



Public Health Emergency Preparedness Cooperative Agreement

Budget Period 1 Supplement

Performance Measure Specifications and Implementation Guidance

July 1, 2018 – June 30, 2019



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Introduction

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

Evaluation is an ongoing process integral to a program's success. Recipient performance information provides CDC with critical information used to demonstrate accountability. By assessing how well this federal investment in the PHEP program has improved the nation's ability to prepare for and respond to public health emergencies, CDC is able to report the progress of the nation's public health preparedness capabilities. Performance measurement data are 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 recipients are able to demonstrate acceptable levels of performance for specific public health preparedness capabilities; and
- Report **recipient accomplishments and performance** in publications, such as CDC's National Snapshot of Public Health Preparedness.

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, such as 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

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>.

Various types of program evaluation can be conducted depending on the purpose of the evaluation. Table 1 below shows two common types of program evaluation: *process* and *outcome* evaluation. Process evaluation provides a method to assess the extent to which and how well program activities have been implemented as well as determines how well activities meet program requirements and objectives. Process evaluation 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.

Outcome evaluation determines whether desired program results have been achieved, the extent to which program activities contributed to these results, and the distant impact within a population, system, or other intended “target” of a program.

Table 1: Types of Evaluation

Type of Evaluation	Sample Evaluation Questions
Process	<ul style="list-style-type: none"> • 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 recipients accomplished their stated objectives? • What outputs have been produced from the activities?
Outcome	<ul style="list-style-type: none"> • 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 because of (at least in part) program activities?

Why do we conduct evaluations?

The two primary reasons for conducting evaluations are

1. To facilitate program improvement or organizational learning; and
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 it is used for ongoing improvements to the program. Program evaluation can help state, local, and territorial PHEP recipients compare 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 recipients 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?

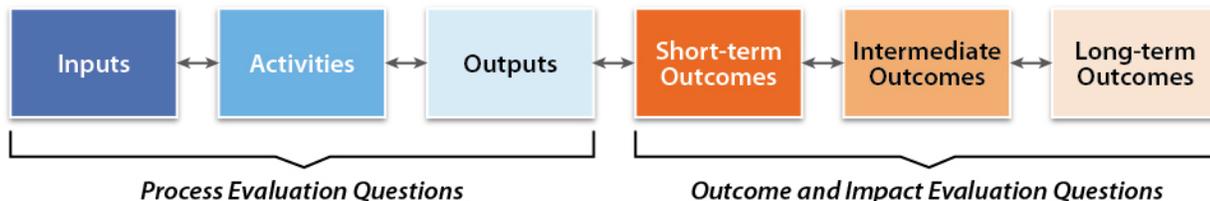
To evaluate a program, understanding the relationships between program resources, activities, outputs, and outcomes is helpful. Logic modeling is one way to display these connections. Logic models identify and propose relationships between and among program resources, activities, outputs, and outcomes.

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 below 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 and positive or negative, and are often divided into short-term, intermediate, and long-term timeframes

Program Improvement

Measures are designed to provide data to recipients 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 the U.S. Department of Health and Human Services, the White House Office of Management and Budget, and others. The data provide evidence that PHEP recipients 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 targets for performance in key areas deemed critical for public health preparedness and response. Finally, some 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?

DSLRL 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, recipients, and program representatives to draft measure specifications, intent, data elements, and reporting criteria.



5. Conduct pilot tests or desk reviews of draft measures with stakeholders (e.g., state and local PHEP recipients) 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

Noting that not every aspect of the PHEP program or the capabilities is amenable to performance measurement is important. 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, including special studies.

Overview of PHEP Performance Measurement

PHEP Performance Measure Categories

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

- **Core public health** – Measures that assess performance in the public health department’s critical, 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.

Recipients 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 supplement (including which recipients 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)	<ul style="list-style-type: none"> Applies to most measures and tools for capabilities 12 and 13. PHEP 12.14 is only required to be reported (i.e., verified) if PHEP funds are allocated toward pulsed-field gel electrophoresis (PFGE) activities. Otherwise, no reporting is required. PHEP 12.15 has been retired as the transition to whole genome sequencing takes place.
Pre-incident Planning	Report only if allocating PHEP funds toward the capability in the capability or contracts plan	<ul style="list-style-type: none"> PHEP 15.1.
Response	Annually required	<ul style="list-style-type: none"> Joint Measure J.1 (formerly Hospital Preparedness Program [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.

Note: CDC may use performance measure data for public reporting, including, but not limited to, the annual CDC preparedness report. Recipients 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 recipient nonsubmission or insufficient submission of data in public reports and documents (including the CDC preparedness report). Examples of nonreporting include not providing performance data that meet minimum requirements or reporting no data (e.g., stating that no incidents or drills were reportable) when data are required.

Key reporting changes to PHEP measures

- CDC has retired the evaluation tool for Capability 1: Community Preparedness (CP). CDC will collect key components of that tool in the 2019 Operational Readiness Review (ORR).
- CDC has migrated performance measure PHEP 3.1. into the ORR online data collection system (DCIPHER). CDC will collect information for this measure, including emergency operations center (EOC) site activation, and staff assembly with incident command staff reported in the ORR. Incidents or no-notice, immediate assembly drills used for this measure should occur between July 1, 2018-June 30, 2019. They should be reported into DCIPHER by September 30, 2019.
- Joint measures will continue to be collected in Budget Period 1 supplement (BP1 supp.). 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 HPP's Health Care Preparedness and Response Capabilities. These new capabilities no longer align directly with CDC's Public Health Emergency Preparedness and Response 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 (i.e., the data collected for J.1 is still information sharing data, and J.2 is still volunteer management data). Portions of information sharing and volunteer management also will be collected in real time as applicable in the operational readiness review.
- CDC has retired PHEP 12.15: PFGE *L. monocytogenes*. The process for sub-typing data results for *Listeria monocytogenes* will be whole genome sequencing. As the transition to WHS occurs, this data will not be collected.
- CDC has slightly adjusted performance measure 13.1, Disease Reporting, with respect to reporting on *E. coli*, STEC. In addition to providing information on recipient-required reporting timeframe, CDC is collecting the total number of disease reports received by a public health department within seven days, in addition to recipient-specific reporting timeframes. This total number of disease reports will be divided by the total number of cases and will allow us to aggregate reporting across jurisdictions for one of the required reported diseases.

Transition to Operational Readiness

In 2014 (Budget Period 3 in the prior project period), CDC implemented a new method to assess state, local, and territorial medical countermeasure dispensing and distribution capabilities. The Medical Countermeasure (MCM) ORR built 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 in the ORR because elements of those capabilities are necessary to support an MCM mission.

During the current supplemental budget period (2018-19), CDC will continue the first full biannual cycle of operational readiness reviews to more broadly assess the planning and operational aspects of all 15 public

health preparedness capabilities to assess progress across the PHEP program, including, but not exclusively, to support MCM operations. Within these capabilities, opportunities exist to integrate efforts to meet both PHEP performance measures and ORR requirements simultaneously.

The ORR process will be used to collect and review all PHEP drill and exercise data as required by CDC-RFA-TP17-1701. CDC will review ORR data to identify planning and operational gaps and provide targeted technical assistance to advance MCM and overall public health operational readiness. Separate ORR guidance will accompany the release of the updated ORR.

Updated Public Health Preparedness Capabilities

In 2011, CDC established 15 capabilities that serve as national standards for public health preparedness planning. Since then, these capability standards have become a vital framework for state, local, tribal, and territorial preparedness programs as they plan, operationalize, and evaluate their ability to prepare for, respond to, and recover from public health emergencies.

In 2017, DSLR began updating the capabilities in response to lessons learned from public health emergency responses, updates to public health preparedness science, revised guidance and resources, findings from internal reviews and assessments, subject matter expert feedback from the practice community, and input from allied federal agencies and professional associations.

The 2018 [Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health](#) recognizes the maturity and experience jurisdictional public health emergency preparedness and response programs have gained since 2011. The document describes the components necessary to advance jurisdictional public health preparedness and response capacity.

During the introduction to each capability in this document there is a section identifying the capability functions, and aligning of measures to capability functions. As a result of the update, the number and nature of the function may have changed slightly. In this document CDC did not revise the functions to reflect the updated function number and language. The retained performance measures are the same for BP1 supplemental as they were in BP1 (2017-2018).

