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Project Title: Public Health Emergency Preparedness Cooperative Agreement

Performance Measure Specifications and Implementation Guidance: Codebook for Data Entry and Reporting

Period of Performance: Fiscal Years 2024–2028

Contents

Introduction and Purpose of Guidance

The Centers for Disease Control and Prevention (CDC) is responsible for developing and implementing standardized, relevant, feasible, and useful performance measures and evaluation strategies as part of the Public Health Emergency Preparedness (PHEP) cooperative agreement. The PHEP program provides 62 jurisdictions with funding to enhance the preparedness, response, and recovery capabilities of state, tribal, local, and territorial public health systems through a continuous cycle of planning, training, equipping, exercising, evaluating, and implementing corrective actions.

Evaluation and Performance Measurement Plan

PHEP recipients must submit an evaluation and performance measurement plan once during the five-year period of performance. The evaluation and performance measurement plan must address the overall methods for collecting and monitoring performance data and specify the data management plan for each activity described in the NOFO CDC-RFA-TU-24-0137. Additionally, the evaluation and performance measurement plan will describe the recipients plans for how the data will be generated, protected, operationalized (data standards and documentation), archived, and disseminated.

Performance Measures by Readiness and Response Framework Strategies

This section details the specific activities PHEP recipients must complete during the five-year performance period, July 1, 2024–June 30, 2029. Performance measures are based on specific short-, intermediate-, and long-term outcomes in alignment with the PHEP logic model (see Appendix A). Recipients must apply the foundational capabilities that the PHEP program has established and track and report progress on 10 cross-cutting priorities anchored in CDC's RRF. Additionally, Section 319C-1(g) of the Public Health Service Act requires recipients meet benchmark requirements and report complete and accurate performance data. Activities with benchmarks are indicated in Tables 1–10. The guidance delineates linkage of related activities by indicating where credit of related activities is associated.

> The Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health, describe the foundational capabilities used to support advancement of preparedness, response, and recovery operations for PHEP recipients.

Performance data are used to inform CDC and partners on recipient progress and areas requiring improvement; facilitate discussions among recipients, key partners, and CDC for opportunities for improvement and sharing of best practices; and inform future PHEP program activities such as work plan and budget plan adjustments during the performance period.

Data Reporting Requirements

CDC's new online platform to collect and maintain all data for the PHEP cooperative agreement is called DSLR Ready Camp. DSLR Ready Camp is built on the Salesforce platform. DSLR Ready Camp will be released for use by recipients in Spring 2025. In the meantime, to meet the reporting requirements outlined in the PHEP cooperative agreement as specified in this document, CDC is providing standardized templates that recipients will use to report

and submit data to CDC. Data submitted via this interim solution will be incorporated into the DSLR Ready Camp system.

Strategy 1

Use CDC's established national preparedness and response capabilities, as applicable, to prioritize a risk-based approach to all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats and modernized laboratory and electronic data systems.

All-Hazards Activities (AHA)

Table 1. Response Readiness Framework: All-Hazards Activities Priorities

Strategy 1: All-Hazard Activities (AHA)	All-hazards risk assessment identifies potential hazards, unique vulnerabilities, and community risk factors that could impact the jurisdiction's public health, medical, and mental/behavioral health infrastructure. Preparedness programs use the identified threats and hazards to strengthen planning and response protocols and capabilities.
Activity	AHA-A: Complete and submit a risk assessment (RA) and data elements (RADE) reflecting the needs of the whole jurisdiction. *AHA-B: Complete and submit multiyear integrated preparedness plans (MYIPP) and data elements. AHA-C: Develop and conduct required exercises. AHA-D: Submit exercise and incident response improvement plan data elements. AHA-E: Maintain capacity and capability to distribute, dispense, administer medical countermeasures, and manage medical material. AHA-F: Review and update CHEMPACK plans. AHA-G: Complete training to ensure baseline competency and integration with preparedness requirements. *PHEP Benchmark
Who must report	62 recipients
Rationale	Risk assessment is an integral part of overall risk management of public health events, and it informs risk mitigation measures and risk communication activities. A systematic all-hazards risk assessment identifies potential hazards, unique vulnerabilities, and community risk factors that could impact the jurisdiction's public health, medical, and mental/behavioral health infrastructure, and guide defensible decision-making and the foundation for appropriate response measures.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. Additional data are collected to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** AHA-A: Complete and submit a risk assessment (RA) and data elements • **AHA-A-RADE-Number: Enter the number of risk assessments (RA) that will be completed and submitted to reflect the needs of the whole jurisdiction.** *Jurisdictions have the autonomy to use a template that meets jurisdictional needs (Threat and Hazard Identification and Risk Assessment (THIRA); Hazard Vulnerability Assessment (HVA); etc.). Recipients may submit either: 1) a single RA coordinated between you and your Cities Readiness Initiative (CRI) local planning jurisdictions or 2) separate risk assessments coordinated by you and your CRI local planning jurisdictions.* • **AHA-A-RADE-DATE: Date RA conducted**. *Date must fall within the expected performance*

period for performance credit. Enter date MM/DD/YYYY.

- ****AHA-A-HE-A-RADE-ROSTER: Risk assessment participants.** *Multiselect or specify the organizations that participated in the RA process. See Appendix B for "roster" choices; local planning jurisdictions participants must include, at a minimum, counties receiving CRI funding. This also meets the HE-A requirement.*
- ****AHA-RADE-RISK1-5: Top five identified risks or hazards.** *Multiselect or specify and rank top five risks from 1, highest ranked risk or hazard to 5, fifth ranked priority risk or hazard for the jurisdiction.*
- **AHA-RADE-REASON1-5: Reason for the ranked risk or hazard that describes the public health vulnerabilities associated with the prioritized risk.** *Multiselect or specify the reason for each of the five ranked risks or hazards.*
- **AHA-A-RADE-EXPERTS: Experts identified for consultation during a public health emergency associated with the prioritized risks.** *Multiselect or specify the type of experts described in response plans to provide consultation during a response for ranked risks or hazards.*
- ****AHA-RADE-AFN: Prioritized access and functional needs (AFN) populations considered in risk assessment**. *Multiselect or specify the populations considered for the RA, see Appendix C.*
- **AHA-A-RADE-SVI**: **Use of CDC/ATSDR Social Vulnerability Index (SVI) to assess community access and functional population needs.** *Select whether this resource was consulted.*
- **AHA-A-RADE-PLACES: Use of CDC/ATSDR PLACES to assess community access and functional population needs.** *Select whether this resource was consulted.*
- **AHA-A-RADE-emPOWER: Use of HHS emPOWER to assess community AFN population needs.** *Select whether this resource was consulted.*

AHA-B: Complete and submit a multiyear integration preparedness plan (MYIPP) and data elements

- ****AHA-B-MYIPP-SUBMIT: Complete and submit MYIPP**. *Consistent with the HSEEP 2020 approach to exercise planning, MYIPP must reflect, at a minimum, three additional years of planning beyond the current budget period, resulting in a four-year progressive exercise and training plan. Jurisdictions are encouraged to follow HSEEP templates but have the autonomy to use a template that best meets the need of the jurisdiction.*
- ****AHA-B-MYIPP-IPPW-DATE: Last date of integrated preparedness planning workshop (IPPW)**. *Enter date MM/DD/YYYY.*
- ****AHA-B-MYIPP-DATE: Last date MYIPP created, updated, or reviewed**. *Enter date MM/DD/YYYY.*
- ****AHA-B-MYIPP-ROSTER-MYIPP:** *Multiselect or specify the organizations that participated (see Appendix B). Coordinate MYIPPs with CRI local planning jurisdictions and frontier, rural, and tribal entities as relevant.*
- ****AHA-B-MYIPP-YEARS: Number of years covered by MYIPP**. *Enter number of years. MYIPP must reflect, at a minimum, three additional years of planning beyond the current budget period, resulting in a four-year progressive exercise and training plan.*
- **AHA-B-MYIPP-RRF: Select RRF areas prioritized during this IPP.** *Multiselect the applicable RRF areas of focus for the budget period.*
- **AHA-B-MYIPP-CAPS: Select capability areas prioritized during this IPP.** *Multiselect one to 15 capabilities described in the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health*

- **AHA-B-MYIPP-EX: Planned exercises**. *See Appendix D*
- **AHA-B-MYIPP-EXSTRENGTH: Select the exercise or response that was used to identify the strength for this IPP.** *Select the relevant exercise. To display jurisdictional options, exercise data must be reported prior to submitting this data element.*
  - **AHA-B-MYIPP-STRENGTH: Select the primary area of strength for the focus of this IPP.** *Select the relevant strength from the corresponding exercise. To display jurisdictional options, exercise data must be reported prior to completing this data element.*
- **AHA-B-MYIPP-EXAOI: Select the exercise or response that was used to identify the area of improvement (AOI) for this IPP.** *Select the relevant exercise. To display jurisdictional options, exercise data must be reported prior to completing this data element.*
  - **AHA-B-MYIPP-AOI: Select the primary area of improvement (AOI) for the focus of this IPP.** *Select the relevant strength from the corresponding exercise. To display jurisdictional options, exercise data must be reported prior to completing this data element.*
- ****AHA-B-MYIPP-PANFLU: Last date pandemic influenza plan or integrated respiratory pathogen pandemic plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-AHA: Last date All-hazards preparedness and response plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-ID: Last date Infectious disease response plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-MCM: Last date MCM distribution and dispensing plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-COOP: Last date COOP plan was created, updated, or reviewed**. *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-VOL: Last date volunteer management plan was created, updated, or reviewed**. *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-CERC: Last date crisis and emergency risk communication (CERC) and information dissemination plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
- **AHA-B-MYIPP-HC: Last date health care system preparedness and response plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*

AHA-C: Develop and conduct required exercises

- ****AHA-C-Exercises**: **Develop and conduct required exercises**. *See Appendix D and Exercise Framework Supplemental Guidance*.

AHA-D: Submit exercise and incident response improvement plan (IP) data elements

- **AHA-D-RESPONSE-NAME:** *Specify the response name.*
- **AHA-D-RESPONSE-START-DATE:** *Enter response activation date MM/DD/YYYY.*
- **AHA-D-RESPONSE-END-DATE:** *Enter response end date MM/DD/YYYY.*
- **AHA-D-RESPONSE-CATEGORY:** *Select or specify the response category.*
- **AHA-D-RESPONSE-ROSTER:** *Multiselect or specify the organizations that participated (see Appendix B).*
- **AHA-D-RESPONSE-OBJECTIVES:** *Multiselect or specify the objectives of the response.*
- **AHA-D-RESPONSE-STRENGTH:** *Create an observation statement focused on an aspect of the response that was performed without challenges or adequately. The statement should reflect a successful response action or attribute.*

