health agency for **Meningococcal Disease** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Meningococcal Disease** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Meningococcal Disease** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	

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6. Total number of disease reports received by a public health agency for **Meningococcal Disease** (confirmed) (denominator).	*[Max 4 digits]*
c. Are the values reported in the denominator and numerator for **Meningococcal Disease** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Meningococcal Disease**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

7. Would you like to report data on **Salmonellosis** (confirmed)?
   ☐ Yes
   ☐ No

8. Total number of disease reports received by a public health agency for **Salmonellosis** (confirmed) (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Salmonellosis** (confirmed) (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Salmonellosis** (confirmed) for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Salmonellosis** (confirmed)drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Salmonellosis**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

Additional Disease(s) of interest to awardee

9. Would you like to report data on other diseases (up to 3)? This is optional.
   ☐ Yes
   ☐ No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 1**. *[max 100 characters]*	
10. Total number of disease reports received by a public health agency for **Disease 1** (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 1** (numerator).	*[Max 4 digits]*
b. Percentage of reports of **Disease 1** for which a control measure was initiated within the appropriate timeframe *[System calculated]*	
c. Are the values reported in the denominator and numerator for **Disease 1** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 1**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

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11. Would you like to report data on a second disease? This disease will be referred to as **Disease 2**.
   ☐ Yes
   ☐ No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 2**.
   [max 100 characters]

12. Total number of disease reports received by a public health agency for **Disease 2** (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 2** (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Disease 2** for which a control measure was initiated within the appropriate timeframe
   [System calculated]

c. Are the values reported in the denominator and numerator for **Disease 2** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 2**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

13. Would you like to report data on a third disease? This disease will be referred to as **Disease 3**.
   ☐ Yes
   ☐ No

a. Please provide the name for the disease of interest. This disease will be referred to as **Disease 3**.
   [max 100 characters]

14. Total number of disease reports received by a public health agency for **Disease 3** (denominator).	*[Max 4 digits]*
a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 3** (numerator).	*[Max 4 digits]*

b. Percentage of reports of **Disease 3** for which a control measure was initiated within the appropriate timeframe
   [System calculated]

c. Are the values reported in the denominator and numerator for **Disease 3** drawn from surveillance and disease reporting covering the entire jurisdiction?	☐ Yes ☐ No
(i). If no, approximately what percentage of the population covered by the surveillance system is included as part of reporting for **Disease 3**?	☐ ≤25% ☐ 26-50% ☐ 51-75% ☐ 76-99%

15. Has the awardee health department reviewed disease reports and related information for the purposes of improving disease reporting between providers, laboratories and the public health system?	☐ Yes ☐ No
a. Has the awardee health department identified corrective actions to improve disease reporting between providers, laboratories and the public health system?	☐ Yes ☐ No
b. Has it implemented them?	☐ Yes ☐ Some ☐ No

16. Please indicate any barriers to timely initiation of control measures. *[Select all that apply]*

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15. Has the awardee health department reviewed disease reports and related information for the purposes of improving disease reporting between providers, laboratories and the public health system?	☐ Yes ☐ No

☐ Communication   ☐ Staffing
☐ Equipment   ☐ Time constraints
☐ Funding   ☐ Training
☐ Participation   ☐ Other, please specify
☐ Policies/procedures   ☐ None
☐ Resource limitations

17. *[Optional]* Please provide any additional clarifying, contextual or other information.
          [Max 1000 characters]

How is this measure operationalized?

*Assessing timeliness***:** Timeliness should be based on calendar days (including weekends and holidays), not business days. Weekends and holidays *should be included* when determining timeliness of control measure initiation.

*Assessing control measure timeliness***:** For a given case to count toward the numerator, awardees will need to compare case data with the Public Health Control Measures Table (Appendix C) 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 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 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 have some flexibility to determine which documented actions will count as an appropriate control measure, though they should use the examples provided in Appendix C as a guide. 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 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 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

Appropriate timeframe: An appropriate timeframe is a period of time 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, plus Salmonellosis, have been standardized for the purpose of this performance measure. Awardees are requested to determine their own target timeframes for any additional diseases they wish to report for PHEP 13.1 and 13.2.

Awardee-required timeframe: The awardee-required timeframe is a jurisdictionally-mandated period of time either by law or regulation for healthcare providers to report notifiable cases of disease.

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; however, CDC may compare awardee performance data for select diseases with final reported counts (in NNDSS) as part of efforts to enhance reliability of PHEP data.

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 PHEP 13.1 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.

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 PHEP 13.2 for more information regarding activities that constitute initiation and examples of control measures. Examples may also be found in Appendix C.

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.

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Capability 14: Responder Safety and Health

Introduction

The Responder Safety and Health capability refers to the ability to protect public health responders 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 ensure that public health responders are medically fit, appropriately trained, and monitored for potential adverse health effects, if needed.

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**

PHEP 14.1, 14.3, and 14.4 have been retired. Awardees may continue to use these measures for their own evaluation purposes, but CDC will not collect these data. Refer to BP2 (2013-20104) performance measure guidance document for more information about these measures.

Please consult the CDC Emergency Responder Health Monitoring and Surveillance (EHRMS) **website** and EHRMS **manual** for general guidance regarding establishing and implementing responder safety and health programs.

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Capability 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. Therefore, coordinated management is crucial.