Table 3 below summarizes the changes in PHEP performance measures during the previous project period. Measures retained are in **bold type**. Measures 5.1 and 15.1, noted with the term “(Recipient),” are oriented toward all entities (recipient or local health department[s]) responsible for supporting capabilities 5 (fatality management) and 15 (volunteer management), respectively, in the recipient’s jurisdiction.

Table 3: Summary of PHEP Performance Measure Modifications

Capability	PHEP Performance Measure	Retain for current project period
1 Community Preparedness	1.1 Identification of Key Organizations	
	1.2 Community Engagement in Risk Identification	
	1.3 Community Engagement in Public Health Preparedness Activities	
	1.4 Community Engagement in Recovery Planning	
	Evaluation Tool	
2 Community Recovery	Evaluation Tool	
3 Emergency Operations Coordination	3.1 Staff Assembly	
	3.2 Incident Action Plan (IAP)	
	3.3 After-Action Report (AAR) and Improvement Plan (IP)	
4 Emergency Public Information and Warning	4.1 Public Message Dissemination	
5 Fatality Management	5.1 Identify Role with Partners (Recipient)	
	5.2 Identify Role with Partners (LHDs)	
6 Information Sharing	6.1 Share Epidemiological/Clinical Data (Recipient)	
	6.2 Share Epidemiological/Clinical Data (LHDs)	
	HPP-PHEP J1 Information Sharing	X
7 Mass Care	7.1 Define Role with Partners (Recipient)	
	7.2 Define Role with Partners (Local Health Departments)	
	Evaluation Tool	
8 Medical Countermeasure Dispensing	MCMDD Composite Score	
9 Medical Materiel Management and Dispensing	MCMDD Composite Score	
10 Medical Surge	N/A	
11 Non-pharmaceutical Interventions	11.1 Determine Role with Partners (Recipient)	
	11.2 Determine Role with Partners (LHDs)	
	11.3 Develop NPI Recommendations with Partners	
12 Public Health Laboratory Testing	12.1 Laboratorian Reporting	



Capability	PHEP Performance Measure	Retain for current project period
1 Community Preparedness	1.1 Identification of Key Organizations	
	1.2 Community Engagement in Risk Identification	
	1.3 Community Engagement in Public Health Preparedness Activities	
	1.4 Community Engagement in Recovery Planning	
	Evaluation Tool	
2 Community Recovery	Evaluation Tool	
3 Emergency Operations Coordination	3.1 Staff Assembly	
	3.2 Incident Action Plan (IAP)	
	3.3 After-Action Report (AAR) and Improvement Plan (IP)	
4 Emergency Public Information and Warning	4.1 Public Message Dissemination	
5 Fatality Management	5.1 Identify Role with Partners (Recipient)	
	5.2 Identify Role with Partners (LHDs)	
6 Information Sharing	6.1 Share Epidemiological/Clinical Data (Recipient)	
	6.2 Share Epidemiological/Clinical Data (LHDs)	
	HPP-PHEP J1 Information Sharing	X
7 Mass Care	7.1 Define Role with Partners (Recipient)	
	7.2 Define Role with Partners (Local Health Departments)	
	Evaluation Tool	
8 Medical Countermeasure Dispensing	MCMDD Composite Score	
9 Medical Materiel Management and Dispensing	MCMDD Composite Score	
10 Medical Surge	N/A	
11 Non-pharmaceutical Interventions	11.1 Determine Role with Partners (Recipient)	
	11.2 Determine Role with Partners (LHDs)	
	11.3 Develop NPI Recommendations with Partners	
12 Public Health Laboratory Testing	12.1 Laboratorian Reporting	

Document Organization

The chapters in the *Budget Period 1 Supplement 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 Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal and Territorial Public Health, October 2018*.

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
<input type="checkbox"/> States	<input type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input type="checkbox"/> Data Utilized By (e.g. GPRA; ORR; NHSPI)
<input type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Data Collected By (e.g. CDC EOC; CDC LRN-C Program; CDC ELC Program; and CDC PulseNet)
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input type="checkbox"/> PAHPRA Benchmark

Modified Table Elements

Annual Requirement – Annual reporting is required for most performance measures. If checked, report at the end of each budget period. Additional details regarding what is required will be included in the box at the bottom of each reporting requirements table. All *response* measures are now included in the category of “annual reporting.” A response check box is no longer provided. 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.

Jurisdictions that fail 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, such as CDC’s annual preparedness report.

Data used 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. This document identifies PHEP measures that already have 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 supplement performance measure guidance document.

If PHEP funds are allocated to the capability or contracts plan – If recipients 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 below) 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 public health departments to know or do 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).



INTRODUCTION

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 key terms are 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 multiagency 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 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 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 or Internet-based technology to convene two or more individuals in a real-time exchange of information to facilitate efficient decision-making. This technology can include, but is not limited to, teleconferencing, web-based meetings, and other types of online, interactive systems and technologies in which voice 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 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 public health preparedness**
- 3. Coordinate with partners and share information through community social networks**
- 4. Coordinate training and provide guidance to support community involvement with preparedness efforts**

CDC retired the Community Preparedness Evaluation Tool. Key aspects of information from this tool will be collected within the ORR. CDC will collect data assessing readiness including how recipient and local CRI planning jurisdictions address at-risk populations with functional and access needs. Refer to the previous project period guidance document for more information about this tool.

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 departments 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 community recovery needs**
- 2. Support recovery operations for public health and related systems for the community**
- 3. Implement corrective actions to mitigate damage from future incidents**

CDC retired the Community Recovery Evaluation Tool. Recipients may continue to use this tool for their own evaluation purposes. Key aspects of information from this tool will be collected within the ORR. Refer to the previous project period guidance document for more information about this tool.

Capability 3: Emergency Operations Coordination

Introduction

Emergency operations coordination 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 departments 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 the need for activation of public health emergency operations**
- 2. Activate public health emergency operations**
- 3. Develop and maintain an incident response strategy**
- 4. Manage and sustain the public health response**
- 5. Demobilize and evaluate public health emergency operations**

CDC has migrated performance measure PHEP 3.1 into the ORR online data collection system (DCIPHER). CDC will collect information for this measure, including emergency operations center (EOC) site activation, and staff assembly with incident command staff reported in the ORR. Incidents or no-notice drills used for this measure should occur between July 1, 2018-June 30, 2019. They should be reported into DCIPHER by October 1, 2019.

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 (PODs). 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 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 ORR. Refer to the [ORR Guidance](#) document for more information.

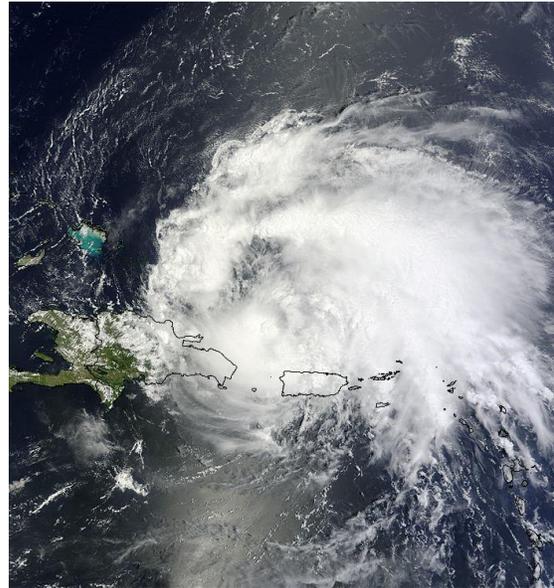
Capability 5: Fatality Management

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 for survivors of the deceased. Preparing for mass-fatality incidents requires collaboration among a variety of agencies, including public health departments, to help ensure a coordinated and thorough response.

The fatality management preincident planning measure is designed to encourage public 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. *An assumption*

made here is that a public health department's role in this capability (e.g., from no role because of legislation/regulation to a supporting role in any number of the capability functions) will vary depending on the jurisdiction. As long as a public 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 recipient-determined role in fatality management.



Capability Functions

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

- 1. Determine the public health agency role in fatality management**
- 2. Identify and facilitate access to public health resources to support fatality management operations**
- 3. Assist in the collection and dissemination of antemortem data**
- 4. Support the provision of survivor mental/behavioral health services**
- 5. Support fatality processing and storage operations**

CDC retired the fatality management performance measurement. Recipients 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.