	• **AHA-D-RESPONSE-AOI:** *Create an observation statement focused on an aspect of the response that was performed with major challenges or was not able to be performed. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action. The narrative must be consistent with the conclusions reached from the exercise as described in the after-action report (AAR).* • **AHA-D-RESPONSE-CA:** *Describe the corrective action to be undertaken. Analyzing the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness. The MYIPP and workforce development plans must also align with the stated corrective actions.* • ****AHA-D-RESPONSE-IP: Submit exercise and incident response improvement plan (IP) data elements.** *Consistent with the HSEEP 2020 approach to exercise planning, the IP must include all consolidated corrective actions. The IP may be an appendix to an AAR. IP and AAR must be submitted when requested by CDC. See Appendix D and Exercise Framework Supplemental Guidance.* AHA-E: Maintain capacity and capability to distribute, dispense, administer medical countermeasures (MCMs) and manage medical materiel • ****AHA-E: Last date of ASPR/SNS site visit validation for maintaining capacity and capability to distribute, dispense, administer MCMs, and manage medical materiel.** *Enter date MM/DD/YYYY. Work with your CRI local planning jurisdictions to ensure they maintain these capabilities.* AHA-F: Review and update CHEMPACK plans • ****AHA-F: Last date CHEMPACK plans were created, updated, or reviewed**. *Enter date MM/DD/YYYY.* AHA-G: Complete training to ensure baseline competency and integration with preparedness requirements • ****AHA-G: Number of preparedness staff who completed jurisdictions annual training requirement**. *Enter the number of* preparedness *staff trained based on jurisdictions' workforce development plan. Numerator = number of staff who completed training per plan; denominator = total number of staff included in training plan. Credit for AHA-G is associated with LOC-C and WKF-B. See also Appendix F, Evaluation of Trainings and Appendix G, Monitoring and Technical Assistance.*
Additional guidance	Use CDC's established national preparedness and response capabilities, as applicable, to prioritize a risk-based approach to all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats and modernized laboratory and electronic data systems. The AHA is designed to improve your response and recovery readiness when used with the exercise framework. It offers a cohesive and structured process that includes: • Identifying and planning for hazards based on identified risks, • Exercising all-hazard plans, • Recognizing opportunities for improvement, and • Refining plans to further improve response capacity. Along with your CRI local planning jurisdictions, you must maintain the capacity and capability to manage, distribute, dispense, and administer MCM according to the Administration for Strategic Preparedness and Response/Strategic National Stockpile (ASPR/SNS) requirements and guidelines. Direct questions to ASPR regarding requirements on validating receipt, stage, and storage (RSS)

	sites and testing inventory data exchange, along with SNS guidance on developing capacity and capability to receive, distribute, dispense, and administer MCM. See also Hospital Preparedness Program details in the PHEP NOFO CDC-RFA-TU-24-0137 (pages 62-63).
How will this data be used?	Preparedness programs use the identified threats and hazards to strengthen planning and response protocols and capabilities. Refined risk assessment for equitable community planning that addresses prioritized populations for all jurisdictional threats informs community preparedness and improves public health readiness, response, and recovery capability. By implementing standardized emergency management practices, jurisdictions will implement timely public health recommendations and control measures for all hazards and be positioned to identify and investigate, at the earliest signals, incidents with public health impact.
Target (if applicable)	Each recipient must complete all AHA activities and submit required data. • AHA-B: 100% of recipients must complete and submit MYIPP.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis. Following are activities with specific deadlines. • AHA-A: Completed RA and RADE by January 31, 2025. • AHA-A: During the period of performance, RA and RADE must be resubmitted if updated based on improvement planning. • AHA-B: MYIPP must be submitted by June 30, 2025. • AHA-B: Review MYIPP each budget period, update, and submit as needed. • AHA-C: Based on jurisdictions' exercise plans, submit data no later than 90 days after completing discussion-based and operation-based exercises or incident responses. • AHA-D: 90 days after completing discussion-based, operation-based exercises, or incident responses

Public Health Laboratory (LAB)

Table 2. Response Readiness Framework: Public Health Laboratory Capacity Priorities

Strategy 1: Public health laboratory capacity (LAB)	Public health laboratory (PHL) testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens, food, water, and other environmental samples. Laboratory services must support the rapid detection of biological samples for the investigation and containment of hazards to the public's health.
Activity	LAB-A: Participate in LRN-C specimen packaging and shipping exercises (SPaSE) *LAB-B: Participate in LRN-B challenge panels *LAB C: Participate in LRN-C proficiency testing LAB D: Implement specified standards for electronic reporting of LRN-B and LRN-C laboratory data LAB E: Develop surge capacity plans for LRN laboratories and incorporate related surge activities in jurisdictional exercises LAB F: Maintain LRN program fiscal strategy *PHEP Benchmark
Who must report	• LAB A, B, D, E, and F: 50 state recipients, Los Angeles County, New York City, and Washington, D.C. • LAB C: 10 states with LRN-C Level 1 laboratories; 32 states with LRN-C Level 2 laboratories; Los Angeles County; and Washington D.C.
Rationale	PHEP funding supports the Laboratory Response Network for Biological Threats Preparedness (LRN-B) and LRN for Chemical Threats Preparedness (LRN-C) laboratories. PHLs must advance capacity and capability to respond to emerging public health threats through initial detection and rapid electronic results sharing.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** LAB-A: Participate in LRN-C specimen packaging and shipping exercises (SPaSE) • ****LAB-A-SPaSE:** *No data entry is required. Data are received directly from LRN-C. LRN-C. Proficiency test results are shown for PHEP funded tests only. SPaSE are applicable to all LRN-C laboratories (Levels 1, 2, and 3); laboratories must demonstrate proper packaging and shipping of specimens by achieving a 90% passing proficiency. Review reported results from LRN-C for data accuracy. Jurisdictions that either "did not participate or did not pass" must document this as an area for improvement on the IPP/MYIPP.* LAB-B: Participate in LRN-B challenge panels • ****LAB-B-challenge:** *No data entry is required. Data are received directly from LRN-B. Proficiency test results are shown for PHEP-funded tests only. Review reported results from LRN-B for data accuracy of sample testing. No more than one PHEP-funded LRN-B proficiency test can be unsuccessful. Failure to meet the benchmark must be documented as an area for improvement on the IPP/MYIPP.* LAB C: Participate in LRN-C proficiency testing • ****LAB-C-proficiency:** *No data entry is required. Data are received directly from LRN-C. LRN-C.*

	Proficiency test results are shown for PHEP-funded tests only. Core methods are applicable to Level 1 and Level 2 laboratories; additional methods are applicable to Level 1 laboratories (up to four additional methods) and are optional for Level 2 laboratories. At least one LRN-C laboratory in the jurisdiction must participate in the exercise. While, core method testing is applicable for both Level 1 and 2 LRN-C laboratories, only Level 1 laboratories must meet the 90% passing proficiency benchmark; at least one proficiency test must be passed for Level 2 laboratories. Likewise, for the additional methods, only Level 1 laboratories must meet the 90% passing proficiency benchmark. Review reported results from LRN-C for data accuracy. Failure to meet the benchmark must be documented as an area for improvement on the IPP/MYIPP. LAB D: Implement specified standards for electronic reporting of LRN-B and LRN-C laboratory data • ****LAB-D:** *No data entry is required. Successfully implementing specified standards for electronic reporting of LRN-B and LRN-C laboratory data is demonstrated by completing LAB A-C (as applicable).* LAB E: Develop surge capacity plans for LRN laboratories • ****LAB-E: Last date laboratory surge plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY.* LAB F: Maintain LRN program fiscal strategy • ****LAB-F: Last date laboratory fiscal allocations was created, updated, or reviewed.** *Enter date MM/DD/YYYY.*
Additional guidance	Laboratory services must support the rapid detection of biological or chemical samples for the investigation and containment of hazards to the public's health. • LAB-B: Recipients with PHEP funding for LRN-B laboratory capacity must pass challenge panel exercises as defined by LRN. • LAB-C: Recipients with PHEP funding for LRN-C laboratory capacity must pass proficiency exercises (core and additional) as defined by LRN. • LAB-D: Recipients with PHEP-funded laboratories must implement specified standards for electronic reporting of LRN-B and LRN-C data for routine and emergency reporting. • LAB-E: Recipients with PHEP-funded laboratories must develop and exercise LRN surge plans.
How will this data be used?	CDC will use these data to verify if the laboratory is qualified to test for certain biological and chemical agents and demonstrate ongoing proficiency of testing capabilities. The LRN proficiency testing challenge counts toward the PHEP programmatic benchmark.
Target (if applicable)	Each recipient must complete all LAB activities (as applicable). Data is received from LRN. • LAB-A-SPaSE: 90% passing proficiency. • LAB-B-LRN-B: LRN-B proficiency testing challenge counts toward PHEP programmatic benchmark. No more than one PHEP-funded LRN-B proficiency test can be unsuccessful. Laboratory questions regarding the LRN PT and the PHEP benchmark, should be directed to the LRN Helpdesk. • LAB-C-LRN-C: o Core: 90% passing proficiency for Level 1 labs and at least one proficiency test must be passed for Level 2 laboratories o Additional: 90% passing proficiency for Level 1 labs
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Data Modernization (DM)

Table 3. Response Readiness Framework: Data Modernization Priorities

Strategy 1: Data modernization (DM)	CDC's Public Health Data Strategy is a mission-focused and goal-driven two-year plan providing accountability for data, technology, policy and administrative actions necessary to meet public health data goals. Its measurable milestones address challenges in data exchange between healthcare organizations and public health authorities and between state, tribal, local, territorial, and federal public health authorities. Data modernization is essential for protecting health and improving lives during public health emergencies.
Activity	DM-A: Incorporate data systems and data source functionality and infrastructure in public health emergency response plans DM-B: Incorporate testing of the functionality and infrastructure of data systems and data sources into jurisdictional exercises
Who must report	62 recipients
Rationale	An effective plan for information and data sharing increases the capacity of public health agencies to electronically exchange accurate health data and information from a variety of sources. Access to timely, relevant information is critical to accurately assess a situation and take appropriate actions to mitigate adverse public health consequences and promote healthy outcomes.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** DM-A: Incorporate data systems and data source functionality and infrastructure in Public Health Emergency response plans • ****DM-A: Last date emergency response plan was created, updated, or reviewed to address data modernization.** *Enter date MM/DD/YYYY.* DM-B: Incorporate testing of the functionality and infrastructure of data systems and data sources into jurisdictional exercises • ****DM-B-CORE: Core public health data source or system selected for modernization.** *Select or specify a public health information system or data source that meets the priorities identified by your jurisdiction for modernization to improve response readiness.* • ****DM-B-BASELINE:** *Describe the baseline functionality for the selected core data source or system.* • ****DM-B: Date core data source or system exercised.** *Enter date MM/DD/YYYY.* • ****DM-B-AOI: Describe the AOI for the selected core data source or system.** *Create an observation statement focused on an aspect of the exercise that was performed with major challenges or was not able to be performed. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action. The narrative must be consistent with the conclusions reached from the exercise as described in the AAR.* • ****DM-B-CA: Describe the corrective action for the selected core data source or system.** *Corrective Action: Describe the corrective action to be undertaken. Analyzing the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness. The MYIPP and workforce development plan must also align with the stated corrective actions.*
Additional guidance	Recipients must modernize data and data systems by demonstrating improvements through exercising at least three core public health data sources or systems prioritized by the jurisdiction or

	as described in the Public Health Data Strategy.
How will this data be used?	Completion of DM activities will ensure that the health departments, hospitals, and laboratories are prepared at the state and local levels to easily exchange information across data collection and other data systems in real-time to respond effectively to public health emergencies.
Target (if applicable)	Each recipient must complete all DM activities and submit required data.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Health Equity (HE)

Table 4a. Response Readiness Framework: Health Equity Priorities

Strategy 1–3: Health equity (HE)	Health equity (HE) in public health preparedness and response refers to the principle and practice of ensuring that all communities and people have fair access to the resources, strategies, and interventions necessary to protect health before, during, and after a public health emergency or disaster. This concept recognizes that some populations may be at greater risk for disproportionate outcomes given socioeconomic status, geography, age, disability, race, ethnicity, or other characteristics historically linked to discrimination or exclusion. Note: HE is applicable across all three strategies and is addressed in relevant sections.
Activity	*HE-A: Update risk assessment to include people who are disproportionately impacted by public health emergencies *PHEP Benchmark
Who must report	62 recipients
Rationale	By focusing on HE in public health preparedness and response, recipients aim to minimize the adverse effects of a public health emergency on populations likely to be disproportionality affected or those with access and functional needs while promoting the well-being of all community members regardless of their background or circumstances.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** HE-A: Update risk assessment to include people who are disproportionately impacted by public health emergencies • **AHA-A-HE-A-RADE-ROSTER: Risk assessment participants**. *Multiselect or specify the organizations that participated in the RA process. See Appendix B for "roster" choices; local planning jurisdictions participants must include, at a minimum, counties receiving CRI funding. Credit for HE-A is associated with AHA-A.*
Additional guidance	Providing equitable resources, strategies, and interventions must be accounted for during all phases of the preparedness life cycle and include: • Identifying and understanding the specific needs of different communities. • Developing and implementing preparedness plans that account for diverse needs. • Ensuring that response efforts are culturally sensitive and linguistically appropriate. • Providing equitable access to medical care, information, resources (such as vaccines or medications), and support services during a crisis. • Engaging with communities to build trust and encourage participation in preparedness activities. • Addressing underlying social determinants of health that contribute to disparities in outcomes. Recipients must complete a RA that identifies prioritized populations and those that are potentially disproportionately affected or have access and functional needs, given the identified risks; see AHA-A). See also CDC Access and Functional Needs Toolkit.

How will this data be used?	PHEP aims to improve preparedness and response support for communities facing health disparities by integrating HE practices into preparedness and response plans. Recipients will be assessed based on whether HE is incorporated into the jurisdictions' preparedness and response plans and exercises.
Target (if applicable)	Each recipient must complete all HE activities and submit required data. • HE-A: 100% of recipients must complete and submit RA that demonstrate HE principles, *credit for HE-A is associated with AHA-A*.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Strategy 2

Use CDC's established national preparedness and response capabilities, as applicable, to improve whole community readiness, response, and recovery through enhanced partnerships and improved communication systems for timely situational awareness and risk communication.