The Volunteer Management pre-incident planning 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 public health/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	●	●		
HPP-PHEP J.2			●	●

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PHEP 15.1: Managing Volunteers

Does public health have plans, processes, and procedures in place to manage **volunteers** supporting a public health or medical incident? [Yes/No]

Measure Applies To :	Circumstances for Reporting:	For Response Only:	Other Considerations:
☑ **States**	☐ Annual Requirement	☐ Incident	☐ Data Utilized By
☑ **Directly Funded Localities**	☑ **If PHEP Funds Allocated to the Capability or Contracts Plan**	☐ Exercise	☐ Data Collected By
☑ **Territories or Freely Associated States (Puerto Rico only)**		☐ Planned Event	☐ PAHPRA Benchmark

Additional Information: If *Volunteer Management* is not a capability to which you have allocated PHEP funding during this budget period, you are not required to complete this performance measure. CDC encourages awardees to address and sustain this capability at some point in the five year grant cycle.

Why is this measure important?

The immediate intent of this measure is to capture the extent to which the public health/medical lead has 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 public health/medical lead is able to efficiently and effectively utilize and incorporate public health/medical volunteers in an incident.

How is the measure calculated?

This is a "yes/no" measure, which CDC calculates based on self-report by the awardee indicating whether the **responsible entity or entities** have completed *all* of the following activities by having plans, processes, procedures and systems in place for:

- 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**

Please note: CDC will monitor, track and report progress *by activity* over time, in addition to tracking the overall performance measure.

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How does this measure align with the ORR?

MCM ORR

While there are no direct links between PHEP 15.1 and the ORR, there are various activities related to volunteer management that are applicable to both. Awardees are encouraged to use activities conducted during BP1 to meet these multiple requirements, where appropriate.

What data must be reported?

1. Were PHEP funds allocated to ***Volunteer Management*** in Budget Period 1? NOTE: If no, continue to next performance measure	☐ Yes ☐ No

NOTE: The following data have been pre-populated into PERFORMS. Please review for accuracy when entering in PERFORMS.

a. At which jurisdictional level(s) does public health have responsibility for:
Receiving volunteers.

☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)

☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)

☐ Both

☐ Other –please specify   [Max 100 characters]

a(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No

b. At which jurisdictional level(s) does public health have responsibility for:
Determining volunteer affiliation, including procedures for integrating or referring non-registered or spontaneous volunteers.

☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)

☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)

☐ Both

☐ Other –please specify   [Max 100 characters]

b(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No

c. At which jurisdictional level(s) does public health have responsibility for:
Confirming volunteer credentials.

☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)

☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)

☐ Both

☐ Other –please specify   [Max 100 characters]

c(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No

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a. At which jurisdictional level(s) does public health have responsibility for: ***Receiving volunteers***.	
d. At which jurisdictional level(s) does public health have responsibility for: ***Assigning roles and responsibilities to volunteers.***	
☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)	
☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)	
☐ Both	
☐ Other –please specify [Max 100 characters]	
d(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No
e. At which jurisdictional level(s) does public health have responsibility for: ***Providing Just-in-Time Training for volunteers.***	
☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)	
☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)	
☐ Both	
☐ Other –please specify [Max 100 characters]	
e(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No
f. At which jurisdictional level(s) does public health have responsibility for: ***Tracking Volunteers.***	
☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)	
☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)	
☐ Both	
☐ Other –please specify [Max 100 characters]	
f(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No
g. At which jurisdictional level(s) does public health have responsibility for: ***Out-processing volunteers.***	
☐ Awardee level (including awardee-led or operated regions, districts, offices, etc.)	
☐ Sub-awardee level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)	
☐ Both	
☐ Other –please specify [Max 100 characters]	
g(i). Has this activity been completed by the entity/entities responsible for its completion?	☐ Yes ☐ No
2. Has this capability been exercised or demonstrated (in a real incident) in this budget period?	☐ Yes ☐ No
a. If yes, has the following been identified/implemented?	
a(i). Have corrective action/improvement plan items related to volunteer management been identified?	☐ Yes ☐ No

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a. At which jurisdictional level(s) does public health have responsibility for: **Receiving volunteers**.	
a(ii). Have corrective action/improvement plan items related to volunteer management been implemented?	☐ Yes ☐ Some ☐ No

3. Please indicate any barriers to completion of elements. *[Select all that apply]*

☐ Communication
☐ Equipment
☐ Funding
☐ Participation
☐ Policies/procedures
☐ Resource limitations
☐ Staffing
☐ Time constraints
☐ Training
☐ Other, please describe other.　　　*[Max 100 characters]*
☐ None

4. *[Optional]* Please provide any additional contextual, clarifying, or other information.
　　　[Max 1000 characters]

How is this measure operationalized?

This measure is meant to address two key questions related to each of the performance elements identified as critical for this measure: (1) Which entity(s) is responsible for completing these performance elements?; and (2) Have they done so?

Awardees are encouraged to develop internal tracking and monitoring processes and tools to ensure that sub-awardees and other entities responsible for any performance elements in this measure are, in fact, making progress towards completion of their activities.

The awardee is responsible for determining which entity(s) is responsible for completing a performance element. This can refer to the awardee's central office, its regional or district offices, local health departments, etc.