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 capability consists of the ability to perform the following functions:

- 1. Identify stakeholders that should be incorporated into information flow and define information sharing needs**
- 2. Identify and develop guidance, standards, and systems for information exchange**
- 3. Exchange information to determine a common operating picture**

Alignment of Performance Measures to Capability

Measure	Function 1	Function 2	Function 3
<u>HPP-PHEP J.1</u>			●

HPP-PHEP J.1: Information Sharing

Percentage of local partners that reported the 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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input checked="" type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Used By: MCM ORR
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By HPP or PHEP (PERFORMS only)
<input checked="" type="checkbox"/> Territories or Freely Associated States		<input checked="" type="checkbox"/> Planned Event	<input type="checkbox"/> PAHPRA Benchmark

Additional Information: Recipients 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 toward the ORR, so ensure MCM-related information sharing is accomplished at least every other year. In alternate years, consider exercising information sharing related to other 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 the 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 in place 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).

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



How does this measure align with the 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. An opportunity to work with partners to align EEI sharing processes for the HPP-PHEP J1 and ORR is available 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) Did at least 1 incident/exercise/planned event occur in BP1 that involved local partners receiving a request for Essential Elements of Information (EEI)?
 - Yes
 - No
- 2) Number of local partners that received a request for EEI (denominator) [Text box]
- 3) Number of local partners that reported requested EEI to the health and medical lead within the requested timeframe (numerator) [Text box]

Performance Measure: Percent of local partners that reported EEI to the health/medical lead within the requested timeframe [Percentage] %

- 4) The request for EEI occurred during a/an: [Select one]
- Incident
 - Full-scale exercise
 - Functional exercise
 - Drill
 - Planned event
- 5) 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)
 - Flooding
 - Earthquake
 - Hurricane/tropical storm
 - Hazardous material
 - Fire
 - Tornado
 - Biological hazard or disease, please specify [Text box]
 - Radiation
 - Other, please specify [Text box]
- 6) Was this incident/exercise/planned event MCM-related? Check to align with ORR
- Yes
 - No
- 7) Please provide the name and date of the incident/planned event/exercise.
- a. Name [Text box]
 - b. Date [MM/DD/YYYY]
- 8) This incident/planned event/exercise utilized or demonstrated one or more functions within the: [Select one]
- HPP Capability
 - PHEP Capability
 - Both HPP and PHEP Capabilities

- 9) Please state how many of each type(s) of local partners responded to the request. [Text box]
- Hospitals
 - Long-term care facilities
 - Community health center
 - Health care organizations (HCOs)
 - Local public health entities (LHDs, district or regional offices, etc.)
- 10) 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. [Text box]
- b. How many local partners of “other” type #1 responded to the request? [Text box]
- c. Please describe other type #2. [Text box]
- d. How many local partners of other type #2 responded to the request? [Text box]
- e. Please describe other type #3. [Text box]
- f. How many local partners of other type #3 responded to the request? [Text box]
- g. Please describe other type #4. [Text box]
- h. How many local partners of “other” type #4 responded to the request? [Text box]
- i. Please describe other type #5. [Text box]
- j. How many local partners of “other” type #5 responded to the request? [Text box]
- 11) Please identify the requesting entity (e.g., public health/medical lead at the state, sub-state regional, or local level).
- State health/medical lead (or designee)
 - Sub-state regional public health/medical lead (or designee)
 - Local health/medical lead (or designee)
 - Other, please specify
- 12) Please identify the types of EEI requested.
- Facility operating status
 - Facility structural integrity
 - Status of evacuations/shelter in-place operations
 - Status of critical medical services (e.g., trauma, critical care)
 - Critical service/infrastructure status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
 - Bed or patient status
 - Equipment/supplies/medications/vaccine status or needs
 - Staffing status
 - Emergency Medical Services (EMS) status

-
- Epidemiological, surveillance, or lab data (e.g., test results, case counts, deaths)
 - School-related data (closure, absenteeism, etc.)
 - POD/mass vaccination sites data (e.g., throughput, open/set-up status, etc.)
 - Other, please specify
- 13) Please identify the type of IT or other communication system used to request EEI from local partners.
- Telecommunications (e.g., cell phone, satellite phone, landline)
 - E-mail
 - Online/web interface (electronic bed or patient tracking, survey tools, WebEOC, or similar, etc.)
 - Health Alert Network
 - Other, please specify
- 14) Were relevant corrective actions/improvement plan items from *prior responses* (including exercises, drills, etc.) related to information sharing incorporated into planning and/or response procedures before this incident/exercise/planned event took place?
- Yes
 - No
 - Some
- 15) Have corrective actions/improvement plan items related to information sharing been identified as a result of this incident/exercise/planned event?
- Yes
 - No
- 16) Have they been implemented?
- Yes
 - No
- 17) Please indicate any barriers to submitting requested EEI within the requested timeframe.
- Communication
 - Equipment
 - Funding
 - Participation
 - Policies/procedures
 - Resource limitations
 - Staffing
 - Time constraints
 - Training
 - Other, please specify
 - None
- 18) *Optional*: Please provide any additional clarifying, contextual, or other information.

NOTE: When completed with reporting of all incidents for Performance Measure HPP-PHEP J1, PERFORMS will prompt the user to address two additional questions: (1) Which of the incidents was the recipient’s best performance (highest percentage)? and (2) Which incident is being used to focus on quality improvement or technical assistance?



How is this measure operationalized?

The purpose of this measure is 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, should be based on established plans, protocols, and procedures. These decisions are ultimately at the discretion of the incident commander or designee.

If large volumes of EEI are collected in an incident, the recipient is responsible for determining which of this information is “essential” and, therefore, able to count toward the numerator and denominator for this performance measure.

Key Measurement Terms

Essential Elements of Information (EEI): This refers to discrete types of reportable public health- or health care-related, incident-specific knowledge communicated or received concerning a particular fact or circumstance. EEI should be reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon preincident, 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, that receive requests for EEIs. Local partners may differ based on the type of incident/exercise/planned event (e.g., HCOs, LHDs, health care coalitions).

Requested timeframe: Requested timeframe is an recipient-defined period of time for receiving requested EEI (e.g., operational period, set time to meet special request [e.g., 1,500 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 or shelter 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 shelter 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 health needs of the impacted population**
- 3. Coordinate public health, health care, and mental/behavioral health services**
- 4. Monitor mass care population health**

CDC retired PHEP 7.1 and the Mass Care Evaluation Tool. Recipients may continue to use this measure and the evaluation tool for their own evaluation purposes, but CDC will not collect these data. Refer to the Budget Period 2 (2013-2014) performance measure guidance document for more information about this measure and the evaluation tool.

Capabilities 8 and 9: Medical Countermeasure Dispensing and Administration, and Medical Materiel Management and Distribution

Introduction

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



Operational Readiness Review (ORR)

The 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 Countermeasure Distribution and Dispensing Composite Score. Refer to the [notice of opportunity announcement \(NOFO\)](#) and [ORR Guidance](#) for information about other requirements related to capabilities 8 and 9, including information on the jurisdictional data sheets (JDS), drills, exercises, POD, and receipt, stage, and store (RSS) checklist requirements.

Capability 10: Medical Surge

Introduction

The medical surge capability refers to the ability to provide adequate medical evaluation and care when the medical infrastructure of an affected community is overwhelmed.

Public 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:

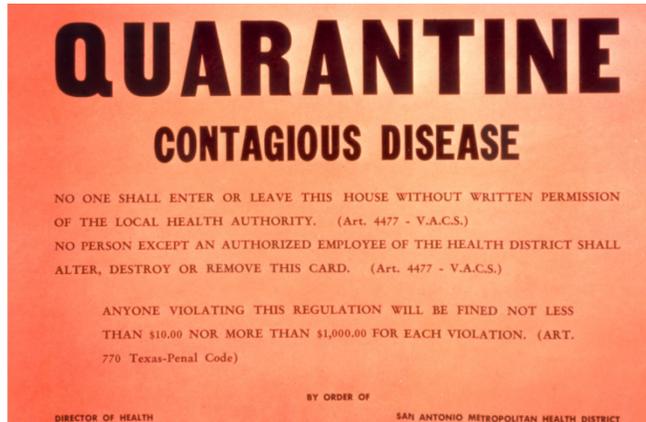
- 1. Assess the nature and scope of the incident**
- 2. Support activation of medical surge**
- 3. Support jurisdictional medical surge operations**
- 4. Support demobilization of medical surge operations**

Currently, no CDC-defined performance measures are available for this capability.