Partnerships (PAR)

Table 5. Response Readiness Framework: Partnership Priority

Strategy 2: Partnerships (PAR)	Public health partners for preparedness and response are a diverse set of stakeholders who collaborate to plan for, respond to, and recover from public health emergencies. These partners come from various sectors and possess knowledge, skills, resources, and perspectives that contribute to a comprehensive understanding of the community.
Activity	*PAR-A: Include critical response and recovery partners in required plans and exercises *PHEP Benchmark
Who must report	62 recipients
Rationale	Partner inclusion will also increase knowledge and support for community involvement in jurisdictions' preparedness and response efforts. CDC encourages PHEP recipients to effectively partner with local, state, territorial, tribal, and federal governments; private sector organizations, including community and non-governmental organizations, and other entities as appropriate to create opportunities to coordinate, amplify, and support whole community planning, readiness, and response goals.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** PAR-A: Include critical response and recovery partners in required plans and exercises • ****PAR-A**: **Include critical response and recovery partners in required plans and exercises.** *Multiselect or specify the organizational partners that participated in the activity. See Appendix B for "roster" choices. Credit for PAR-A is associated with all RRF activities that require partner engagement.*
Additional guidance	Strong, fully engaged community (jurisdictional) partners are critical for public health preparedness. Public and private partners are often perceived as trusted sources and support preparedness by working with the health department to provide input and mitigate identified health risks for the communities they serve. Partners also help identify community roles and responsibilities and coordinate the delivery of essential health services to strengthen community resilience as early as possible before, during, and after a public health emergency. Jurisdictions can leverage partner insights to develop and disseminate information that address the needs of at-risk populations that may be disproportionately affected by a public health response. See also partner detail in the PHEP NOFO CDC-RFA-TU-24-0137 (page 60). Engaging community partners that work with at-risk populations is essential for preparedness planning. The 2019 Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAIA), Public Law No. 116-22 requires the health and medical needs of all individuals, including at-risk populations, be protected. The Americans with Disabilities Act (ADA) also protects people with disabilities and prohibits discrimination. Updated in 2008, the ADA Amendments Act (ADAAA)

	mandates that individuals with access and functional needs be included in all disaster plans developed for a community under Title II. PAHPAIA defines at-risk individuals as children, pregnant women, older adults, individuals with disabilities, or others who may have access or functional needs in the event of a public health emergency, as determined by the Secretary of Health and Human Services.
How will this data be used?	CDC will use this information to verify jurisdictions adopt a whole community planning approach.
Target (if applicable)	Each recipient must complete the PAR activity and submit required data. • PAR: 100% of recipients must complete. *Credit for PAR-A is associated with all RRF activities that require partner engagement.*
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Risk Communications (RSK)

Table 6. Response Readiness Framework: Risk Communication (RSK) Priorities

Strategy 2: Risk communications (RSK)	Providing emergency public information and warnings during a public health event is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel. Timely risk communication is necessary during all phases of an incident through multiple methods to a variety of audiences, including communities and incident management partners, to understand the current situation and take appropriate actions.
Activity	RSK-A: Develop or update CERC and information dissemination plans *RSK-B: Identify and implement communication surveillance, media relations, and digital communication strategies in exercises RSK-C: Identify and implement specific CERC activities that meet the diverse needs of communities of focus *PHEP Benchmark
Who must report	62 recipients
Rationale	An effective plan for information and data sharing increases the capacity of public health agencies to electronically exchange accurate health data and information from a variety of sources during incidents.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** RSK-A: Develop or update crisis and emergency risk communication (CERC) and information dissemination plans • **RSK-A-DATE: Last date CERC and information dissemination plan was created, updated, or reviewed** *Enter date MM/DD/YYYY.* RSK-B: Identify and implement communication surveillance, media relations, and digital communication strategies in exercises • **RSK-B: Identify and implement communication surveillance, media relations, and digital communication strategies in exercises.** *Multiselect or specify the communication objectives included in exercises. Credit for RSK-B is associated with AHA-C (see Appendix D).* RSK-C: Identify and implement specific CERC activities that meet the diverse needs of communities of focus • **RSK-C: Identify and implement specific CERC activities that meet the diverse needs of communities of focus.** *Report engagement with established CERC communities of practice involved with preparedness, response, and recovery activities. Credit for RSK-C is associated with WKF-C and exercise requirements (see Appendix D).*
Additional guidance	Recipients must engage partners that represent prioritized populations to develop and disseminate culturally appropriate messages for use during public health responses. In addition to clear messaging for the whole community, an effective CERC plan must address the capacity of public health agencies to electronically exchange accurate health data and information from a variety of sources during incidents. Access to timely, relevant information flow is critical to

	incident partners' ability to understand the current situation and take appropriate actions. Engage partners and exercise the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, territorial, and tribal levels of government and the private sector.
How will this data be used?	CDC will evaluate recipient's ability to identify and incorporate best practices for strengthening risk communication and reducing mis-/dis-information into plans for communication during public health emergencies.
Target (if applicable)	Each recipient must complete all RSK activities and submit required data. • RSK-B: 100% of recipients must complete. Credit for *RSK-B is associated with AHA-C.*
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Recovery (REC)

Table 7. Response Readiness Framework: Recovery (REC) Priorities

Strategy 2: Recovery activity (REC)	Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations.
Activity	REC-A: Incorporate recovery operations into public health MYIPP
Who must report	62 recipients
Rationale	It is important to prioritize community recovery efforts into response and preparedness plans to support health department reconstitution and incorporate lessons learned from responses.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** REC-A: Incorporate recovery operations into public health multiyear integrated preparedness plans • **REC-A: Last date recovery plan was created, updated, or reviewed.** *Recipients have the autonomy to define protocols for recovery but must document when recovery is incorporated into base plans or a stand-alone recovery plan annex. Enter date MM/DD/YYYY.*
Additional guidance	Communities should consider collaborating with jurisdictional partners to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to a level of functioning comparable to pre-incident levels or improved levels where possible. • FEMA. (2022). *Community Recovery Management Toolkit*. Retrieved from https://www.fema.gov/emergency-managers/national-preparedness/frameworks/community-recovery-management-toolkit. • FEMA. (2021). *FEMA's Recovery and Resilience Resource Library*. Retrieved from https://www.fema.gov/emergency-managers/practitioners/recovery-resilience-resource-library. • ASPR, TRACIE. (2022). *Topic Collection: Recovery Planning*. Retrieved from https://asprtracie.hhs.gov/technical-resources/18/recovery-planning/110.
How will this data be used?	Incorporating recovery into the preparedness life cycle helps ensure the earliest possible recovery and return of the public health system to pre-incident levels or improved functioning post response. During this performance period, recipients must progressively exercise recovery objectives to demonstrate how the jurisdiction's plans will readily return the community to routine public health function post response. Partners involved in response and recovery should be actively engaged in training and exercises. Lessons learned from exercises should prompt updates to relevant plans and be documented as strengths or areas for improvements in the MYIPP (see AHA-B).
Target (if applicable)	Each recipient must complete the REC activity and submit all required data.
Recommended data source	Data must be compiled by the recipient while conducting the activity. Data can be stored in any format that is available to the recipient.
Reporting frequency	Progress on all activities must be reported, at minimum, on a quarterly basis. Activities with specific deadlines are noted below.

	• REC-A must be completed by June 30, 2025; thereafter, review each budget period and update as needed.

Health Equity (HE)

Table 4b. Response Readiness Framework: Health Equity Priorities

Strategy 1–3: Health Equity (HE)	Health equity (HE) in public health preparedness and response refers to the principle and practice of ensuring that all communities and people have fair access to the resources, strategies, and interventions necessary to protect health before, during, and after a public health emergency or disaster. This concept recognizes that some populations may be at greater risk for disproportionate outcomes given socioeconomic status, geography, age, disability, race, ethnicity, or other characteristics historically linked to discrimination or exclusion. Note: HE is applicable across all three strategies and is addressed in relevant sections.
Activity	HE-B: Engage partners to incorporate HE principles into preparedness plans and exercises
Who must report	62 recipients
Rationale	By focusing on HE in public health preparedness and response, recipients aim to minimize the adverse effects of a public health emergency on populations likely to be disproportionality affected or those with access and functional needs while promoting the well-being of all community members regardless of their background or circumstances.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** HE-B: Engage partners to incorporate health equity principles into preparedness plans and exercises • ****HE-B**: **Engage partners to incorporate HE principles into preparedness plans and exercises.** *See Appendix B for "roster" choices. Credit for HE-B is associated with exercise requirements (see Appendix D).*
Additional guidance	Providing equitable resources, strategies, and interventions must be accounted for during all phases of the preparedness life cycle and include: • Identifying and understanding the specific needs of different communities. • Developing and implementing preparedness plans that account for diverse needs. • Ensuring that response efforts are culturally sensitive and linguistically appropriate. • Providing equitable access to medical care, information, resources (such as vaccines or medications), and support services during a crisis. • Engaging with communities to build trust and encourage participation in preparedness activities. • Addressing underlying social determinants of health that contribute to disparities in outcomes. Recipients must complete a risk assessment that identifies prioritized populations, those that are potentially disproportionately affected or have access and functional needs, given the identified risks; see AHA-A). **See also CDC Access and Functional Needs Toolkit.**
How will this data be used?	PHEP aims to improve preparedness and response support for communities facing health disparities by integrating health equity practices into preparedness and response plans. Recipients will be assessed based on how well health equity is incorporated into the jurisdictions' preparedness and response plans and exercises.
Target (if applicable)	Each recipient must complete the HE activity and submit all required data.

Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Strategy 3

Use CDC's established national preparedness and response capabilities, as applicable, to improve capacity to meet jurisdictional administrative, budget, and public health surge management needs and to improve public health response workforce recruitment, retention, resilience, and mental health.

Administrative and Budget Preparedness (ADM)

Table 8. Response Readiness Framework: Administrative and Budget Preparedness (ADM) Priorities

Strategy 3: Administrative and budget preparedness (ADM)	ADM activities intend to improve the overall policies, systems, and mechanisms that support human and financial resource requirements that underpin the agency's ability to respond rapidly to a new public health threat. Flexible and scalable policies, processes, and systems will improve administrative and budget preparedness and ensure timely access to resources for supporting jurisdictional responses.
Activity	ADM-A: Update administrative preparedness plans using lessons learned from emergency responses ADM-B: Integrate administrative and budget preparedness recommendations into training and exercises ADM-C: Improve adherence to guidance related to spending, lapsing of funds, awarding of local contracts, and other administrative and budgetary requirements *ADM-D: Reduce the time PHEP-funded positions at the recipient level remain vacant *ADM-E: Distribute or award funds to local health departments and tribal entities within 90 days after the start of the budget period *PHEP Benchmark
Who must report	62 recipients
Rationale	Recipients must comply with federal regulations as stated in the terms and conditions of the funding award for appropriate use of federal funds including restrictions, tracking, and reporting requirements. Recipients must ensure fiscal and programmatic accountability are in place to document authorized, disbursed, and unobligated funds and demonstrate overall annual improvement.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** ADM-A: Update administrative preparedness plans using lessons learned from emergency responses • **ADM-A-DATE: Last date ADM plan was created, updated, or reviewed.** *Update administrative preparedness plans using lessons learned from emergency responses. Enter date MM/DD/YYYY.* ADM-B: Integrate administrative and budget preparedness recommendations into training and exercises • **ADM-B: Integrate ADM recommendations into training and exercises.** *Credit for ADM-B is associated with AHA-C (see Appendix D), AHA-G, and WKF-B.*