In order to check that a given performance element has been completed, *all responsible entities* must have completed the stated activity. For example, if a state funds 10 LHDs to identify public health roles in fatality management in relation to key partners (performance element #1), all 10 LHDs must have completed that work for the awardees to indicate that performance element #1 is complete. Awardees are encouraged to describe yearly progress in the optional text box (data element 8, above). For example, "This year, 8 out of 10 LHDs have completed performance elements 1 through 7." CDC staff will be able to use this information to track progress within the awardee jurisdiction and provide technical assistance as needed.

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Response

HPP-PHEP J.2: Volunteer Management

Percentage of volunteers **deployed** to support a public health/medical incident within the **requested timeframe**.

Measure Applies To:	Circumstances for Reporting:	Data May Be Taken From:	Other Considerations:
☑ **States**	☑ **Annual Requirement**	☑ **Incident**	☐ Data Utilized By:
☑ **Directly Funded Localities**	☐ If PHEP Funds Allocated to the Capability or Contracts Plan	☑ **Exercise**	☑ **Data Collected By: HPP and/or PHEP (PERFORMS only)**
☑ **Territories or Freely Associated States**		☐ Planned Event	☑ **PAHPRA Benchmark**

Additional Information: Awardees that experience two or more incidents involving deployment of volunteers must report data from *at least* two of these. Awardees that experience one incident involving volunteer deployment must report on it. Awardees that do not experience an incident involving volunteer deployment do not have to report on this measure; however, they must conduct a call down acknowledgment drill.

How is the measure calculated?

Numerator: Number of volunteers, determined to be needed for the response by the public health/medical lead or other authorized official, that arrived on scene (including staging area or other designated area) within the requested timeframe

Denominator: Number of volunteers determined to be needed for the response by the public health/medical lead or other authorized official

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 public 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 other requirements for reporting measure data?

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

- *Awardees that experience two or more incidents or exercises* involving deployment of volunteers *must report on at least* two of those.
  - One data point must reflect the awardee's best performance (highest percentage).

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- o The other data point must reflect performance that, based on a determination from the awardee, calls for focused quality improvement and – if applicable – technical assistance.
  - o Awardees are encouraged to submit data on additional incidents and exercises as well. There are no specific reporting requirements or parameters for additional data points.
- *Awardees that experience only one incident or exercise* involving deployment of volunteers must report on it.
- *Awardees that experience no incidents or exercises* involving deployment of volunteers in BP1 do not need to report on this measure; however, they must conduct a call down and acknowledgement drill. The call down and acknowledgement drill contains the following required data elements:
  - o Number of volunteers contacted (registered in the ESAR-VHP system)
  - o Number of volunteer contacted (registered in other systems)
  - o Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe
  - o Number of volunteers registered in other systems that acknowledged contact within the requested timeframe
  - o The requested timeframe for acknowledgment (e.g., 4 hours, 8 hours, 12 hours, etc.)
  - o Date of call down drill
- The call down and acknowledgement drill, above, may *not* be reported in lieu of performance measure HPP-PHEP J.2, if there occurred incidents or exercises involving actual deployment of volunteers in the budget period.
- In future budget periods, awardees may be required to exercise actual volunteer deployment if there are no volunteer deployments during a public health/medical incident in consecutive budget periods.

How does this measure align with the ORR?

It is likely that a surge related to an incident will require additional staffing, involving persons whose primary role is not preparedness and response. Volunteers include any additional personnel required to respond to an incident. This measure and the ORR collect information about the system used to monitor volunteers. Awardees are encouraged to use activities conducted during BP1 to meet multiple requirements, where appropriate. If there are no incidents during this project period that require additional volunteers, those utilized during a drill or exercise reported in the ORR can be used for this measure.

What data must be reported?

1. This performance measure is required if an incident/exercise involving the management of volunteers occurred within the Budget Period 1. Did an incident/exercise involving the deployment of volunteers occur?

☐ Yes

☐ No [If no, only Question 15 is required]

For each incident or exercise reported for demonstration of the Volunteer Management Capability, please enter the following information:

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2. The number of volunteers determined to be needed for the response by the public health/medical lead or other authorized official (denominator)

3. The number of volunteers who arrived at staging area/on scene within the requested timeframe (numerator) *[Max 5 digits]*
   Of these:
       a. Number of deployed volunteers registered in ESAR-VHP *[Max 5 digits]*
       b. Number of deployed volunteers registered in other systems   *[Max 5 digits]*
       Total *[Max 5 digits]*   *[System Calculated]* *(Note: Sum of 3a and 3b must equal value entered for Question 3.)*

    Percentage of volunteers deployed to support a public health/medical incident within an appropriate timeframe   *[System Calculated]*
    (Performance Measure for HPP/PHEP – J.2)

4. Requested timeframe for on-scene (including staging area or other designated area) arrival of volunteers
        [Max 100 characters]

5. The request for volunteers occurred during a(n):
   [Select one]
   ☐ Incident
   ☐ Full Scale Exercise
   ☐ Functional Exercise
   ☐ Drill

6. This incident or exercise utlized or demonstrated one or more functions within the:
   [Select one]
   ☐ HPP Volunteer Management Capability
   ☐ PHEP Volunteer Management Capability
   ☐ Both HPP and PHEP Volunteer Management Capabilities