Capability 11: Nonpharmaceutical Interventions

Introduction

The nonpharmaceutical interventions (NPI) capability refers to the ability of public health departments, in coordination with their partners, to recommend or implement nondrug and nonvaccine-based containment, mitigation, or decontamination strategies 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 health care 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 nonpharmaceutical interventions**
2. **Determine nonpharmaceutical interventions**
3. **Implement nonpharmaceutical interventions**
4. **Monitor nonpharmaceutical interventions**

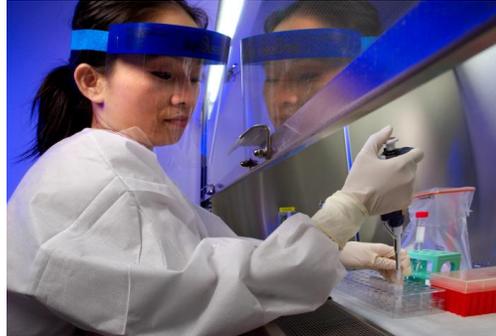
CDC retired PHEP 11.1 and 11.3. Recipients may continue to use these measures for their own evaluation purposes, but CDC will not collect these data. Refer to the Budget Period 2 (2013-2014) performance measures guidance document for more information about these measures.

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 used by the Laboratory Response Network (LRN-Biological and LRN-Chemical) 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. Conduct laboratory testing and report results**
- 2. Enhance laboratory communications and coordination**
- 3. Support training and outreach**

*Alignment of Performance Measures to Capability**

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

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

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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input type="checkbox"/> Data Used By
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected by CDC EOC
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input type="checkbox"/> 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 an effective public health emergency response. As stewards of PHEP funds, the recipient 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). This 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 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 in place 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 DSLR.

Recipients 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 recipient at any time during the BP to verify contact information for on-call (and alternate on-call) LRN-B/LRN-C laboratorians or epidemiologists.



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.

BP1 Supplement drill direction for recipients with separate biological and chemical laboratories

Drill #1: CDC EOC → LRN-C → EPI → CDC EOC

Drill #2: CDC EOC → EPI → LRN-B → CDC EOC

BP1 Supplement drill direction for recipients 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

Failure to complete a critical activity within each drill segment may result in pitfalls that may prevent the recipient 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

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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Utilized By NHSPI
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By: CDC LRN-C Program
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> 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, ensuring that this qualification is maintained and that the recipient's preparedness office is aware of the laboratory's testing capability is important. Additional methods build upon the foundation established by the core methods, providing modifications to core techniques, which allows for laboratories to test for additional agents and, thereby, expand their testing capabilities. A key objective is to ensure that recipient 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 in place for reporting measure data?

This measure is required for recipients with Level 1 laboratories. It is optional for recipients with Level 2 laboratories.

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

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



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. [Click or tap here to enter text.](#)



Pre-Incident

Core Public Health

Response

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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Used By NHSPI
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By CDC LRN-C Program
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> If Emergency Response Required Use of this Capability, Regardless of Funding	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> 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, ensuring that this qualification is maintained and that the recipient preparedness office is aware of the laboratory’s testing capability is important. 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 recipient preparedness offices are aware of proficiency-testing activities and capabilities and validate the information on an annual basis in the PHEP reporting system.



Pre-Incident

Core Public Health

Response



What other requirements are in place for reporting measure data?

This measure is required for recipients with Level 1 or Level 2 laboratories.

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

Proficiency testing data must be validated by the recipient 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]
 - 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

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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Used By NHSPI
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By CDC LRN-C Program
<input type="checkbox"/> Territories or Freely Associated States	<input type="checkbox"/> Optional	<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> PAHPRA Benchmark



How is the measure calculated?

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

A recipient will be rated as “Passed” if at least one LRN-C laboratory in the jurisdiction participated and passed. If an applicable recipient 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 recipient 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 in place for reporting measure data?

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



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

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



What data must be reported?

1. 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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Used By: NHSPI
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By CDC LRN-B Program
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> 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 proficiency testing 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, ensuring that this qualification is maintained is important so that CDC’s LRN and the recipient preparedness offices are aware of recipient testing capabilities.



What other requirements are in place for reporting measure data?

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



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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 or passing LRN-B proficiency testing. [Select all that apply]
 - Communication
 - 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) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet (PN) national database **within 4 working days** of receiving isolate at the PFGE laboratory. PFGE measures for *E. coli* will be collected through 2018 and reported as end of the year measures.

Measure Applies To	Circumstances for Reporting	Data May Be Taken From	Other Considerations
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input checked="" type="checkbox"/> Data Used By: GPRA
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago)	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan (for PFGE activities)	<input type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By CDC ELC Program and CDC PulseNet
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input type="checkbox"/> 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 PN database within 4 **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 PN national database.

Performance Target: 90%.



Why is this measure important?

Recipients 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 PN 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 in place for reporting measure data?

Data for this performance measure will be collected by the Epidemiology and Laboratory Capacity cooperative agreement program (from its recipients) as well as extracted from the PN national database and shared with DSLR. PHEP recipients that allocate PHEP funding toward PFGE activities will be required to verify these data. Data from this measure, irrespective of PHEP funding, may be reported in the National Health Security Preparedness Index. **The reporting period for this performance measure is calendar year (CY) 2017.**



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 isolates, number of human isolates sent to another laboratory (out of state) for PFGE sub-typing. (ELC)
2. Number of primary patterns from subtyped human isolates uploaded into the PN national database (PN*) (denominator)
 - a. Of these primary patterns, 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 subtyping of *E. coli* O157:H7 human isolates that were submitted to the PN database within 4 working days of receipt at PFGE laboratory (numerator) (PN).
4. If the calculated percentage for this performance measure (determined by CDC PN) is less than 90 percent, please describe barriers or challenges to meeting this target (90 percent of subtyping results submitted to PN within 4 working days of receipt at PFGE laboratory).

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



How is this measure operationalized?

Recipients should not count duplicates in the human isolates they receive if they are not subtyped. Human isolates refers to reference or clinical human isolates.



PHEP 12.15: PFGE *L. monocytogenes*

This measure has been retired. It is being replaced by Whole Genome Sequencing. Once the transition to WGS is complete, the data will be collected as the performance measure. No reporting for this measure is required for this period because of this transition.

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).

On-call epidemiologist: An on-call epidemiologist is the person from the recipient epidemiology office or public 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 or contacting a properly trained laboratorian that can begin testing samples. Security personnel can only receive samples.

Submission of results within 4 working days: Submission of results within four working days is the target of this measure. PFGE subtyping results are submitted to PN 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.



Capability 13: Public Health Surveillance and Epidemiological Investigation

Introduction

This capability includes activities related to surveillance and 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 departments 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 or support public health surveillance
2. Conduct public health and epidemiological investigation
3. Recommend, monitor, and analyze mitigation actions
4. Improve public health surveillance and epidemiological investigation systems

Alignment of Measures to Capability

Measure	Function 1	Function 2	Function 3	Function 4
<u>PHEP 13.1</u>	●			
<u>PHEP 13.2</u>			●	



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PHEP 13.1: Disease Reporting

Percentage of reports of selected reportable diseases received by a public health department within the recipient-required timeframe.

Measure Applies To	Circumstances for Reporting	Data May Be Taken From	Other Considerations
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input type="checkbox"/> Data Used By
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago and Los Angeles County)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Data Collected By
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input type="checkbox"/> PAHPRA Benchmark



How is the measure calculated?

Numerator: Number of reports of selected reportable disease received by a public health department within the recipient-required timeframe.

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



Why is this measure important?

Case reporting of reportable diseases is a prerequisite for an effective public health system. Timely reporting permits public health departments 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 recipient-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 departments 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 recipient health department (or vice versa) or notification from an recipient to CDC.



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What other requirements are in place for reporting measure data?

Recipients should report jurisdictionwide (e.g., statewide) performance measure data for PHEP 13.1. Recipients 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.

Recipients are required to report data on case reports with CDC notification dates between Morbidity and Mortality Weekly Report (MMWR) Week 27, 2018 (beginning July 1, 2018) through MMWR Week 26, 2019 (ending June 29, 2019).