	ADM-C: Improve adherence to guidance related to spending, lapsing of funds, awarding of local contracts, and other administrative and budgetary requirements • **ADM-C-MON: Improve adherence to guidance related to spending, lapsing of funds, awarding of local contracts, and other ADM requirements.** *Recipients must monitor local subrecipients ADM and provide information upon request. No additional data entry is required.* ADM-D: Reduce the time PHEP-funded positions at the recipient level remain vacant • ****ADM-D-RECIPIENT: Reduce the time PHEP-funded positions at the recipient level remain vacant.** *Recipients will provide quarterly updates on all staff at the recipient level funded by PHEP. Include any permanent, temporary, or contract staff employed using PHEP dollars. There is no need to estimate full-time equivalent (FTEs) percentages. Each quarter recipients will report the total number of staff on the last day of the quarter (ADM-D1), number of new hires in the quarter (ADM-D2), and number of staff at the start of the quarter (ADM-D3). CDC will automatically calculate the retention rate (D1-D2)/D3*100). Credit for ADM-D is associated with WKF-A.* • ****ADM-D-LOCAL: Include provisions in subrecipient monitoring plans that require local health departments to report vacancies through required reporting mechanisms.** *Recipients will provide quarterly updates on all local jurisdictional staff funded by PHEP. Include any permanent, temporary, or contract staff employed using PHEP dollars. There is no need to estimate full-time equivalent (FTEs) percentages. Each quarter recipients will report the total number of local jurisdictional staff on the last day of the quarter (ADM-D1), number of new hires in the quarter (ADM-D2), and number of staff at the start of the quarter (ADM-D3). CDC will automatically calculate the retention rate (D1-D2)/D3*100). Credit for ADM-D is associated with WKF-A.* ADM-E: Distribute or award funds to local health departments and tribal entities within 90 days after the start of the budget period • ****ADM-E: Date PHEP funds received (Notice of Award).** *Enter date MM/DD/YYYY.* • ****ADM-E-PROCUREMENT-DATE: Date local sub-recipient contract procurement was approved.** *The procurement date is the date of official approval to move forward with the procurement, which is defined as obtaining all necessary approvals to allow the procurement to take place. Necessary approvals are determined by the recipient agency and may include multiple levels of leadership approval within an agency or specific processes to acquire a vendor to perform a service or provide support. An approval date must be entered for each local subrecipient contract listed in the budget. Enter date MM/DD/YYYY.* • ****ADM-E-SUBCONTRACT-DATE: Date local sub-recipient contract executed.** *Contract execution is the date all relevant parties sign the contract, and the contract is finalized. An execution date must be entered for each local subrecipient contract listed in the budget. Enter date MM/DD/YYYY.* • **ADM-E-90MET: Allocate all funds to local health departments within 90 days.** *Select how well this activity was performed overall.* • **ADM-E-90BARRIERS:** *Multiselect or specify the challenges for not meeting the 90-day target for any local subrecipient contracts.*
Additional guidance	ADM-B: Recipients must have PHEP-funded staff complete the jurisdiction's minimum training requirements and participate in exercises as relevant (see AHA-G & WKF-B).
How will this data be used?	This measure intends to understand how recipients have improved their overall procurement process by implementing these policies by assessing the timeliness of an agency's procurement

	cycle time. This information would further help in identifying the need for continued funding and improvements or opportunities in the public health system's ability to spend money more efficiently.
Target (if applicable)	Each recipient must complete all ADM activities and submit required data. • ADM-D: 100% of recipients must show progress toward reducing workforce vacancies. *Credit for ADM-D is associated with WKF-A*. • ADM-E: 100% recipients (with applicable subcontracts) must award all PHEP funds to local and tribal entities within 90 days.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis. Following are activities with specific deadlines. • ADM-A must be completed by June 30, 2025; thereafter, review each budget period and update as needed. • ADM-B must be completed by June 30, 2026; thereafter, review each budget period and update as needed.

Workforce (WKF)

Table 9. Response Readiness Framework: Workforce (WKF) Priorities

Strategy 3: Workforce (WKF)	A sufficient public health workforce is needed to accelerate prevention, preparedness, and response to emerging health threats and improve public health outcomes. Increased hiring and retention of diverse public health staff is an intended outcome during this period of performance. Types of hiring activities include, but are not limited to, expanding recruitment efforts, creating new positions, improving hiring incentives, and streamlining new hiring mechanisms.
Activity	*WKF-A: Develop plans, processes, and procedures to recruit, hire, train, and retain a highly qualified and diverse workforce WKF-B: Provide guidance, direction, and training to maintain a ready responder workforce across the entire health department WKF-C: Actively engage in at least one community of practice that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency *PHEP Benchmark
Who must report	• WKF-A & WKF-B: 62 recipients • WKF-C: 50 state recipients, Chicago, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.; recommended for the remaining territories and freely associated states
Rationale	Maintaining a workforce development plan that address a coordinated approach to training staff and implementing procedural improvements for a well-qualified, response-ready workforce is essential for administering and promoting public health practices. The intent of this measure is to understand the number of positions supported by PHEP funds within health departments. This includes positions supported within health departments that have received direct funding, and positions supported within local health departments from funds distributed from state health department recipients.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** WKF-A: Develop plans, processes, and procedures to recruit, hire, train, and retain a highly qualified and diverse workforce • ****WKF-A-ADM-D-VACANT:** Develop plans, processes, and procedures to recruit, hire, train, and retain a highly qualified and diverse workforce. *Recipients will report the number of vacant positions for permanent staff by job classification. If staff positions cover several job classification categories, select the category that reflects most of the staff responsibility (>50% of workload), do not double-count staff vacancies for those that cross categories.* • ****WKF-A-ADM-D:** Develop plans, processes, and procedures to recruit, hire, train, and retain a highly qualified and diverse workforce. *Vacancy rates will be validated from personnel budget line items (BLI), in the budget work plan. Baseline rates are calculated from the application budget and subsequent rates are based on respective quarterly progress updates. Numerator = number of staff vacancies earmarked in the personnel BLI; denominator = total number of personnel allocated. No additional data entry is required. Credit for WKF-A is associated with ADM-D.* WKF-B: Provide guidance, direction, and training to maintain a ready responder workforce across the entire health department

	• **WKF-B-AHA-G-DATE-PREPSTAFF: Last date workforce development plan was created, updated, or reviewed to address PHEP-funded, preparedness staff training.** *Enter date MM/DD/YYYY. Credit for WKF-B is associate with AHA-G.* • **WKF-B-DATE-SURGE: Last date workforce development plan was created, updated, or reviewed to address surge staff training.** *The workforce development plan (or equivalent) must address surge staff training. Recipients must have surge staff complete jurisdiction's minimum training requirements. Staff may be counted as trained if they participated in the specified training at any point. Enter date MM/DD/YYYY. Credit for WKF-B is associated with AHA-G.* • ****WKF-B-LOC-B-TOTAL: Total number of surge staff**. *Enter the projected number of surge staff identified to support a large-scale response activation. Credit for WKF-B is associated with AHA-G and LOC-C.* • **WKF-B- LOC-B-ROLES: Surge staff participants/role.** *Multiselect or specify the roles identified for surge in the event the public health response exceeds current staffing levels (see Appendix B)* WKF-C: Actively engage in at least one community of practice (CoP) that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency • ****WKF-C-COP:** *Recipients must participate in a CoP. Multiselect or specify at least one CoP that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency. See Appendix E for additional information about One PHEP CoP.* • ****WKF-C-BP: Period of participation.** *Multiselect the budget periods that the jurisdiction participated in a CoP.* • ****WKF-C-TOPICS:** *Multiselect or specify the topic of focus the CoP addressed* • ****WKF-C-AOI: Area of Improvement**. *Given the selected topics of the CoP, create an observation statement that addressed an area of improvement for the jurisdiction. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.* • ****WKF-C-CA: Corrective Action**: *Describe the corrective action that resulted from participating in the CoP. Analyzing the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness.* • **WKF-C-BEST-PRACTICE:** *Describe a best or promising practice that resulted from participating in the CoP. Create an observation statement focused on an aspect of the practice that conveys a successful action or attribute adopted by the jurisdiction. Uploading examples is optional.*
Additional guidance	Throughout the performance period, monitor and mitigate existing or anticipated staff vacancies and develop strategies for surge staff to support a range of emergency responses. Include health department preparedness staff and surge staff outside the preparedness program who fill key incident command roles in preparedness training and periodic exercises. Primary response staff must participate in exercises on a rotational basis as determined by the health department. PHEP staff and surge jurisdictional staff must participate in full-scale exercises involving federal agencies. Actively engage in a CoP that discusses gaps, strengths, barriers and improves PHEP workforce capacity and resiliency. See also Appendix E, CDC One PHEP CoP.
How will this data be	Workforce activities will improve capacity to meet routine and surge needs by increasing support,

used?	retention, and resiliency of a well-qualified, diverse, and response ready public health staff.
Target (if applicable)	Each recipient must complete all WKF activities and submit required data. WKF-A: Recipients must reduce workforce vacancy rates funded by PHEP. The benchmark is dependent on the jurisdiction's vacancy rate at the start of the five-year performance period. • Jurisdictions with less than or equal to 20% vacancy rates must decrease vacancy **to 10%** by the end of the five-year performance period. • Jurisdictions with greater than 20% vacancy rates must demonstrate a **decrease of at least 10%** by the end of the five-year performance period.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Local Support (LOC)

Table 10. Response Readiness Framework: Local support (LOC) Priorities

Strategy 3: Local support (LOC)	States must support local readiness efforts and ensure local planning jurisdictions are prepared to respond and recover from public health emergencies. The local support activities pertain to all local planning jurisdictions, tribal entities, rural partners, and other subrecipients within recipients' geographic boundaries.
Activity	LOC-A: Engage local jurisdictions, including rural, frontier, and tribal entities, in public health preparedness planning and exercises LOC-B: Provide direct technical assistance and surge support staffing to increase local readiness LOC-C: Include local representation on senior advisory committees (SAC)
Who must report	50 state recipients
Rationale	Local planning jurisdictions are critical to advancing readiness and mitigating the impacts of morbidity and mortality prior to or during a public health emergency.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** LOC-A: Engage local jurisdictions, including rural, frontier, and tribal entities, in public health preparedness planning and exercises • **LOC-A-PLANS: Engage local jurisdictions in public health preparedness planning.** *Multiselect or specify the local planning jurisdictions that participated. See Appendix B for "roster" choices.* • **LOC-A-RURAL: Engage rural and frontier jurisdictions (as applicable) in public health preparedness planning.** *Multiselect or specify the local planning jurisdictions that participated. See Appendix B for "roster" choices.* • **LOC-A-TRIBE: Engage tribal entities (as applicable) in public health preparedness planning.** *Multiselect or specify the local planning jurisdictions that participated. See Appendix B for "roster" choices.* LOC-B: Provide direct technical assistance and surge support staffing to increase local readiness • **LOC-B: Last date surge support plan was created, updated, or reviewed.** *Enter date MM/DD/YYYY. Credit for LOC-B is associated with AHA-G and WKF-B.* LOC-C: Include local representation on senior advisory committees (SAC) • **LOC-C-HE-C-ROSTER: Include health equity representatives on the SAC** *to increase advocacy for communities of focus. Multiselect or specify the organizations that participated (see Appendix B). Credit for LOC-C associated with HE-C.* • **LOC-C-BP: Period of participation** *Multiselect the budget periods that the jurisdiction participated in a SAC.* • **LOC-C-TOPICS**: *Multiselect or specify the topic of focus addressed by the SAC.* • **LOC-C-AOI:** *Given the selected topics of the SAC, create an observation statement that addressed an area of improvement for the jurisdiction. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.* • **LOC-C-CA:** *Describe the corrective action that resulted from participating in the SAC. Analyzing*

	the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness. • **LOC-C-BEST-PRACTICE:** *Describe a best or promising practice that resulted from participating in the SAC. Create an observation statement focused on an aspect of the practice that conveys a successful action or attribute adopted by the jurisdiction.*
Additional guidance	States must assure local planning jurisdictions have or have access to resources that support all preparedness, response, and recovery activities. • LOC-A: Engage local jurisdictions, including rural, frontier, and tribal entities, in public health preparedness planning and exercise. • LOC-C: States must include, at a minimum, one local jurisdictional representative on the jurisdiction's advisory committee.
How will this data be used?	These data verify how recipients assure local planning jurisdictions are involved in developing and implementing capacity-building activities that support local readiness and response for plans, exercises, and surge needs.
Target (if applicable)	Each recipient must complete LOC activities and submit all required data.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Health Equity (HE)