7. The name and date of the incident or exercise.
       a. Name   *[Max 100 characters]*   b. Date *[MM/DD/YYYY]*

8. The type of incident or exercise upon which the request for volunteers was based:
   [Select only one, even if multiple hazards existed in one incident]
   ☐ Extreme weather (e.g., heat wave, ice storm)
   ☐ Flooding
   ☐ Earthquake
   ☐ Hurricane/tropical storm
   ☐ Hazardous material
   ☐ Fire
   ☐ Tornado
   ☐ Biological hazard or disease - Please specify *[Max 100 characters]*
   ☐ Radiation
   ☐ Other (Please Specify) *[Max 100 characters]*

9. The entity that made the original request for volunteers *[Select one]*
   ☐ Local health department
   ☐ State health department
   ☐ Healthcare organization
   ☐ Healthcare coalition
   ☐ Other, please specify: *[Max 100 characters]*

10. The requested location for the deployment *[Select one]*

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☐ Staging/assembly area(s) (not actual incident site)
☐ Hospital(s)
☐ Shelter(s)

☐ Points of Dispensing (POD or PODs)
☐ Alternate care site(s), please specify
[Max 750 characters]
☐ Other, please specify *[Max 100 characters]*

11. The number of volunteers who were contacted for potential deployment	*[Max 5 digits]*	

12. Please indicate any barriers to deploying volunteeer to support a public health/medical incident within requested timeframe.
    [Select all that apply]
☐ Communication
☐ Equipment
☐ Funding
☐ Participation
☐ Policies/procedures
☐ Resource limitations
☐ Staffing
☐ Time constraints
☐ Training
☐ Other, please specify
☐ None

13. Continuous Quality Improvement:		
a. Were relevant corrective actions/improvement plans items from *prior responses* (including exercises, drills, etc.) related to volunteer management incorporated into planning and/or response procedures before this incident/drill took place?		☐ Yes ☐ No ☐ Some
b. Have corrective actions/improvement plan items related to volunteer management been identified as a result of this incident/drill?		☐ Yes ☐ No
i. Have they been implemented?		☐ Yes ☐ No ☐ Some

14. [Optional] Please provide any additional clarifying, contextual, or other information *[Max 1,000 characters]*

15. Awardees that experience no incidents or exercises involving deployment of volunteers in BP1 do not need to report on this measure; however they must conduct a call down and acknowledgement drill. Please enter the following information on the call down drill.

a. Number of volunteers contacted (registered in the ESAR-VHP system) *[Max 5 digits]*

b. Number of volunteers contacted (registered in other systems) *[Max 5 digits]*

c. Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe *[Max 5 digits]*

d. Number of volunteers registered in other systems that acknowledged contact within the requested timeframe *[Max 5 digits]*

e. Requested timeframe for acknowledgment: Hours   Mins

NOTE: When completed with reporting of all incidents for Performance Measure HPP-PHEP J2, PERFORMS will prompt the user to address two additional questions: 1) Which of the incidents was the awardee's best performance (highest percentage) and 2) which incident is being used to focus on quality improvement or technical assistance.

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How is this measure operationalized?

The numerator and denominator for this measure should refer to aggregate numbers of volunteers across a given incident. For example, the public health/medical lead determines in Week 1 of an incident that 100 volunteers are needed. In Week 2 it is determined that an additional 100 volunteers are needed. The denominator for this incident is 200.

Awardees should ensure that the number of volunteers included in the denominator does *not* refer to the total number of *potential* volunteers that have been contacted to determine deployment availability or "requested" to deploy. It should only refer to the number of volunteers that the public health/medical lead has determined are needed for the response and has requested for the incident. This number may or may not coincide with how many have been "requested" to deploy via a call down or activation, and should be independent of how many are known to be available. For example, the public health/medical lead determines that 75 volunteers are needed on-scene within 3 days, and makes this request to the state volunteer coordinator, who contacts 900 individuals currently in the ESAR-VHP database. After contacting the entire database of potential volunteers, the volunteer coordinator informs the public health/medical lead that only 20 are available for deployment. The public health/medical lead agrees to take however many are available. Twenty volunteers arrive at the staging area within the 3 day timeframe. The numerator for this incident is 20. The denominator is 75. The denominator is *not* 20 even though the public health/medical lead "agrees" that 20 is acceptable, since this number did not reflect true need, but rather was a function of how many volunteers were available for deployment. Similarly, the denominator is not 900 since this number simply reflects how many individuals were contacted for potential deployment.

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Key Measurement Terms

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.

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 a specified number of needed volunteers, typically by local response entities, to the health and medical lead at the local, regional or state level.

Requested timeframe: Requested timeframe is the period of time in which volunteers are requested to report for duty.

Responsible entity or entities: A responsible entity or entities refers to an organization at the awardee or sub-awardee level, which is accountable for completing the specific activity or element associated with one or more PHEP performance measures.

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 medical and non-medical professionals (e.g., from the ESAR-VHP system, Medical Reserve Corps, etc.)