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

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

Recipients 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 recipient jurisdiction (e.g., Shigella, Pertussis)

Recipients should calculate the numerator and denominator for this performance measure at the public health system level to reflect how disease reporting actually occurs in the recipient’s jurisdiction, irrespective of whether reporting first comes through the state or local level. Recipients should ensure counts exclude duplicate cases.

Recipients 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 department (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 department within seven days. This number will now serve as the numerator to create the percentage of reports received within seven days. This data will be a new performance measure that can be aggregated across all recipients. Continue submitting information on recipient-defined reporting period as well. This information is still of interest to key CDC stakeholders.



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What data must be reported?

- 1) Total number of disease reports received by a public health agency for **Botulism** (confirmed) (denominator). [Text box] [Click or tap here to enter text.](#)
 - a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Botulism** (confirmed) (numerator). [Text box] [Click or tap here to enter text.](#)
 - b. Percentage of reports of **Botulism** (confirmed) received by a public health agency within the recipient-required timeframe [System calculated] [Click or tap here to enter text.](#)
 - c. Are the values reported in the denominator and numerator for **Botulism** drawn from surveillance and disease reporting covering the entire jurisdiction?
 - Yes
 - No

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 recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
 - e. For **Botulism**, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
 - 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).
- a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Tularemia** (confirmed and probable) (numerator).
 - b. Percentage of reports of **Tularemia** (confirmed and probable) received by a public health agency within the recipient-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
 - (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 recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - e. For **Tularemia**, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - 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).



- a. Total number of disease reports received by public health agency within recipient-required timeframe for ***E. Coli, STEC***
 - b. Percent of reports of ***E. Coli, STEC*** received by a public health agency within the recipient-required timeframe [System calculated]
 - c. Total number of disease reports received by a public health agency within 7 days (numerator):
 - d. Percentage of reports of ***E. coli, STEC*** (confirmed) received by a public health agency within 7 days: [System calculated]
 - e. 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***? [select one]
 - <25%
 - 26-50%
 - 51-75%
 - 76-99%
 - f. For ***E. coli, STEC***, please indicate the recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - g. For ***E. coli, STEC***, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - h. 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).

- a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Hepatitis A, acute** (confirmed) (numerator).
- b. Percentage of reports of **Hepatitis A, acute** (confirmed) received by a public health agency within the recipient-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 recipient-required reporting timeframe for providers.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days
- Other, please specify: [Text box]

e. For **Hepatitis A, acute**, please indicate the recipient-required reporting timeframe for laboratories.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days
- Other, please specify: [Text box]

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

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



- a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Measles** (confirmed) (numerator). [Text box]
 - b. Percentage of reports of **Measles** (confirmed) received by a public health agency within the recipient-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 recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
 - e. For **Measles**, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
 - 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). [Text box]
- a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Meningococcal Disease** (confirmed) (numerator). [Text box]



- b. Percentage of reports of **Meningococcal Disease** (confirmed) received by a public health agency within the recipient-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 recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
- e. For **Meningococcal Disease**, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify: [Text box]
- 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). [Text box]
- Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Salmonellosis** (confirmed) (numerator). [Text box]
 - Percentage of reports of **Salmonellosis** (confirmed) received by a public health agency within the recipient-required timeframe. [System calculated]
 - 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%
 - For **Salmonellosis**, please indicate the recipient-required reporting timeframe for providers.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - For **Salmonellosis**, please indicate the recipient-required reporting timeframe for laboratories.
 - Immediately
 - 24 Hours
 - 48 Hours
 - 72 Hours
 - 7 Days
 - Other, please specify:
 - 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 Recipient

- 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**.

[Text box]

10) Total number of disease reports received by a public health agency for **Disease 1** (denominator). [Text box]

a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Disease 1** (numerator). [Text box]

b. Percentage of reports of **Disease 1** received by a public health agency within the recipient-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 recipient-required reporting timeframe for providers.

Immediately

24 Hours

48 Hours

72 Hours

7 Days

Other, please specify: [Text box]

e. For **Disease 1**, please indicate the recipient-required reporting timeframe for laboratories.

Immediately

24 Hours

48 Hours

72 Hours

7 Days

Other, please specify: [Text box]

f. Case event date type for **Disease 1**

Date of diagnosis – lab-confirmed

Date of diagnosis – presumptive/clinical

Date of laboratory report



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- 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**.

[Text box]

12) Total number of disease reports received by a public health agency for **Disease 2** (denominator). [Text box]

- a. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for **Disease 2** (numerator). [Text box]
- b. Percentage of reports of **Disease 2** received by a public health agency within the recipient-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 recipient-required reporting timeframe for providers.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days
- Other, please specify: [Text box]

e. For **Disease 2**, please indicate the recipient-required reporting timeframe for laboratories.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days
- Other, please specify: [Text box]

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**.

[Text box]

14) Total number of disease reports received by a public health agency for **Disease 3** (denominator).
[Text box]

- b. Total number of disease reports received by a public health agency within the recipient-required reporting timeframe for Disease 3 (numerator). [Text box]
- c. Percentage of reports of **Disease 3** received by a public health agency within the recipient-required timeframe. [System calculated] Note: Displayed as a percentage in PERFORMS
- d. 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%

e. For **Disease 3**, please indicate the recipient-required reporting timeframe for providers.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days
- Other, please specify: [Text box]

f. For **Disease 3**, please indicate the recipient-required reporting timeframe for laboratories.

- Immediately
- 24 Hours
- 48 Hours
- 72 Hours
- 7 Days



Other, please specify: [Text box]

g. 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

15) Has the recipient 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 recipient 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
- Equipment
- Funding
- Participation
- Policies/procedures
- Resource limitations
- Staffing
- Time constraints
- Training
- Other, please specify
- None

17) [Optional] Please provide any additional clarifying, contextual or other information. [Text box]



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 departments are typically determined at the recipient level through statute or regulation (e.g., providers should report measles within 24 hours to the public health department). For the purpose of this measure, recipients 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. Recipients 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 department.

Note: For each disease, recipients 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 department. The result is a period of time that falls either within or outside the recipient-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 department.

Case event date types – considerations for selection: With input from LHDs, recipients should select one case event date type for each disease prior to the start of the performance period. All public 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: Recipients may select different case event date types for each of the six diseases included in this performance measure. Recipients also may choose the same case event date type for multiple diseases. Although recipients 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 recipients (and LHDs) have or will have a standardized process and defined data field in place in their surveillance system(s) to capture this information. Recipients 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), recipients 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 department: Recipients should use the time that a public health department 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: Many jurisdictions may have 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: Because of the feasibility of recognizing and reporting suspected measles cases prior to lab confirmation, CDC recommends recipients select date of diagnosis—presumptive or date of specimen collection for this disease.

Reporting timeframes – provider and lab differences: In some recipient jurisdictions, reporting timeframes for select diseases differ depending on whether reported by providers or labs. Recipients 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, recipients should count the first instance of reporting the case for the purpose of this performance measure.

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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input type="checkbox"/> Data Used By
<input checked="" type="checkbox"/> Directly Funded Localities (Excludes Chicago and Los Angeles County)	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Data Collected By
<input type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input type="checkbox"/> 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 department.



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 department.

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.



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What other requirements are there for reporting measure data?

Recipients should report jurisdictionwide (e.g., statewide) performance measure data for PHEP 13.2. Recipients 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.

Recipients are required to report data on case reports with CDC notification dates between Morbidity and Mortality Weekly Report (MMWR) Week 27, 2018 (beginning July 1, 2018) through MMWR Week 26, 2019 (ending June 29, 2019).

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

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

Recipients 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 recipient jurisdiction (e.g., Shigella, Pertussis) (Recipients must provide their own target timeframe[s] for initiation of control measures for these diseases.)

Recipients should calculate the numerator and denominator for this performance measure by disease and should ensure counts exclude duplicate cases.

Recipients should exclude cases of disease from the numerator that meet inclusion criteria, but are missing pertinent data (e.g., 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 department (the denominators) are the same in 13.1 and 13.2.





What data must be reported?