Table 4c. Response Readiness Framework: Health Equity Priorities

Strategy 1–3: Health Equity (HE)	Health equity (HE) in public health preparedness and response refers to the principle and practice of ensuring that all communities and people have fair access to the resources, strategies, and interventions necessary to protect health before, during, and after a public health emergency or disaster. This concept recognizes that some populations may be at greater risk for disproportionate outcomes given socioeconomic status, geography, age, disability, race, ethnicity, or other characteristics historically linked to discrimination or exclusion. Note: HE is applicable across all three strategies and is addressed in relevant sections.
Activity	HE-C: Include HE representatives on senior advisory committees (SAC) to increase advocacy for communities of focus.
Who must report	62 recipients
Rationale	By focusing on HE in public health preparedness and response, recipients aim to minimize the adverse effects of a public health emergency on populations likely to be disproportionality affected or those with access and functional needs while promoting the well-being of all community members regardless of their background or circumstances.
Data elements	Each recipient must submit the described data elements to CDC. Data marked with "**" contributes to recipients' performance evaluation. CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. **The technical specification for all data elements is described in the following bullets. Relevant answer choices are found in Appendix B, Appendix C, or as specified. Data will be submitted via DSLR Ready Camp.** HE-C: Include health equity representatives on senior advisory committees (SAC) to increase advocacy for communities of focus • ****HE-C-LOC-C-ROSTER**: **Include HE representatives on the SAC** *to increase advocacy for communities of focus***.** *Multiselect or specify the organizations that participated (see Appendix B). Credit for HE-C is associated with LOC-C.*
Additional guidance	Providing equitable resources, strategies, and interventions must be accounted for during all phases of the preparedness life cycle and include: • Identifying and understanding the specific needs of different communities. • Developing and implementing preparedness plans that account for diverse needs. • Ensuring that response efforts are culturally sensitive and linguistically appropriate. • Providing equitable access to medical care, information, resources (such as vaccines or medications), and support services during a crisis. • Engaging with communities to build trust and encourage participation in preparedness activities. • Addressing underlying social determinants of health that contribute to disparities in outcomes. Recipients must complete a RA that identifies prioritized populations and those that are potentially disproportionately affected or have access and functional needs, given the identified risks; see AHA-A). See also **CDC Access and Functional Needs Toolkit.**
How will this data be used?	PHEP aims to improve preparedness and response support for communities facing health disparities by integrating HE practices into preparedness and response plans. CDC will assess recipients based on how well HE is incorporated into the jurisdictions' preparedness and response

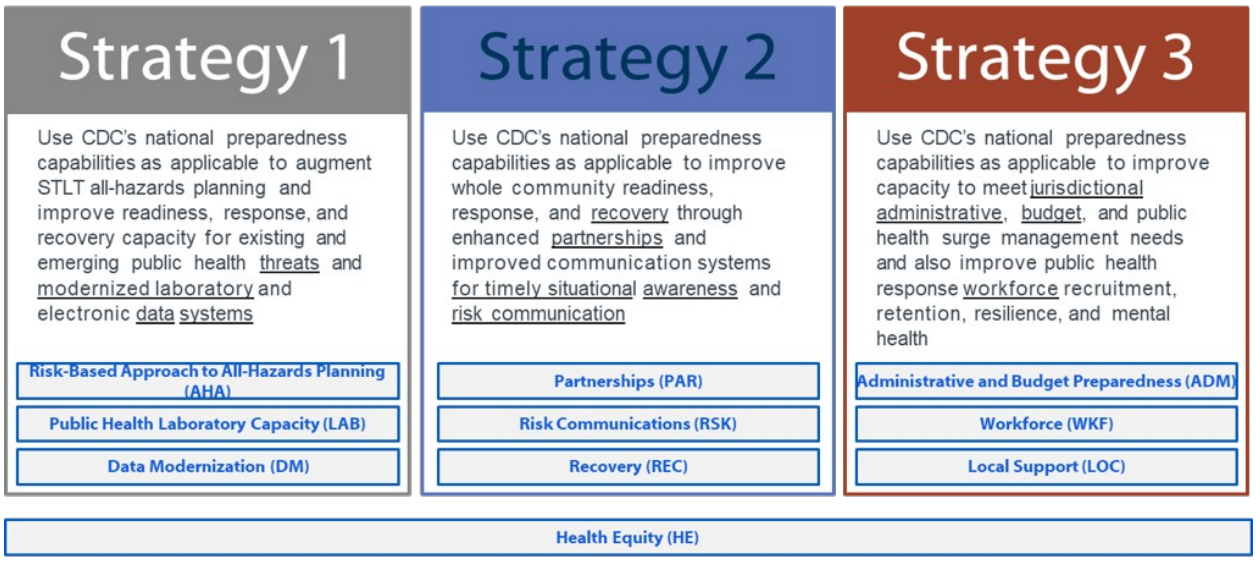
	plans and exercises.
Target (if applicable)	Each recipient must complete the HE activity and submit all required data.
Recommended data source	Recipients must compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis.

Appendix A: PHEP Logic Model

The logic model shows the strategies and activities of the program along with the outcomes we expect over time. You must achieve and report on the outcomes for the five-year performance period.

Strategies and activities	Short-term outcomes	Intermediate outcomes	Long-term outcomes
Strategy 1 (ST1) • Use CDC's established national preparedness and response capabilities, as applicable, to prioritize a risk-based approach to all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats and modernized laboratory and electronic data systems **Strategy 2 (ST2)** • Use CDC's established national preparedness and response capabilities, as applicable, to improve whole community readiness, response, and recovery through enhanced	ST1 • Refined risk assessment for equitable community planning that address prioritized populations for all jurisdictional threats • Completed exercise requirements that identify areas for improved readiness, response, and recovery • Modernized electronic data systems to advance timely identification and reporting of incidents or events that require public health action • Improved capacity of public health laboratory networks and surveillance systems to detect and report existing and emerging public health threats	ST1 • Improved public health readiness, response, and recovery capability that follows standardized emergency management practices • Implemented timely public health recommendations and control measures for all hazards • Earliest identification and investigation of incidents with public health impact • Enhanced ability of laboratories to respond to public health incidents by applying modern methods ST2 • Timely communication of situational awareness and risk information	All strategies (ST1-3) • Earliest possible recovery and return of the public health system to pre-incident levels or improved functioning • Prevent or reduced morbidity and mortality for all impacted populations from incidents with public health consequences whose scale, rapid onset, or unpredictability stresses the public health system

Strategies and activities	Short-term outcomes	Intermediate outcomes	Long-term outcomes
improved communication systems for timely situational awareness and risk communication **Strategy 3 (ST3)** • Use CDC's established national preparedness and response capabilities, as applicable, to improve capacity to meet jurisdictional administrative, budget, and public health surge management needs and to improve public health response workforce recruitment, retention, resilience, and mental health	ST2 • Revamped communication strategies and tools • Developed and maintained partnerships to ensure messages and dissemination strategies are effective for the whole community ST3 • Established mechanisms to meet administrative, workforce, and response surge requirements • Revamped preparedness training requirements to promote readiness, response, recovery, and resiliency • Established communities of practice focused on readiness, response, and recovery guidance and resources	• Timely coordination and support of response and recovery activities with health care systems and partners • Integrated equity into public health response and recovery ST3 • Increased hiring and retention of surge staff resources • Prepared public health workforce ready to sustain public health investigations, response, and recovery • Active engagement in communities of practice	


Strategy 1
Use CDC's national preparedness capabilities as applicable to augment STLT all-hazards planning and improve readiness, response, and recovery capacity for existing and emerging public health threats and modernized laboratory and electronic data systems
Risk-Based Approach to All-Hazards Planning (AHA)
Public Health Laboratory Capacity (LAB)
Data Modernization (DM)
Strategy 2
Use CDC's national preparedness capabilities as applicable to improve whole community readiness, response, and recovery through enhanced partnerships and improved communication systems for timely situational awareness and risk communication
Partnerships (PAR)
Risk Communications (RSK)
Recovery (REC)
Strategy 3
Use CDC's national preparedness capabilities as applicable to improve capacity to meet jurisdictional administrative, budget, and public health surge management needs and also improve public health response workforce recruitment, retention, resilience, and mental health
Administrative and Budget Preparedness (ADM)
Workforce (WKF)
Local Support (LOC)
Health Equity (HE)

Appendix B: Roster Answer Choices

Data Elements	Data Type	Answer Choices
ROSTER-NAME: Partner Organization Name	Text	
ROSTER-PRIM-CAT: Primary Partner Category	Select	1. Administration for Strategic Preparedness and Response (ASPR) 2. Critical infrastructure 3. Data/Information Partners 4. Department of Health Partners (Internal) 5. Education 6. Federal Groups and Organizations (not HHS CIOs) 7. Health and Human Services (HHS, not ASPR) 8. Local planning jurisdictions 9. Military/National Guard/Uniform Services 10. Non-governmental organizations/Private Sector Organizations 11. State Groups and Organizations 12. Tribes and Native Populations 13. Other, specify
ROSTER-SUB-CAT: Subcategory	Select	See table below for detail
ROSTER-AFN-POPS: AFN populations partners serve or represent	Multiselect	•Children and youth •Hospitalized people •Incarcerated people •Marginalized populations (not otherwise specified; social, political, or economic exclusions, etc.) •Older population •People experiencing homelessness •People with chronic conditions or injuries •People with cognitive impairment •People with clinical mental, behavioral health needs •People with developmental disability or disability (not otherwise specified) •People with hearing impairment •People with Limited English proficiency (LEP) or language barriers •People of low socioeconomic status •People with mobility impairment •People with transportation instability •People with visual impairment •Pregnant people •Underserved communities (rural communities, uninsured, etc.) •Other, specify
ROSTER-RRF: Partner involvement	Multiselect	•Exercising •Mitigation •Planning •Prevention •Recovery •Response •Training •Other, specify
ROSTER-RRF-ACTIVITY: Activity involving partner	Multiselect	• ADM-A: Recipients must update administrative preparedness plans • ADM-B: Integrate ADM preparedness recommendations into training

		and exercises • ADM-C: Improve adherence to guidance related to ADM requirements • ADM-D: Reduce the time PHEP-funded positions remain vacant • ADM-E: Award funds to LHD & tribal entities within 90 days of the BP start • AHA-A: Complete and submit a risk assessment & required data elements • AHA-B: Complete and submit MYIPP plans and data elements • AHA-C: Develop and conduct required exercises • AHA-D: Submit exercise and incident response improvement plan data elements • AHA-E: Maintain MCM capability • AHA-F: Review and update CHEMPACK plans • AHA-G: Complete baseline training preparedness requirements • DM-A: Incorporate data modernization into public health response plans • DM-B: Incorporate data modernization into public health exercises • HE-A: Update risk assessment (RA) to address prioritized populations • HE-B: Engage whole community partners in preparedness plans and exercises • HE-C: Include health equity representative on Senior Advisory Committee (SAC) • LAB-A: Participate in LRN-C specimen packaging and shipping (SPaS) exercises • LAB-B: Participate in LRN-B challenge panels • LAB-C: Participate in LRN-C proficiency testing • LAB-D: Implement specified standards for electronic reporting of lab data • LAB-E: PHEP funded LRN-B labs must demonstrate lab surge plans are exercised • LAB-F: Maintain LRN program fiscal strategies • LOC-A: Engage locals (rural/frontier/tribal) in plans and exercises • LOC-B: Provide direct TA and surge staffing to increase local readiness • PAR-A: Include critical response & recovery partners in plans and exercises • REC-A: Incorporate recovery in MYIPP • RSK-A: Develop or update CERC and information dissemination plans • RSK-B: Exercise communication objectives for mis/disinformation in exercises • RSK-C: Implement specific CERC activities for diverse needs of whole community • WKF-A: Develop process to retain a highly qualified and diverse workforce • WKF-B: Provide training plans for a ready responder public health workforce • WKF-C: Engage in a community of practice to support PHEP workforce activities
ROSTER-IMPACT: Describe the partner action that resulted from participating in the	text	Optional narrative

activity		

Primary Partner Category		Subcategory
1. Administration for Strategic Preparedness and Response (ASPR)	Multiselect	• HHS Coordination Operations and Response Element (HCORE) • Hospital Preparedness Program (HPP) • Regional Administrator (RA)/Regional Emergency Coordinator (REC) • Strategic National Stockpile (SNS) • Other, specify
2. Critical infrastructure	Multiselect	• Aviation services • Bridge services • Communication services • Cyber, internet, or web services • Financial / bank / commerce services • Food services • Manufacturing services (supply-chain) • Power & Energy - Electric services • Power & Energy - Gas services • Railroad services • Recreation services • Road / highway services • Transportation services (medical) • Transportation services (non-medical) • Utility services • Waste (hazardous) management • Waste (non-hazardous) management • Water services • Other, specify
3. Data/Information Partners	Multiselect	• Audiovisual Production Specialist • Communications Specialist • Computer/Information Technology Analysis or Specialist • Engineer • Statistician • Web Developer and administrator • Other, specify
4. Department of Health Partners (Internal)	Multiselect	• Accountant • Administrative or Business Services Specialist • Audiovisual Production Specialist • Behavioral Scientist • Biologist/Microbiologist • Chemist/Research Chemist • Communications Specialist / Public Information Officer • Computer/Information Technology Analysis or Specialist • Contracts/Grants Analyst or Manager • Emergency Response Specialist • Engineer • Environmental Health Scientist or Specialist • Epidemiologist • Exercise coordinator/SME • Finance/Budget Administrator