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APPENDICES

Appendix A: Alignment of Capabilities, Performance Measures, and Reporting Requirements

		Applies To			Reporting Criteria		Comments
Capability and Measure (if retained)	Function Alignment	States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded	Accountability, Exclusions
Community Preparedness							
Community Recovery							
Emergency Operations Coordination							
Emergency Public Information and Warning							
Fatality Management							
Information Sharing							
HPP-PHEP J1	3	X	X	X	X		Two data points required
Mass Care							
Medical Countermeasure Dispensing							
Medical Materiel Management and Distribution							
Medical Surge							
Non-Pharmaceutical Interventions							
Public Health Laboratory Testing							
PHEP 12.2	4	X	X		X		Two drills per year; excludes Chicago

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Capability and Measure (if retained)	Function Alignment	States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded[j]	Accountability, Exclusions
			Applies To		Reporting Criteria[i]		Comments
Capability and Measure (if retained)	Function Alignment	States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded[j]	Accountability, Exclusions
PHEP 12.5	3	X	X		X		PAHPRA Benchmark, Level 1 Required, Level 2 Optional; Excludes Chicago
PHEP 12.6	3	X	X		X		PAHPRA Benchmark, Levels 1 and 2 Required; Excludes Chicago
PHEP 12.7	2	X	X		X		PAHPRA Benchmark; Excludes Chicago
PHEP 12.11	3	X	X		X		PAHPRA Benchmark; Excludes Chicago
PHEP 12.14	5	X	X			X	GPRA Measure; Excludes Chicago
PHEP 12.15	5	X	X			X	Excludes Chicago
PH Surveillance and Epidemiologic Investigation							
PHEP 13.1	1	X	X		X		Excludes Chicago, L.A. County
PHEP 13.2	3	X	X		X		Excludes Chicago, L.A. County
Responder Safety and Health							
Volunteer Management							
PHEP 15.1	1, 2	X	X	Puerto Rico only		X	
HPP-PHEP 15.1	3, 4	X	X	X	X		Must do call-down drill if no volunteer deployments; ORR

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Appendix B: PHEP 12.2: 24/7 Emergency Contact Drill (Bidirectional) Overview

Importance of this Drill to 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, awardees play a crucial role in assuring effective and efficient communication between laboratory and epidemiology staff, and for fostering improvements in communication systems 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 on-call epidemiologist and on-call laboratorian (and vice versa). The measure is **not intended to adhere to or assess CDC's emergency notification protocol with state public health laboratories or state epidemiologists**. Although conducted by CDC Emergency Operations Center (EOC), the drill is <u>not</u> an EOC or LRN measure of performance; it is strictly a PHEP performance measure and examines system-level performance at the jurisdictional level. It does not replace or substitute any other CDC drill (e.g., LRN notification drill).

Measure Details

The 24/7 Emergency Contact Drill (PHEP 12.2) applies to 53 PHEP awardees: the 50 states, Washington D. C., Los Angeles County, and New York City. The 24/7 emergency contact drill is **bi-directional**, therefore two (2) drills are held each budget period; one in each "direction." In BP 1,3, and 5, "Drill #1," the on-call LRN-B *laboratorian* is contacted first by CDC EOC. In "Drill #2" the on-call *epidemiologist* is contacted first by CDC EOC. The drills can occur at any point during the budget period.

Drills will be **unannounced** and **after-hours,** conducted between 8:00 p.m. and 11:00 p.m. (awardee's local time) over a 5-day period, Monday through Friday. The order of the drills may vary (e.g. Drill #2 of a drill cycle may be conducted before Drill #1 of the cycle). The following graphic illustrates the flow of direction for drills #1 and #2 during budget periods 1 through 5.

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Drill Directions for Awardees

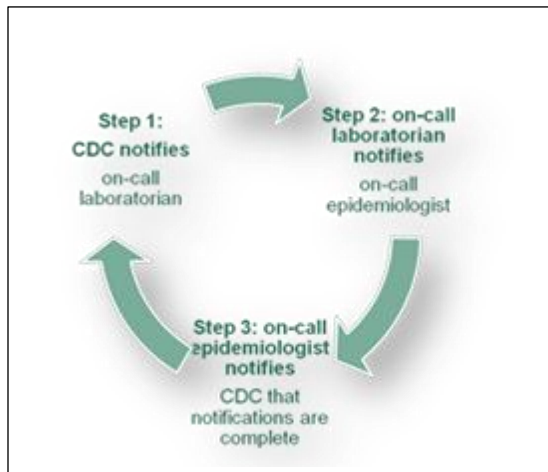*BP1, BP3 and BP5 drill direction:*

Drill #1: CDC EOC→LRN-B→EPI→CDC EOC

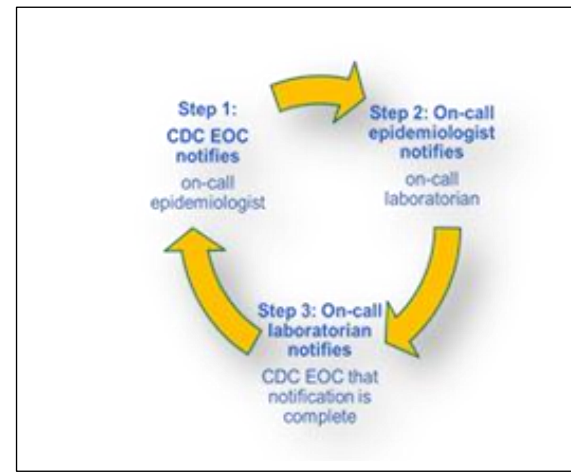Drill #2: CDC EOC→EPI→LRN-C→CDC EOC

BP2 and BP4 drill direction:

Drill #1: CDC EOC→LRN-C→EPI→CDC EOC

Drill #2: CDC EOC→EPI→LRN-B→ CDC EOC

Drill #1:

Drill #2:

The time to complete the drill is measured using a start time and stop time **(Performance Target is 45 minutes)**.