- 1) Total number of disease reports received by a public health agency for **Botulism** (confirmed) (denominator). [Text box]
 - a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Botulism** (confirmed) (numerator). [Text box]
 - 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). [Text box]
 - a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Tularemia** (confirmed and probable) (numerator). [Text box]
 - 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
 - (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). [Text box]
 - a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **E. coli, STEC** (confirmed) (numerator). [Text box]



- 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). [Text box]
- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Hepatitis A, acute** (confirmed) (numerator). [Text box]
 - 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). [Text box]
- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Measles** (confirmed) (numerator). [Text box]
 - 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). [Text box]
- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Meningococcal Disease** (confirmed) (numerator). [Text box]
 - b. Percentage of reports of **Meningococcal Disease** (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 **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). [Text box]
- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Salmonellosis** (confirmed) (numerator). [Text box]
 - 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 Recipient

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**. [Text box]

10) Total number of disease reports received by a public health agency for **Disease 1** (denominator). [Text box]

- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 1** (numerator). [Text box]
- 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%

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**. [Text box].

12) Total number of disease reports received by a public health agency for **Disease 2** (denominator). [Text box]

- a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 2** (numerator). [Text box]
- 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**. [Text box]

14) Total number of disease reports received by a public health agency for **Disease 3** (denominator). [Text box]

a. Total number of disease reports for which a control measure was initiated within the appropriate timeframe for **Disease 3** (numerator). [Text box]

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 recipient 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 recipient 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]

- Communication
- Equipment
- Funding
- Participation
- Policies/procedures
- Resource limitations
- Staffing
- Time constraints
- Training
- Other, please specify: [Text box]
- None

17. **[Optional]** Please provide any additional clarifying, contextual or other information. [Text box]



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, recipients 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. Recipients should use the time that the first report of a selected disease was received by a public health department 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 department: [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. Recipients 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 are

- This performance measure is meant to capture *initiation* of public health control measures, *not* completion.





CAPABILITY 13

- In general, the intent of this performance measure is *not* to capture the first phone call to a health care provider to discuss a case patient, unless that discussion entails recommendations or education regarding specific control measures (e.g., calling a parent or a day care center to exclude an infectious child from child care because of *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, doing so will meet the intent of the measure and count toward the numerator.
- Recipients 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.



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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. Recipients are requested to determine their own target timeframes for any additional diseases they wish to report for PHEP 13.1 and 13.2.

Recipient-required timeframe: The recipient-required timeframe is a jurisdictionally-mandated period of time either by law or regulation for health care providers to report notifiable cases of disease.

Case: Recipients 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 MMWR print criteria for each disease. Because of the provisional nature of some case data and the likelihood of eventual rule-outs of some cases, the fact that case counts may change following recipient reporting for this performance measure is understood. Recipients are not required to reconcile this performance measure data to their final National Notifiable Disease Surveillance System (NNDSS) data; however, CDC may compare recipient 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. Five options are available for case event date types, all defined below. Recipients may use 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) or physiological effects (e.g., presence or increase in antibodies associated with a disease) from laboratory testing. This determination 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 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 (e.g., a provider, not the public health department). 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 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 also may 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 a recipient 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.

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 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 and support risk-specific safety and health training**
- 3. Monitor responder safety and health during and after incident response**

CDC has retired PHEP 14.1, 14.3, and 14.4. Recipients may continue to use these measures for their own evaluation purposes, but CDC will not collect these data. Refer to the Budget Period 2 (2013-2014) 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 department’s response to an incident of public health significance. Public health and medical volunteers enable the public health and health care systems to surge and meet the elevated needs of an event or incident. Therefore, coordinated management is crucial.



The volunteer management preincident planning measure gauges the extent to which public 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. Recruit, coordinate, and train volunteers
2. Notify, organize, assemble, and deploy volunteers
3. Conduct or support volunteer safety and health monitoring and surveillance
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			●	●



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
<input checked="" type="checkbox"/> States	<input type="checkbox"/> Annual Requirement	<input type="checkbox"/> Incident	<input type="checkbox"/> Data Used By
<input checked="" type="checkbox"/> Directly Funded Localities	<input checked="" type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input type="checkbox"/> Exercise	<input type="checkbox"/> Data Collected By
<input checked="" type="checkbox"/> Territories or Freely Associated States (Puerto Rico only)		<input type="checkbox"/> Planned Event	<input type="checkbox"/> 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 recipients 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, 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 measure is a “yes/no” measure, which CDC calculates based on self-report by the recipient 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 nonregistered or spontaneous volunteers
- Confirming volunteer credentials
- Assigning roles and responsibilities to volunteers
- Providing just-in-time training for volunteers
- Tracking volunteers
- Out-processing volunteers



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



How does this measure align with the ORR?

While no direct links exist between PHEP 15.1 and the ORR, various activities related to volunteer management are applicable to both. Recipients are encouraged to use activities conducted during BP1 Supplement 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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other – please specify: [Text box]

- (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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)



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- Both
- Other – please specify: [Text box]

(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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other – please specify: [Text box]

(i). Has this activity been completed by the entity/entities responsible for its completion?

- Yes
- No

d. At which jurisdictional level(s) does public health have responsibility for: **Assigning roles and responsibilities to volunteers.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other –please specify: [Text box]

(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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other –please specify: [Text box]

(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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other –please specify: [Text box]

(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.**

- Recipient level (including recipient-led or operated regions, districts, offices, etc.)
- Sub-recipient level or autonomous local level entities (including autonomous regions, districts, counties, LHDs, coalitions, etc.)
- Both
- Other –please specify: [Text box]

(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?

(i). Have corrective action/improvement plan items related to volunteer management been identified?

- Yes
- No

(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. [Text box]
- None

1. **[Optional]** Please provide any additional contextual, clarifying, or other information. [Text box]



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?

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

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

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 recipients to indicate that performance element #1 is complete. Recipients are encouraged to describe yearly progress in the optional text box (data element 8, above). For example, “This year, eight 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 recipient jurisdiction and provide technical assistance, as needed.



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
<input checked="" type="checkbox"/> States	<input checked="" type="checkbox"/> Annual Requirement	<input checked="" type="checkbox"/> Incident	<input type="checkbox"/> Data Used By
<input checked="" type="checkbox"/> Directly Funded Localities	<input type="checkbox"/> If PHEP Funds Allocated to the Capability or Contracts Plan	<input checked="" type="checkbox"/> Exercise	<input checked="" type="checkbox"/> Data Collected By HPP or PHEP (PERFORMS only)
<input checked="" type="checkbox"/> Territories or Freely Associated States		<input type="checkbox"/> Planned Event	<input checked="" type="checkbox"/> PAHPRA Benchmark

Additional Information: Recipients that experience two or more incidents involving deployment of volunteers must report data from **at least** two of these incidents. Recipients that experience one incident involving volunteer deployment must report on it. Recipients that do not experience an incident involving volunteer deployment do not have to report on this measure; however, they must conduct a call-down and 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—to determine key bottlenecks and chokepoints that 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 volunteer activities in health care organizations.



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What other requirements for reporting measure data?

- Recipients may report the numerator and denominator of this measure *by incident or exercise* at the state, sub-state, regional, or local level.
- **Recipients that experience two or more incidents or exercises** involving deployment of volunteers **must report on at least** two of those incidents.
 - One data point must reflect the recipient’s best performance (highest percentage).
 - The other data point must reflect performance that, based on a determination from the recipient, calls for focused quality improvement and, if applicable, technical assistance.
 - Recipients are encouraged to submit data on additional incidents and exercises as well. No specific reporting requirements or parameters are in place for additional data points.
- **Recipients that experience only one incident or exercise** involving deployment of volunteers must report on it.
- **Recipients that experience no incidents or exercises** involving deployment of volunteers in BP1 Supplement 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:
 - Number of volunteers contacted (registered in the Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP] system)
 - Number of volunteer contacted (registered in other systems)
 - Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe
 - Number of volunteers registered in other systems that acknowledged contact within the requested timeframe
 - The requested timeframe for acknowledgment (e.g., 4 hours, 8 hours, 12 hours)
 - 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 incidents or exercises occurred involving actual deployment of volunteers in the budget period.
- In future budget periods, recipients may be required to exercise actual volunteer deployment if no volunteer deployments occurred during a public health/medical incident in consecutive budget periods.



How does this measure align with the ORR?

A surge related to an incident requiring additional staffing is likely and will involve 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. Recipients are encouraged to use activities conducted during BP1 Supplement to meet multiple requirements, where appropriate. If no incidents that require additional volunteers occur during this project period, those utilized during a drill or exercise reported in the ORR can be used for this measure.