		• Health Education Specialist • Health Equity coordinator/SME • Health Informatics Specialist • Health Scientist • Hospital/Healthcare SME • Human Resources Specialist • Immunization SME • Infectious Disease SME • Laboratorian • Leadership • Medical Officer • Non-Infectious Disease SME • PHEP Director • PHEP Staff • Planning coordinator/SME • Program Manager and/or Analyst • Procurement Officers • Public Affairs Officer/Public Relations • Public Health Adviser • Public Health Analyst • Public Health Program Specialist • Radiation SME • Recovery and Mitigation coordinator/SME • Safety and Occupational Health Specialist • Secretary • Social/Behavioral Scientist • Statistician • Surge Staff • Toxicologist • Training coordinator/SME • Web Developer and Administrator • Writer-Editor • Other, specify
5. Education	Multiselect	• Colleges/Universities • Private schools PreK-12 • Public schools PreK-12 • Technical/Trade schools • Other, specify
6. Federal Groups and Organizations (except HHS CIOs)	Multiselect	• Association of Public Health Laboratories (APHL) • Association of State and Territorial Health Officials (ASTHO) • Council for State and Territorial Epidemiologists (CSTE) • Department of Homeland Security (DHS); • Environmental Protection Agency (EPA); • Federal Emergency Management Agency (FEMA); • National Association of County and City Health Officials (NACCHO) • National Emergency Management Association (NEMA) • Pacific Islanders Health Officer Association (PIHOA) • Other, specify
7. Health and Human Services (HHS)	Multiselect	• Administration for Children and Families (ACF) • Administration for Community Living (ACL) • Administration for Strategic Preparedness and Response (ASPR),

		data entered in choice #1 • Advanced Research Projects Agency for Health (ARPA-H) • Agency for Healthcare Research and Quality (AHRQ) • Agency for Toxic Substances and Disease Registry (ATSDR) • Assistant Secretary for Administration (ASA) • Assistant Secretary for Health (ASH) • Assistant Secretary for Legislation (ASL) • Assistant Secretary for Planning and Evaluation (ASPE) • Assistant Secretary for Public Affairs (ASPA) • Center for Faith-Based and Neighborhood Partnerships (CFBNP) • Centers for Disease Control and Prevention (CDC) • Centers for Medicare and Medicaid Services (CMS) • Food and Drug Administration (FDA) • Health Resources and Services Administration (HRSA) • Immediate Office of the Secretary (IOS) • Indian Health Service (IHS) • National Institutes of Health (NIH) • Office for Civil Rights (OCR) • Office of Global Affairs (OGA) • Office of Inspector General (OIG) • Office of Intergovernmental and External Affairs (IEA) • Office of Medicare Hearings and Appeals (OMHA) • Office of the General Counsel (OGC) • Office of the National Coordinator for Health Information Technology (ONC) • Office of the Secretary Substance Abuse and Mental Health Services Administration (SAMHSA)
8. Local planning jurisdictions	Multiselect	Jurisdictional risk list
9. Military/National Guard/Uniform Services	Multiselect	• Army • Air Force • Coast Guard • Navy • Marine Corps • National Oceanic and Atmospheric Administration Commissioned Officer Corps • National Guard/Reserve Corps • Space Force • U.S. Public Health Service Commissioned Officer Corps
10. Non-governmental organizations / Private Sector partners	Multiselect	• Community-based Organizations (CBOs); • Faith-based Organizations (FBOs) • Pharmacies • Private Business • Regional Partners, specify • Warehouses • Volunteers • Other, specify
11. State Groups and Organizational partners (external	Multiselect	• Emergency Management • Emergency Medical Services (EMS, non-federal) • Environmental Health Agencies (non-federal)

Public Health partners)		• Governor's Office • Healthcare Coalitions or Organizations • Hospitals or Healthcare Facilities • Jurisdictional Government Agencies • Laboratory General • Laboratory Response Network – Biologics • Laboratory Response Network – Chemical • Law Enforcement Agencies • Mental Health/Behavioral Health Services • Nursing homes/Long-term care facilities • Policy Office/Legal/General Counsel • Professional Healthcare Organizations (Physician, Nurse, etc.) • Other, specify
12. Tribes and Native Populations	Multiselect	Federal tribe list
13. Other, specify	Text	Optional narrative

Appendix C: Answer Choices

Data Elements	Data Type	Answer Choices
AHA-A-RADE-NUMBER	Number	Enter number of risk assessments for the jurisdiction
AHA-A-RADE-DATE	Date	MM/DD/YYYY
AHA-A-RADE-ROSTER	Multiselect	See Appendix B: Roster
AHA-A-RADE-RISK1-5	Multiselect (5)	•**Bold** indicates primary category. Use the jurisdictional risk assessment to select the top 5 ranked risks or hazards •**Biological** = agricultural disease outbreak, Anthrax, foodborne disease, food insecurity, or famine, infectious diseases (Ebola, smallpox, novel diseases, etc.), non-infectious diseases, pandemic COVID, pandemic influenza, respiratory viruses (SARS, etc.), vector-borne diseases, or zoonotic diseases •**Community resources or utility failures** = electrical outage, fuel shortage, generator shortage, sewer failure, supply chain disruption (water, food, pharmaceuticals, etc.), or utilities disruption •**Environmental** = chemical attack, spill, or release; hazardous materials incident or release; nuclear facility failure; radiological dispersal; or water sanitation, supply contamination, or shortage •**Mass gathering** = large public events; mass care services; mass sheltering; medical resource shortages; special or VIP events; or volunteer or staffing shortages •**Natural disaster** = asteroids or meteorites; avalanches; droughts; dust storms; earthquakes; expansive soils; extreme cold; extreme heat; floods; fogs, hailstorms, hurricanes, tropical storms, or cyclones; ice storms; landslides; lightning; mudflows; sinkholes or subsidence; snowstorms or blizzards; soil erosion; solar flare; storm surge; thunderstorms; tornadoes; tsunamis; volcanoes; wildfires; or windstorms •**Occupational safety or industrial hygiene** = agricultural infestation; arboviral response; factory incident; mining incident; power plants; refinery incident; or safety standard issues • **Structural failure** = dam failure; infrastructure collapse (bridges, buildings, etc.); levee failure •**Technological (failures or disruptions);** communication network disruptions or failures; cyber-attacks; or information systems disruptions or failures •**Terrorism or violence threats (including explosives)** = agro-terrorism or food supply contamination; CBRNE attack (chemical, biological, radiological, nuclear and explosive); hate crimes; hostage situations; kidnapping; mass shootings or active shooter; riots; weapons of mass destruction; or workplace violence •**Transportation** = aviation; highways; maritime; or railroads •**Other, specify**
AHA-A-REASON1-5	Multiselect	Access to medications; chemical exposure; chronic disease management; communication challenges (mis/dis-information); displacement or homelessness; environmental health concerns; first responder health; food and waterborne disease; healthcare system

		surge needs; infectious disease; injuries and trauma; mental health / psychological distress; radiation exposure; respiratory problems; social disruption; other, specify
AHA-A-RADE-EXPERTS	Multiselect	• Accountant • Administrative or Business Services Specialist • Audiovisual Production Specialist • Behavioral Scientist • Biologist/Microbiologist • Chemist/Research Chemist • Communications Specialist / Public Information Officer • Computer/Information Technology Analysis or Specialist • Contracts/Grants Analyst or Manager • Emergency Response Specialist • Engineer • Environmental Health Scientist or Specialist • Epidemiologist • Exercise coordinator/SME • Finance/Budget Administrator • Health Education Specialist • Health Equity coordinator/SME • Health Informatics Specialist • Health Scientist • Hospital/Healthcare SME • Human Resources Specialist • Immunization SME • Infectious Disease SME • Laboratorian • Leadership • Medical Officer • Non-Infectious Disease SME • PHEP Director • PHEP Staff • Planning coordinator/SME • Program Manager and/or Analyst • Procurement Officers • Public Affairs Officer/Public Relations • Public Health Adviser • Public Health Analyst • Public Health Program Specialist • Radiation SME • Recovery and Mitigation coordinator/SME • Safety and Occupational Health Specialist • Secretary • Social/Behavioral Scientist • Statistician • Surge Staff • Toxicologist • Training coordinator/SME • Web Developer and Administrator • Writer-Editor • Other, specify

AHA-RADE-AFN	Multiselect	•Children and youth •Hospitalized people •Incarcerated people •Marginalized populations (not otherwise specified; social, political, or economic exclusions, etc.) •Older population •People experiencing homelessness •People with chronic conditions or injuries •People with cognitive impairment •People with clinical mental, behavioral health needs •People with developmental disability or disability (not otherwise specified) •People with hearing impairment •People with Limited English proficiency (LEP) or language barriers •People of low socioeconomic status •People with mobility impairment •People with transportation instability •People with visual impairment •Pregnant people •Underserved communities (rural communities, uninsured, etc.) •Other, specify
AHA-A-RADE-SVI	Select	Yes; No
AHA-A-RADE-PLACES	Select	Yes; No
AHA-A-RADE-emPOWER	Select	Yes; No
AHA-B-MYIPP-SUBMIT	Select	Not started; in progress; complete; deferred
AHA-B-MYIPP-DATE	Date	MM/DD/YYYY
AHA-B-MYIPP-IPPW-DATE	Date	MM/DD/YYYY
AHA-B-MYIPP-ROSTER	Multiselect	See Appendix B: Roster
AHA-B-MYIPP-YEARS	Number	Enter number
AHA-B-MYIPP-RRF	Multiselect	Administrative and budget preparedness activities (ADM); all-hazards activities (AHA); data modernization activities (DM); health equity activity (HE); local support activities (LOC); partnerships activity (PAR); public health laboratory capacity activities (LAB); recovery activity (REC); risk communications activities (RSK); workforce activities (WKF)
AHA-B-MYIPP-CAPS	Multiselect	Capability 1:Community Preparedness; Capability 2: Community Recovery; Capability 3: Emergency Operations Coordination; Capability 4: Emergency Public Information and Warning; Capability 5: Fatality Management; Capability 6: Information Sharing; Capability 7: Mass Care; Capability 8: Medical Countermeasure Dispensing and Administration; Capability 9: Medical Materiel Management and Distribution; Capability 10: Medical Surge; Capability 11: Nonpharmaceutical Interventions; Capability 12: Public Health Laboratory Testing; Capability 13: Public Health Surveillance and Epidemiological Investigation; Capability 14: Responder Safety and Health; Capability 15: Volunteer Management
AHA-B-MYIPP-EX	Multiselect	1. ADM-B: Administrative Preparedness 2. BIO100: Biological Incident 100 3. CHEM: Chemical Incident 4. RADNUC: Radiological/Nuclear Incident