Start Time: Date and time that the CDC EOC first dials the contact number for the appropriate on-call laboratorian or epidemiologist, depending on drill direction.

Stop Time: Date and time the on-call laboratorian or epidemiologist (depending on drill direction) contacts CDC EOC that the drill notification cycle is complete.

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Drill Process

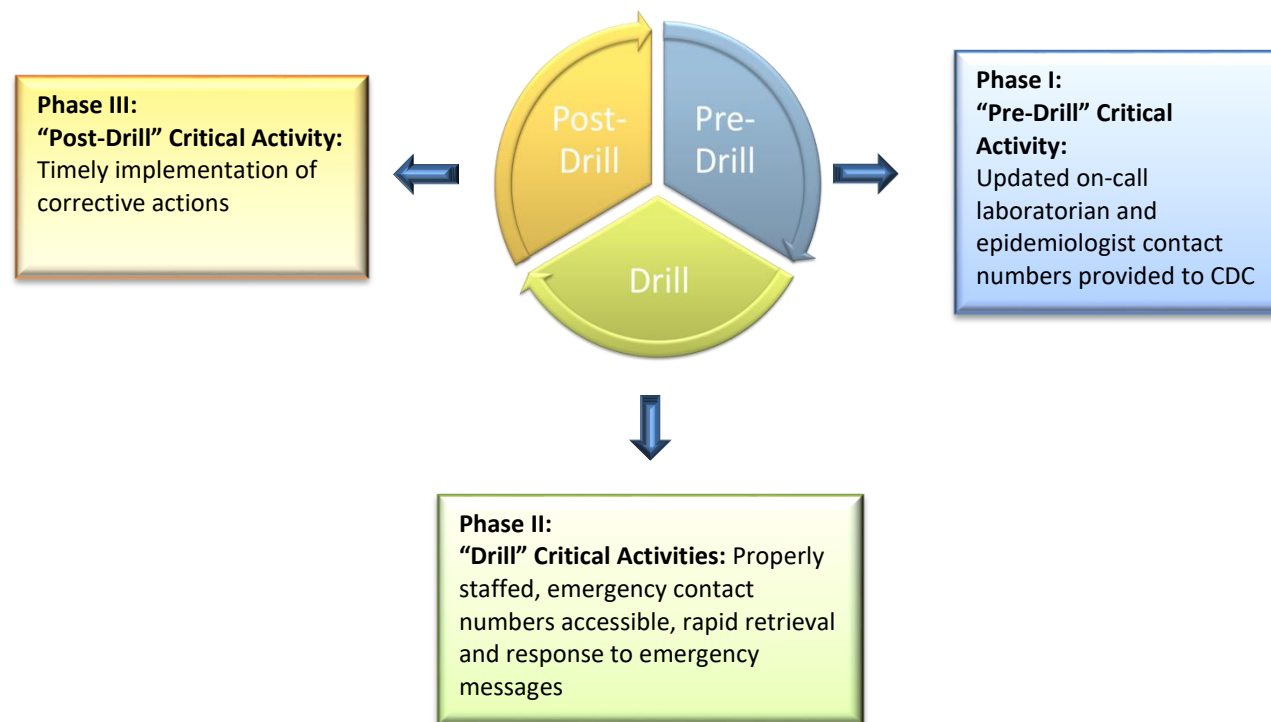The 24/7 emergency contact drill is composed of three (3) major phases—

Phase I: Pre-drill
Phase II: Drill
Phase III: Post drill

Each phase is comprised of various activities which must be completed in order to ensure the successful completion of the 24/7 emergency contact drill. Failure to complete a critical activity within each drill segment may result in pitfalls that may prevent the awardee from successfully completing the drill within the 45-minute time target. The critical activities for each drill segment are identified in the diagram below.

24/7 Drill Phases and Critical Activities for Drill Success

Phase III:
"Post-Drill" Critical Activity: Timely implementation of corrective actions

Post-Drill

Pre-Drill

Drill

Phase I:
"Pre-Drill" Critical Activity: Updated on-call laboratorian and epidemiologist contact numbers provided to CDC

Phase II:
"Drill" Critical Activities: Properly staffed, emergency contact numbers accessible, rapid retrieval and response to emergency messages

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Phase I: **Pre-Drill Activities**

To complete this phase successfully, two (2) tasks should be completed.