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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 Supplement. 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:

- 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). [Text box]

Of these:

- a. Number of deployed volunteers registered in ESAR-VHP. [Text box]
- b. Number of deployed volunteers registered in other systems. [Text box]

Total. [Text box] [System Calculated] (Note: Sum of 3a and 3b must equal value entered for Question 3.)

- c. 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. [Text box]
- 5) The request for volunteers occurred during a(n): [Select one]
 - Incident
 - Full-scale exercise
 - Functional exercise
 - Drill
- 6) This incident or exercise utilized 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 [Text box]
 - b. Date [MM/DD/YYYY]



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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): [Text box]

9) The entity that made the original request for volunteers [Select one]

- Local health department
- State health department
- Health care organization
- Health care coalition
- Other, please specify: [Text box]

10) The requested location for the deployment [Select one]

- Staging/assembly area(s) (not actual incident site)
- Hospital(s)
- Shelter(s)
- Points of dispensing (POD or PODs)
- Alternate care site(s), please specify: [Text box]
- Other, please specify: [Text box]

11) The number of volunteers who were contacted for potential deployment. [Text box]

12) Please indicate any barriers to deploying volunteer 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: [Text box]

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

14) **[Optional]** Please provide any additional clarifying, contextual, or other information. [Text box]

15) Recipients that experience no incidents or exercises involving deployment of volunteers in BP1 Supplement 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). [Text box]

b. Number of volunteers contacted (registered in other systems). [Text box]

c. Number of volunteers in the ESAR-VHP system that acknowledged contact within the requested timeframe. [Text box]

d. Number of volunteers registered in other systems that acknowledged contact within the requested timeframe. [Text box]

e. Requested timeframe for acknowledgment: Hours [Text box] Mins [Text box]

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 recipient'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, the lead determines that an additional 100 volunteers are needed. The denominator for this incident is 200.

Recipients 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 three 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 three-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 recipient or subrecipient level that 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, or locations.

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)

APPENDICES



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

		Applies To	Reporting Criteria	Comments
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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	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 and Administration							
Medical Materiel Management and Distribution							
Medical Surge							

Capability and Measure (if retained)	Function Alignment	States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded	Accountability, Exclusions
Nonpharmaceutical Interventions							
Public Health Laboratory Testing							
PHEP 12.2	4	X	X		X		Two drills per year (excludes Chicago)
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
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
Public Health Surveillance and Epidemiological Investigation							
PHEP 13.1	1	X	X		X		Excludes Chicago, Los Angeles County
PHEP 13.2	3	X	X		X		Excludes Chicago, Los Angeles County

Capability and Measure (if retained)	Function Alignment	States	Directly Funded Localities	Territories and Freely Associated States	Annual Reporting	Report if PHEP Funded	Accountability, Exclusions
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 data acceptable

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

Importance of this Drill to PHEP Recipients

Timely communication between on-call epidemiologists and laboratorians (and vice versa) is critical for effective public health emergency response. As stewards of PHEP funds, recipients play a crucial role in ensuring 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's Emergency Operations Center (EOC), the drill is not an EOC or Laboratory Response Network (LRN) measure of performance; it is strictly a PHEP performance measure that 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 recipients: the 50 states, Washington D. C., Los Angeles County, and New York City. The 24/7 emergency contact drill is **bidirectional**; therefore, two 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's EOC. In Drill #2 the on-call *epidemiologist* is contacted first by CDC's EOC. The drills can occur at any point during the budget period.

Drills will be **unannounced** and **after hours**, conducted between 8 p.m. and 11 p.m. (recipient's local time) over a five-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 PHEP Budget Periods 1 through 5 and BP1 Supplement.

Drill Directions for Recipients

BP1, BP3 and BP5 drill direction:

Drill #1: CDC EOC → LRN-B → EPI → CDC EOC

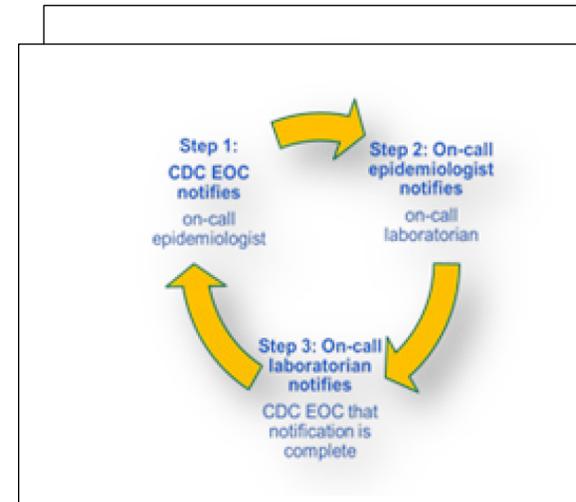
Drill #2: CDC EOC → EPI → LRN-C → CDC EOC

Drill #1:

BP 1 Supplement, BP2 and BP4 drill direction:

Drill #1: CDC EOC → LRN-C → EPI → CDC EOC

Drill #2: CDC EOC → EPI → LRN-B → CDC EOC



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 CDC’s 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’s EOC that the drill notification cycle is complete.

Drill Process

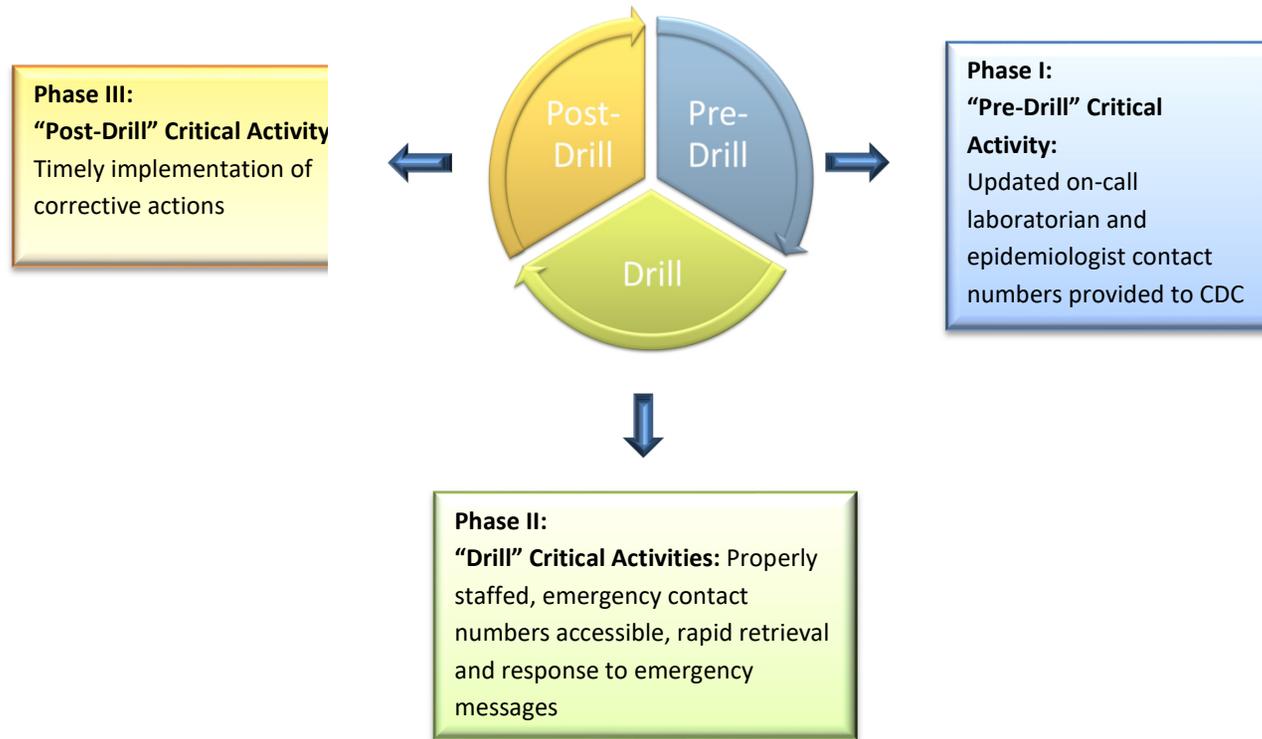
The 24/7 emergency contact drill is composed of three (3) major phases:

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

- Phase III: Post-drill

Each phase comprises various activities that must be completed 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 recipient 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 I: Pre-drill Activities