		5. RFT: Rural/frontier/tribal coordination 6. NAT: Natural Disasters 7. CAP100: Capstone 100 8. CAP200: Drill Capstone 200 9. CCD: Drill Critical contacts 10. IDE: Drill Inventory data exchange 11. BIO200: Functional Biological incident 200 12. CAP300: Functional Capstone 300 13. CAP400: Full-scale exercise Capstone 400 see *Appendix D*
AHA-B-MYIPP-EXSTRENGTH	Text/Multiselect	Open-ended; as exercise data is entered it will populate a dropdown menu to facilitate future data entry
AHA-B-MYIPP-STRENGTH	Text/Multiselect	Open-ended; as exercise data is entered it will populate a dropdown menu to facilitate future data entry
AHA-B-MYIPP-EXAOI	Text/Multiselect	Open-ended; as exercise data is entered it will populate a dropdown menu to facilitate future data entry
AHA-B-MYIPP-AOI	Text/Multiselect	Open-ended; as exercise data is entered it will populate a dropdown menu to facilitate future data entry
AHA-B-MYIPP-PANFLU	Date	MM/DD/YYYY
AHA-B-MYIPP-AHA	Date	MM/DD/YYYY
AHA-B-MYIPP-ID	Date	MM/DD/YYYY
AHA-B-MYIPP-MCM	Date	MM/DD/YYYY
AHA-B-MYIPP-COOP	Date	MM/DD/YYYY
AHA-B-MYIPP-VOL	Date	MM/DD/YYYY
AHA-B-MYIPP-CERC	Date	MM/DD/YYYY
AHA-B-MYIPP-HC	Date	MM/DD/YYYY
AHA-C-Exercises	Select	Not started; in progress; complete; deferred; see exercise requirements (see Appendix D).
AHA-D-RESPONSE-NAME	Text	Open-ended
AHA-D-RESPONSE-START-DATE	Date	MM/DD/YYYY
AHA-D-RESPONSE-END-DATE	Date	MM/DD/YYYY
AHA-D-RESPONSE-CATEGORY	Select One	•**Bold** indicates primary category. Once selected, subset options display. •**Biological** = agricultural disease outbreak, Anthrax, foodborne disease, food insecurity, or famine, infectious diseases (Ebola, smallpox, novel diseases, etc.), non-infectious diseases, pandemic COVID, pandemic influenza, respiratory viruses (SARS, etc.), vector-borne diseases, or zoonotic diseases •**Community resources or utility failures** = electrical outage, fuel shortage, generator shortage, sewer failure, supply chain disruption (water, food, pharmaceuticals, etc.), or utilities disruption •**Environmental** = chemical attack, spill, or release; hazardous materials incident or release; nuclear facility failure; radiological dispersal; or water sanitation, supply contamination, or shortage •**Mass gathering** = large public events; mass care services; mass sheltering; medical resource shortages; special or VIP events; or volunteer or staffing shortages •**Natural disaster** = asteroids or meteorites; avalanches; droughts; dust storms; earthquakes; expansive soils; extreme cold; extreme heat; floods; fogs, hailstorms, hurricanes, tropical storms, or cyclones; ice

		storms; landslides; lightning; mudflows; sinkholes or subsidence; snowstorms or blizzards; soil erosion; solar flare; storm surge; thunderstorms; tornadoes; tsunamis; volcanoes; wildfires; or windstorms •**Occupational safety or industrial hygiene** = agricultural infestation; arboviral response; factory incident; mining incident; power plants; refinery incident; or safety standard issues • **Structural failure** = dam failure; infrastructure collapse (bridges, buildings, etc.); levee failure •**Technological (failures or disruptions);** communication network disruptions or failures; cyber-attacks; or information systems disruptions or failures •**Terrorism or violence threats (including explosives)** = agro-terrorism or food supply contamination; CBRNE attack (chemical, biological, radiological, nuclear and explosive); hate crimes; hostage situations; kidnapping; mass shootings or active shooter; riots; weapons of mass destruction; or workplace violence •**Transportation** = aviation; highways; maritime; or railroads •**Other, specify**
AHA-D-RESPONSE-ROSTER	Multiselect	See Appendix B: Roster
AHA-D-RESPONSE-OBJECTIVES	Multiselect	Multiselect or specify the objectives of the response
AHA-D-RESPONSE-STRENGTH	Text	Open-ended
AHA-D-RESPONSE-AOI	Text	Open-ended
AHA-D-RESPONSE-CA	Text	Open-ended
AHA-D-RESPONSE-IP	Text	Open-ended
AHA-E	Date	MM/DD/YYYY
AHA-F	Date	MM/DD/YYYY
AHA-G	Number	Numerator = number of staff that completed training per plan; denominator = total number of staff included in training plan. Credit for AHA-G is associated with LOC-C and WKF-B. See also Appendix F, Evaluation of Trainings and Appendix G, Monitoring and Technical Assistance.
LAB-A-SPaSE	Not Applicable	Data received directly from LRN-C
LAB-B-CHALLENGE	Not Applicable	Data received directly from LRN-B
LAB-C-PROFICIENCY	Not Applicable	Data received directly from LRN-C
LAB-D		No data entry is required. Successfully implementing specified standards for electronic reporting of LRN-B and LRN-C laboratory data is demonstrated by completing LAB A-C (as applicable).
LAB-E	Date	MM/DD/YYYY
LAB-F	Date	MM/DD/YYYY
DM-A	Date	MM/DD/YYYY
DM-B-CORE	Select One	•Case data •Emergency department data •Health care capacity and utilization data •Immunization data •Laboratory data •Vital statistics data •Wastewater surveillance data •Other, specify

DM-B-BASELINE	Text	Open-ended
DM-B	Date	MM/DD/YYYY
DM-B-AOI	Text	Open-ended
DM-B-CA	Text	Open-ended
AHA-A-HE-A-RADE-ROSTER	Multiselect	See Appendix B: Roster
PAR-A	Multiselect	See Appendix B: Roster
RSK-A-DATE	Date	MM/DD/YYYY
RSK-B	Multiselect/Text	Multiselect or specify the communication objectives
RSK-C	Not Applicable	Credit for RSK-C is associated with WKF-C and exercise requirements (see Appendix D)
REC-A	Date	MM/DD/YYYY
HE-B	Multiselect	See Appendix B: Roster
ADM-A-Date	Date	MM/DD/YYYY
ADM-B	Not Applicable	Credit for ADM-B is associated with AHA-C (see Appendix D), AHA-G, and WKF-B; no additional data entry required.
ADM-C-MON	Not Applicable	Recipients must comply with federal financial reporting
ADM-D1-RECIPIENT	Number	Total number of staff on the last day of the quarter
ADM-D2-RECIPIENT	Number	Number of new hires in the quarter
ADM-D3-RECIPIENT	Number	Number of staff at the start of the quarter
ADM-D1-LOCAL	Number	Total number of staff on the last day of the quarter
ADM-D2-LOCAL	Number	Number of new hires in the quarter
ADM-D3-LOCAL	Number	Number of staff at the start of the quarter
ADM-E	Date	MM/DD/YYYY
ADM-E-PROCUREMENT-DATE	Date	MM/DD/YYYY
ADM-E-SUBCONTRACT-DATE	Date	MM/DD/YYYY
ADM-E-90MET	Select One	Performed without challenges; performed with challenges; unable to perform; not applicable
ADM-E-90BARRIERS	Multiselect	• Administrative barriers (general): contract or procurement, expedited processing, legal barriers • Infrastructure barriers (general): equipment, information technology or systems, laboratory infrastructure • Local jurisdiction recovery • Personnel barriers (general): lack of subject matter experts. lack of trained personnel, vacancies • Other, specify
WKF-A-VACANT	Number	Job Classification Categories 1. **Agency leadership and management**: department/bureau director, deputy director, public health agency director, program director, health officer. 2. **Program manager:** public health program manager. 3. **Business, improvement, and operations staff**: attorney or legal counsel, business support: accountant/fiscal, business support services: administrator, business support services: coordinator, grants or contracts specialist, human resources personnel, other business support services, community health planner, quality improvement worker, training developer/manager, workforce development staff. May include positions focused on accreditation and performance improvement. 4. **Office and administrative support staff:** clerical

		personnel/administrative assistant; clerical personnel -secretary; customer service/support professional; custodian, other facilities or operations worker; implementation specialist, medical/vital Records staff. 5. **Information technology and data system staff**: information systems manager/information technology specialist, IT support staff, public health informatics specialist, informatics staff, web developer/computer programmer. 6. **Public information, communications, and policy staff**: public information specialist, policy analyst, communications specialist, web content writer/content developer. 7. **Laboratory workers**: laboratory technician, laboratory quality control worker, laboratory scientist/medical technologist, laboratory aide or assistant. 8. **Epidemiologists, statisticians, data scientists, other data analysts**: epidemiologist, population health specialist, statistician, economist, data or research analyst, data scientist, program evaluator. 9. **Behavioral health and social services staff**: behavioral health professional, disease intervention specialist/contact tracer, peer counselor, health navigator, social worker/social services professional. 10. **Community health workers and health educators**: health educator, community health worker. 11. **Public health physician, nurse and other clinicians or healthcare providers**: nursing and home health aide, nutritionist or dietitian, other oral health professional, other nurse -clinical services, physician assistant, public health dentist, health/preventive medicine physician, registered nurse: public health or community health nurse, registered nurse: unspecified, pharmacist, licensed practical or vocational nurse, nurse practitioner emergency medical technician/advanced emergency medical, technician/paramedic, emergency medical services worker, other health professional/clinical support staff, physical/occupational/rehabilitation therapist, public health veterinarian. 12. **Preparedness staff**: emergency preparedness/management worker. 13. **Environmental health worker**s: environmental health worker, environmental health technician, environmental health physicist, environmental health scientist, environmental engineer. 14**. Animal control and compliance/inspection staff**: licensure/regulation/enforcement worker, sanitarian or inspector, animal control worker, disability claims/benefits examiner or adjudicator 15. **Other, specify**
WKF-A-ADM-D	Not Applicable	No additional data entry required.
WKF-B-AHA-G-DATE-PREPSTAFF	Date	MM/DD/YYYY
WKF-B-DATE-SURGE	Date	MM/DD/YYYY
WKF-B-LOC-B-TOTAL	Number	Total number of surge staff
WKF-B- LOC-B-ROLES	Multiselect	See Appendix B: Roster
WKF-C-COP	Multiselect	One PHEP CoP; recipient CoP; regional centers, other, specify
WKF-C-BP	Multiselect	BP1: July 2024–June 2025; BP2: July 2025–June 2026; BP3: July 2026–June 2027; BP4: July 2027–June 2028; BP5: July 2028–June 2029

WKF-C-TOPICS	Multiselect/Text	HE-C: Health equity principles; LOC-A: Local planning jurisdiction support and technical assistance; RSK-C: Crisis and emergency risk communication related to preparedness, response, and recovery; WKF-C: Workforce recruitment, hiring, training, retention, or resiliency; other, specify
WKF-C-AOI	Text	Open-ended
WKF-C-CA	Text	Open-ended
WKF-C-BEST-PRACTICE	Text	Open-ended
LOC-A-PLANS	Multiselect	Local planning jurisdiction list
LOC-A-RURAL	Multiselect	Local planning jurisdiction list
LOC-A-TRIBE	Multiselect	Federal tribe list
LOC-B	Date	MM/DD/YYYY
LOC-C-HE-C-ROSTER	Multiselect	See Appendix B: Roster
LOC-C-BP	Select	BP1: July 2024–June 2025; BP2: July 2025–June 2026; BP3: July 2026–June 2027; BP4: July 2027–June 2028; BP5: July 2028–June 2029
LOC-C-TOPICS	Multiselect/Text	HE-C: Health equity principles; LOC-A: Local planning jurisdiction support and technical assistance; RSK-C: Crisis and emergency risk communication related to preparedness, response, and recovery; WKF-C: Workforce recruitment, hiring, training, retention, or resiliency; other, specify
LOC-C-AOI	Text	Open-ended
LOC-C-CA	Text	Open-ended
LOC-C-BEST-PRACTICE	Text	Open-ended
HE-C-LOC-C-ROSTER	Multiselect	See Appendix B: Roster

Appendix D: Exercise Data Elements

AHA-C: Discussion- and Operations-based Exercises	The exercise framework aims to improve and support the need for public health agencies to exercise plans based on the jurisdiction's prioritized risks and threats through a series of discussion- and operations-based exercises over the five-year period of performance.
Activity	1. ADM-B: Administrative Preparedness 2. BIO100: Biological Incident 100 3. CHEM: Chemical Incident 4. RADNUC: Radiological/Nuclear Incident 5. RFT: Rural/frontier/tribal coordination 6. NAT: Natural Disasters 7. CAP100: Capstone 100 8. CAP200: Drill Capstone 200 9. CCD: Drill Critical contacts 10. IDE: Drill Inventory data exchange 11. BIO200: Functional Biological incident 200 12. CAP300: Functional Capstone 300 13. CAP400: Full-scale exercise Capstone 400
Who must report	All 62 recipients are required to conduct the exercises unless exempt as noted below. • **RFT** only applies to the 50 state recipients and Puerto Rico • **CCD** only applies to the 50 state recipients, Los Angeles County, New York City, Washington, D.C. and Puerto Rico. Chicago is exempt from participating in the laboratory component. • **CAP400:** only applies to the 50 state recipients, Chicago, Los Angeles County, New York City, Washington, D.C. and Puerto Rico
Rationale	The exercise framework is designed to promote use of common terminology, current standards of practice, and improve collaboration with emergency management, health care coalitions, other government sectors, and private industry within jurisdictional exercise programs.
Data elements	Each recipient must provide the following data to CDC. Data marked with "**" contributes to recipients' performance evaluation. Additional data are collected to evaluate program impact and address national preparedness, readiness, and response. The data elements are the same for all discussion- and operations-based activities and will be linked to the corresponding exercise as listed in the activity section above. • **EXERCISE-NAME:** *Specify the exercise name.* • ****EXERCISE-START-DATE:** *Enter exercise activation date MM/DD/YYYY* • ****EXERCISE-END-DATE:** *Enter exercise end date MM/DD/YYYY* • ****EXERCISE-CATEGORY:** *Select or specify the exercise category.* • ****EXERCISE-ROSTER:** *Multiselect or specify the organizations that participated (see Appendix B). At least one annual exercise must include participants or partners that represent populations prioritized in the RA such as older adults; children and youth; people with chronic illness and disabilities; people experiencing homelessness and transportation instability; or people with language barriers.* • ****EXERCISE-OBJECTIVES:** *Multiselect or specify the objectives of the response.* • ****EXERCISE-STRENGTH:** *Create an observation statement focused on an aspect of the exercise that was performed without challenges or adequately. The statement should reflect a successful response action or attribute.* • ****EXERCISE-AOI:** *Create an observation statement focused on an aspect of the exercise that*