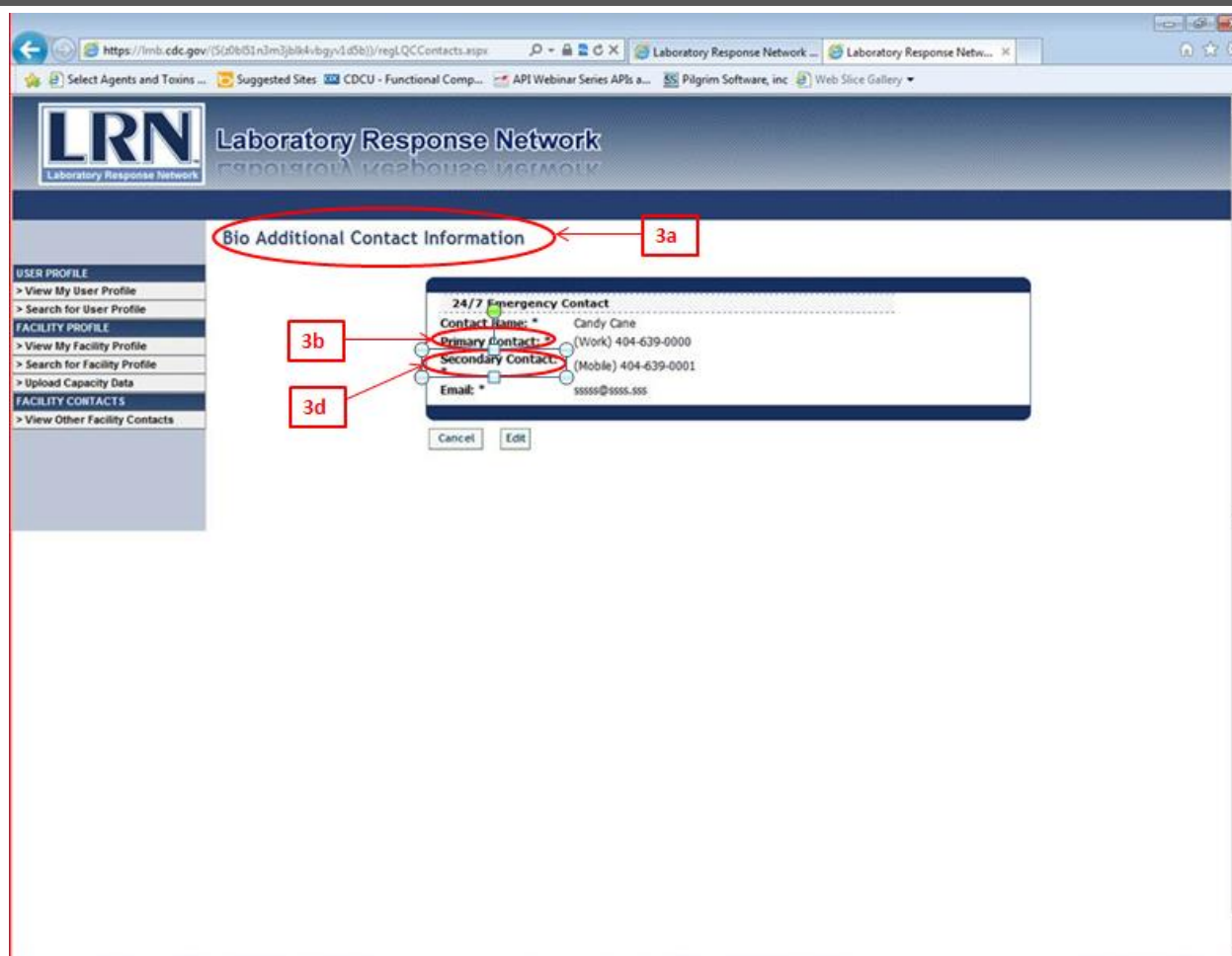**Task 1: Verify and update on-call contact numbers**

In order for CDC EOC to initiate the drill, correct contact information for either the on-call laboratorian or the on-call epidemiologist, depending on the drill direction, must be available.

The PHEP director should ensure that the CDC EOC uses the correct information by:

    a.   Ensuring the PHEP program is aware of and has access to the on-call epidemiologist and alternate on-call epidemiologist contact information from the state epidemiologist.

    b.   Ensuring that the state LRN director (biological and chemical) keeps updated contact information on file with the CDC LRN program by updating on-call LRN-B and LRN-C laboratorian contact information on the LRN website at https://lrnb.cdc.gov.

Process to update on-call LRN-B and LRN-C laboratorian contact information:

    c.   The individuals at the awardee level that have rights to update/modify on-call contact information are as follows:

        I.   Laboratory Director
       II.   Laboratory Administrator
      III.   BT Coordinator

    d.   Access the LRN website: **https://lrnb.cdc.gov/**

    e.   **To update the on-call LRN-B laboratorian contact information**

        I.   Go to the 'Bio Additional Contact Information' page
       II.   Under the 'Responsible Official' box, click "24/7 Emergency Contact", 'Primary Contact:'
      III.   Enter the number to contact the on-call LRN-B laboratorian during *non-regular business hours, including after-hours, evenings, weekends, holidays, etc.*
      IV.   Then click "24/7 Emergency Contact ", 'Secondary Contact:'
       V.   Enter the *alternate* number to contact the on-call LRN-B laboratorian during *non-regular business hours, including after-hours, evenings, weekends, holidays, etc.*

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Note: CDC staff may request the PHEP director to verify on-call (and alternate on-call) laboratorian contact numbers at any time.

f. **To update after-hours and alternate on-call LRN-C laboratorian contact information**
   I. Go to the 'Chem Facility Contacts' page
   II. Under the 'Facility Contact Information' box, click "24/7 Emergency Contact", 'Primary Contact:'

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III.   Enter the number to contact the on-call LRN-C laboratorian during *non-regular business hours, including after-hours, evenings, weekends, holidays, etc.*
IV.   Then click "24/7 Emergency Contact ", 'Secondary Contact:'
V.   Enter the *alternate* number to contact the on-call LRN-C laboratorian during *non-regular business hours, including after-hours, evenings, weekends, holidays, etc.*

g. Process to Verify and/or Change On-call Epidemiologist Contact Information (i.e., contact number during non-regular business hours, including after-hours, evenings, weekends, holidays, etc.):