To complete this phase successfully, two tasks should be completed:

Task 1: Verify and update on-call contact numbers

For CDC's 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 CDC's EOC uses the correct information by ensuring that

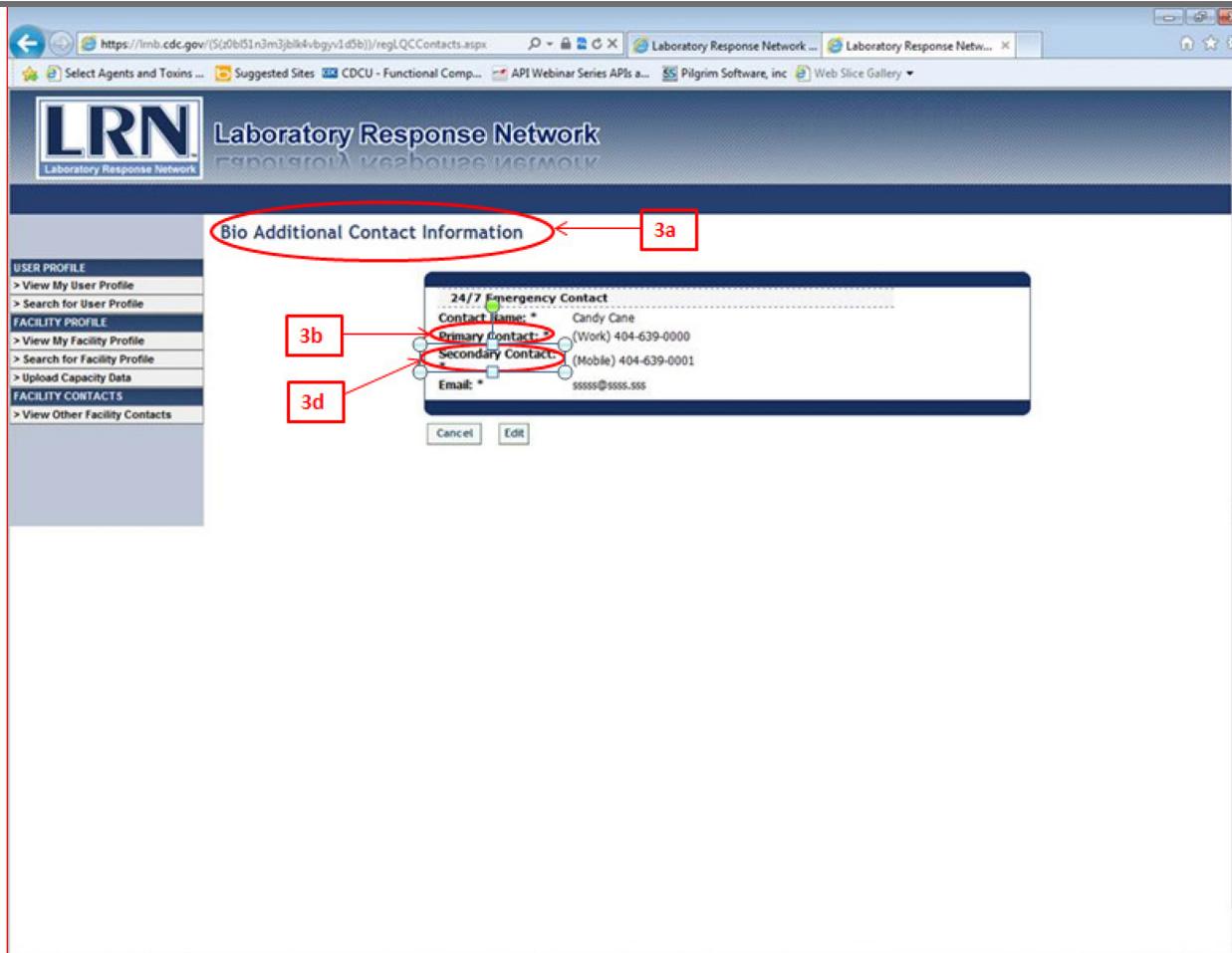
- a. The PHEP program is aware of and has access to the on-call epidemiologist and alternate on-call epidemiologist contact information from the state epidemiologist.
- b. The state LRN director (biological and chemical) keeps updated contact information on file with CDC's LRN program by updating on-call LRN-B and LRN-C laboratorian contact information on the LRN website at <https://lrnb.cdc.gov>.

The process to update on-call LRN-B and LRN-C laboratorian contact information is as follows:

- c. The individuals at the recipient level who have rights to update/modify on-call contact information are as follows:
 - I. Laboratory director
 - II. Laboratory administrator
 - III. Bioterrorism coordinator
- d. Access the LRN website: <https://lrnb.cdc.gov/>

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 nonregular business hours, including after-hours, evenings, weekends, and holidays.
- IV. Then click "24/7 Emergency Contact, " "Secondary Contact."
- V. Enter the alternate number to contact the on-call LRN-B laboratorian during nonregular business hours, including after regular hours, evenings, weekends, and holidays.



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

e. 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."

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

[https://lmb.cdc.gov/S\(g0g4lygkwulqnt5dqrqvyk2j\)/regFacilityContacts.aspx](https://lmb.cdc.gov/S(g0g4lygkwulqnt5dqrqvyk2j)/regFacilityContacts.aspx)

LRN Laboratory Response Network

Facility Contacts 4a

Please enter the Emergency Contact Primary Contact
[Return to Facility Profile](#)

Facility Contact Information

Lab Director: * Ms. Beth Schweitzer

24/7 Emergency Contact: * 4b

Contact Name: Fanta Grape

Primary Contact: * 4c 555-658-1257 Ext:

Secondary Contact: * 4d 555-639-5858 Ext:

Email: *

Additional notes:

CT Proficiency Testing - primary: * Select Contact

CT Proficiency Testing - alternate: Select Contact

CT Material - primary: * Select Contact

CT Material - alternate: Select Contact

CT Training - primary: * Select Contact

CT Training - alternate: Select Contact

f. The process to verify or change on-call epidemiologist contact information (i.e., contact number during nonregular business hours, including after regular hours, evenings, weekends, and holidays) is as follows:

- 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 automatically 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 jurisdictional state epidemiologist to ensure awareness and access to the on-call (and alternate on-call) contact information. CDC staff may request that the PHEP director 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 access to each other’s contact information. CDC’s EOC only *initiates* the drill; the on-call laboratorian or on-call epidemiologist is responsible for continuing the drill by calling the next person, who must then call CDC’s EOC to complete the drill.

The recipient is responsible for ensuring 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, DSLR's Applied Science and Evaluation Branch (ASEB) will generate a data collection spreadsheet for CDC's EOC watch officers to conduct the drills.
3. CDC's 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's EOC watch officers will leave a message and wait 10 minutes for the on-call contact to return the call to CDC's EOC watch officer before calling the alternate on-call contact number, if one is provided. If no alternate on-call contact number is listed, CDC's EOC watch officer will dial the on-call contact number again.
4. CDC's 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 CDC's 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's EOC that the drill notification cycle is complete.

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

Phase III: Postdrill Activities

- CDC's EOC will provide DSLR the completed drill data collection worksheets with recipients' 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's EOC will be provided to DSLR for analysis and reporting.
- Recipients that do not complete the drill cycle within 4 hours will receive drill notifications with a "did not complete" rating. During follow-up, these recipients will be asked to state the challenges, barriers, or root causes preventing them from completing the drill as well as proposed corrective actions. Root causes, corrective actions, and the corrective action implementation timeframe should be provided to DSLR within 30 calendar days of receiving results.
- DSLR will e-mail a copy of each recipient's official drill notification to the recipient and carbon copy the recipient's project officer.
- Recipients are expected to confirm receipt of the e-mail and notify the appropriate individuals (e.g., laboratory director of the participating lab, state epidemiologist) of the drill results. Recipients 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 recipients to verify the initial results before preparing a final report.
- Results of the BP1 Supplement 24/7 emergency contact drills should be used to encourage program and system improvement within recipient jurisdictions as well as drill execution by CDC.

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
<i>E. coli</i> (STEC)	Contact tracing Education: contacts, as applicable Exclusions: child care, food handling, as applicable	Within three days of initial case identification
Hepatitis A, Acute	Contact tracing Education: contacts Immunization (active/passive) administered or recommended to contacts, as appropriate	Within one 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 three days of initial case identification