I. Log in to *Epi-X* at https://epix2.cdc.gov.
II. Click **My Profile** from the top navigation menu.
III. Scroll down to the **On-Call Epidemiologist Contact Information** section.
IV. Click in the box to indicate that you are an on-call epidemiologist for your state/territory/large city.
V. Select your jurisdiction in the **State** drop-down list and if applicable select the appropriate **Large City**.
VI. Enter a primary telephone number in the **Primary On-Call Telephone** field.
VII. A **Notes** field is included if you want to include additional information such as "this number is our after-hours answering service and the service connects with the on-call epidemiologist…"
VIII. Enter a secondary telephone number in the **Secondary On-Call Telephone** field, if appropriate.
IX. Enter a tertiary telephone number in the **Tertiary On-Call Telephone** field, if appropriate.
X. Complete the dates you are on-call in the **On-Call Period** section. This information will auto-populate in the **On-Call Roster** that can be accessed by clicking the **On-Call Roster** link located in the left navigation of the *Epi-X* home page.
XI. Click the **Save Changes** button at the bottom of the page.

Note: On-call contact information must be valid for after-hour notifications. *PHEP directors are strongly encouraged to communicate with their jurisdiction's state epidemiologist to ensure awareness and access to the on-call (and alternate on-call) contact information CDC staff may request the PHEP director to verify on-call (and alternate on-call) epidemiologist's contact numbers at any time.*

Task 2: Ensure on-call staff have/have access to on-call contact numbers
PHEP directors should ensure that the on-call laboratorians and on-call epidemiologists have/have access to each other's contact information. 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 next person, who must then call the CDC EOC to complete the drill.

It is the awardee's responsibility to ensure that lines of communication are identified and clear and contact information between these two key entities (laboratory and epidemiology) is known, understood, shared, and tested.

Phase II: **Drill Activities**

1. Depending on the drill direction, DSLR will obtain the most recent on-call laboratorian and epidemiologist contact numbers from the appropriate source.

2. Using the updated on-call contact information, ASEB will generate a data collection spreadsheet for CDC EOC Watch Officers to conduct the drills.

3. CDC EOC Watch Officers will use the data collection spreadsheet and a standardized call script to conduct the drill calls. If the on-call contact that is listed cannot be reached, CDC EOC Watch Officers will leave a message and wait ten (10) minutes for the on-call contact to return the call to CDC EOC Watch Officer before calling the alternate on-call contact number, if one is provided. If there is no alternate on-call contact number, CDC EOC Watch Officer will dial the on-call contact number again.

4. CDC EOC Watch Officers will record drill start time and stop time as well as the names of the on-call laboratorian and epidemiologist participating in the drill.

    Start Time: Date and time that the CDC EOC first dials the contact number for the appropriate on-call laboratorian or epidemiologist, depending on drill direction.

    Stop Time: Date and time the on-call laboratorian or epidemiologist (depending on drill direction) contacts CDC EOC that the drill notification cycle is complete.

5. The CDC EOC will conduct drill calls between the hours of 8 p.m. and 11 p.m., local (awardee) time, during the traditional work week, i.e., Monday through Friday.

Phase III: **Post-Drill Activities**

- CDC EOC will provide DSLR the completed drill data collection worksheets with awardees' drill start times, stop times, drill date, and names and contact phone numbers of the participating epidemiologist and laboratorian.

- All drill data collected by CDC EOC will be provided to DSLR for analysis and reporting.

- Awardees that do not complete the drill cycle within four (4) hours will receive drill notifications with a "did not complete" rating. During follow-up, these awardees will be asked to state the challenges, barriers and/or root causes preventing them from competing the drill –

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as well as proposed corrective actions. Root causes, corrective actions, and the corrective action implementation timeframe should be provided to DSLR within 30 calendar days of receiving results.

- DSLR will e-mail a copy of each awardee's official drill notification to the awardee and carbon copy the awardee's project officer.

- Awardees are expected to confirm receipt of the e-mail and notify the appropriate individuals (e.g., laboratory director of the participating lab and state epidemiologist) of the drill results. Awardees are to consult with the laboratories and epidemiologists during the drill verification process to ensure accuracy of drill results.

- DSLR staff will follow-up with awardees to verify the initial results before preparing a final report.

- Results of the BP2 24/7 emergency contact drills should be used to encourage program and system improvement within awardee jurisdictions as well as drill execution by CDC.

PHEP Directors Ensuring Success:
- Form and maintain close working relationships with participating biological and chemical laboratory directors.
- Work with biological and chemical laboratory programs to ensure the CDC LRN program has up-to-date after hours contact numbers.
- Work with the State Epidemiologist to ensure that CDC *Epi-X* staff has up-to-date on-call epidemiologist contact information.
- Ensure that DSLR has up-to-date on-call epidemiologist contact information in case a number needs to be verified.
- Notify participating laboratory 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 PHEP project officer and laboratory director (biological and/or chemical) to implement strategies to improve communication cycle.

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Appendix C: Examples of Public Health Control Measures for the Selected Six Diseases (plus Salmonellosis)

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
E. coli (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
Salmonellosis (optional)	Identification and exclusion of sources of infection (e.g., food, animals, contaminated water, food handlers) Recommendation: environmental cleaning / disinfection Recommendation: hand hygiene procedures	Within 3 days of initial case identification