	was performed with major challenges or was not able to be performed. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action. The narrative must be consistent with the conclusions reached from the exercise as described in the After-Action Report. • ****EXERCISE-CA:** *Describe the corrective action to be undertaken. Analyzing the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness. The MYIPP and Workforce Development plans must also align with the stated corrective actions.* • ** **EXERCISE-IP: Submit exercise and incident response improvement plan data elements.** *Consistent with the HSEEP 2020 approach to exercise planning, IP must include all consolidated corrective actions. The IP may be an appendix to an AAR. IP and AAR must be submitted when requested by CDC.*
Additional guidance	*See Exercise Framework Supplemental Guidance* for additional detail to support planning and implementing of all exercise activities. Five central RRF program priorities must be included in all exercises: • Partnerships (PAR) • Health Equity (HE) • Risk Communications (RSK) • Data Modernization (DM) • Recovery (REC)
How will this data be used?	Each exercise activity is associated with a PHEP program requirement, and every exercise requirement must include at least one associated area identified for improvement. Effective improvement planning serves as an important tool throughout the integrated preparedness cycle (HSEEP 2020). Actions identified during improvement planning help strengthen a jurisdiction's capability to plan, equip, train and exercise (HSEEP 2020). The MYIPP (see AHA-B) documents a progressive exercise approach that must be adjusted annually to reflect changes in preparedness priorities given exercises or real-world experiences.
Target (if applicable)	Each recipient must complete all exercises and submit required data.
Recommended data source	Recipients must compile data while conducting the exercise. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients must report progress on all activities, at a minimum, on a quarterly basis. Each exercise must be completed one time during the performance period. Following are noted exceptions. • CCD: Completed each budget period, that is five times during the period of performance. • IDE: Completed each budget period, that is five times during the period of performance. • BIO100 must precede BIO200; both only need to be completed one time during the performance period. • **The capstone exercises must correspond to one of the five ranked RA risks submitted by the jurisdiction**. Recipients must complete capstone exercises in sequential order: CAP100 (first), CAP200 (second), CAP300 (third), CAP400 (fourth). o Recipients who complete the BIO100 can receive credit for the CAP100 if the focus of the capstone exercise is biologic.

Appendix E: One PHEP Community of Practice (CoP)

WKF-C: ONE PHEP	CDC will facilitate the One PHEP CoP to help meet the WKF-C activity requirement to participate in a CoP. One PHEP CoP will foster a collaborative environment for professionals and advance collective expertise in the expansive fields of public health response readiness. The objectives of the One PHEP CoP are to address gaps and common challenges in public health readiness and response by: • Enhancing connections across jurisdictions • Facilitating peer-to-peer learning, brainstorming, and problem-solving • Sharing of applicable public health preparedness knowledge, promising practices, and resources
Activity	WKF-C-ONE-PHEP-CoP: Actively engage in at least one CoP that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency
Who must report	All recipients must participate in a community of practice and respond to annual monitoring questions. Additionally, recipients participating in the One PHEP CoP will provide information specific to One PHEP participation in baseline, quarterly, and annual surveys.
Rationale	Peer-to-peer learning and sharing support the capacity-building components of this cooperative agreement and help support implementation of program activities and requirements. The One PHEP CoP monitoring and evaluation will assess the degree to which the One PHEP CoP meets intended goals and objectives, including: addressing identified gaps, supporting knowledge transfer, and encouraging replication, scalability, or adaption of strategies and resources to bolster capabilities and outcomes. Additionally, this information will provide data to inform decision making for future CoP activities and capacity building initiatives. The One PHEP CoP will use an interactive platform to support a collaborative environment for participants to advance collective expertise through peer-to-peer knowledge transfer, learning, and sharing of resources and best practices. In addition to collecting survey data, information from the platform, including but not limited to participant registration, workgroup participation, and observation. Notes from work group meetings, engagements with chats, discussions, and shared information and resources will also inform the overall evaluation.
Data elements	Each recipient must provide the following data to CDC. Data marked with "**" contributes to recipients' performance evaluation. Additional data are collected to evaluate program impact and address national preparedness, readiness, and response. One PHEP CoP baseline survey • ****WKF-C-OnePHEP-GOALS:** *Describe anticipated outcomes from participating in One PHEP CoP.* • **WKF-C-OnePHEP-PEER:** *Describe the methods of peer-to-peer interaction that are preferred.* • **WKF-C-OnePHEP-TOPICS:** *Describe how readiness and response are advanced in the jurisdiction by addressing 1) workforce subject matter expertise related to RRF, 2) workforce resilience, and 3) data modernization, core public health systems.* • **WKF-C-OnePHEP-RRF:** *Rate (using a Likert scale) the jurisdiction's workforce expertise related to the 10 RRF areas.* • **WKF-C-OnePHEP-RESILIENCE:** *Rate (using a Likert scale) the jurisdiction's workforce resilience.* • **WKF-C-OnePHEP-DMCORE:** *Rate (using a Likert scale) the effectiveness of the jurisdiction's core public health systems*.

	One PHEP CoP quarterly survey • ****WKF-C-OnePHEP-QS-ENGAGE:** *Rate (using a Likert scale) the jurisdiction's engagement with the CoP in the given quarter.* • **WKF-C-OnePHEP-QS-PEER:** *Rate (using a Likert scale) the extent the One PHEP CoP increased via peer-to-peer interactions: knowledge and resource sharing, problem solving, innovation, and partner connections* • **WKF-C-OnePHEP-QS-BUILD:** *Describe how, beyond peer-to-peer interactions, One PHEP CoP increased or built: knowledge and resource sharing, problem solving, innovation, and partner connection.* • **WKF-C-OnePHEP-QS-RSA-RATE:** *Rate (using a Likert scale) the extent the jurisdiction replicated, scaled, or adapted strategies learned in the One PHEP CoP.* • **WKF-C-OnePHEP-QS-RSA-DESCRIBE:** *Describe what the jurisdiction either replicated, scaled, or adapted that resulted from knowledge, promising practices, or shared resources exchanged during the One PHEP CoP.* • **WKF-C-OnePHEP-QS-RSA-OTHER:** *Describe what other factors, beyond the One PHEP CoP, facilitated the jurisdiction's ability to replicate, scale, or adapt strategies to advance readiness and response.* • **WKF-C-OnePHEP-QS-RSA-BARRIERS:** *Describe what other factors, beyond the One PHEP CoP, were barriers to the jurisdiction's ability to replicate, scale, or adapt strategies to advance readiness and response.* • **WKF-C-OnePHEP-QS-AOI Area of Improvement:** *Given the selected topics of the CoP, create an observation statement that addressed an area of improvement for the jurisdiction. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.* • **WKF-C-OnePHEP-CA: Corrective Action**: *Describe the corrective action that resulted from participating in the CoP. Analyzing the root cause of the identified AOI will inform the focus of the corrective action. Specific, measurable, achievable, realistic, and time-bound (SMART) corrections that address the AOI should strengthen operational readiness.* • **WKF-C-OnePHEP-SATISFACTION-RATE:** *Rate (using a Likert scale) the jurisdictions overall satisfaction, relevance of topics, discussions, and quality of resources.* • **WKF-C-OnePHEP-SATISFACTION-OTHER:** *Describe experiences and suggestions for improvement for the One PHEP CoP.* One PHEP CoP annual survey • ****WKF-C-OnePHEP-AS-GOALS:** *Describe the extent that anticipated outcomes from participating in the One PHEP CoP were achieved.* • ****WKF-C-OnePHEP-AS-NOTGOALS:** *Describe the extent that anticipated outcomes from participating in the One PHEP CoP were not addressed.* • **WKF-C-OnePHEP-BESTPRACTICE:** *Describe a best or promising practice that resulted from participating in the One PHEP CoP. Create an observation statement focused on an aspect of the practice that conveys a successful action or attribute adopted by the jurisdiction.* • **WKF-C-OnePHEP-AS-TOPICS:** *Describe the jurisdiction's greatest needs by addressing 1) workforce subject matter expertise related to RRF, 2) workforce resilience, and 3) data modernization, core public health systems.* • **WKF-C-OnePHEP-GOVERNANCE-STRUCTURE:** *Rate (using a Likert scale) the effectiveness of the governance structure* • **WKF-C-OnePHEP-GOVERNANCE-OTHER:** *Describe any feedback for improvements of changes to the governance structure*

Additional guidance	See also Training and Compliance detail in the PHEP NOFO CDC-RFA-TU-24-0137 (pages 63-64).
How will this data be used?	This One PHEP monitoring and evaluation plan provides a framework to monitor and evaluate the utility and feasibility of the evaluation results by: 1. Identifying the resources needed to implement and support One PHEP CoP work throughout the performance period. 2. Assessing One PHEP effectiveness in increasing peer-to-peer collaboration. 3. Describing how One PHEP CoP facilitates knowledge sharing and resource development to support response readiness activities. 4. Informing the evolution of the One PHEP CoP.
Target (if applicable)	Each recipient participating in One PHEP must submit required data requirements.
Recommended data source	Data should be compiled by the recipient while conducting the activity. Data can be stored in any format that is available to the recipient.
Reporting frequency	Progress on all activities must be reported, at minimum, on a quarterly basis. Activities with specific deadlines are noted below. • Some baseline survey questions will also be included in the quarterly survey. • Baseline survey questions will also be included in the annual survey.

Appendix F: Evaluation of Trainings

AHA-G-TRAIN	Trainings Surveys
Activity	AHA-G: Evaluation of trainings
Who must report	Participants in trainings
Rationale	Trainings and technical assistance are important capacity-building components of the PHEP cooperative agreement and support implementation of program activities and requirements. Evaluation of trainings will measure how well the trainings are conducted and support the advancement of readiness and response related to reporting and monitoring, implementing the RRF activities, program requirements, and addressing knowledge acquisition and transfer.
Data elements	CDC collects additional data to evaluate program impact and address national preparedness, readiness, and response. CDC will send training participants a voluntary survey to measure the value of provided trainings. Responses are optional for all questions. ### Training Surveys **The following survey questions are applicable for instructor-led, webinar-based, and asynchronous trainings.** • **AHA-G-TRAIN-NAME:** *Select the name of the training.* • **AHA-G-TRAIN-DATE:** *Enter date MM/DD/YYYY.* • **AHA-G-TRAIN-FU:** *Indicate if willing to participate in a follow-up survey one to four months following the initial training (yes/no).* • **AHA-G-TRAIN-SATISFACTIO**N**:** *Rate (using a Likert scale) overall satisfaction of the training.* • **AHA-G-TRAIN-APPLICABLE**: *Rate (using a Likert scale) the extent the training information. aligned with learning objectives, increased knowledge, and provided applicable skills.* • **AHA-G-TRAIN-RECOMMEND:** *Indicate whether course is recommended for colleagues (yes/no) and describe why or why not.* • **AHA-G-TRAIN-CONTENT-GAPS:** *Rate (using a Likert scale) the extent the training addressed knowledge gaps in preparedness capabilities, RRF activities, or monitoring and reporting.* • **AHA-G-TRAIN-CONTENT-ORGANIZATION:** *Rate (using a Likert scale) the organization of material in the training.* • **AHA-G-TRAIN-CONTENT-FEEDBACK:** *Open-ended narrative for additional feedback about the training content or use.* • **AHA-G-TRAIN-USE:** *Describe knowledge gained from the training and how it will be applied by creating an observation statement focused on an aspect of the resource that conveys a successful action or attribute adopted by the participant or jurisdiction.* • **AHA-G-TRAIN-VALUE:** *Describe the most valuable aspect of the training.* • **AHA-G-TRAIN-AOI: Area of Improvement:** *Create an observation statement that addressed an area of improvement for the resource. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.* • **AHA-G-TRAIN-Update:** *Describe the improvement or update suggested for this training. Analyzing the root cause of the identified AOI will inform the focus of the improvements or updates for the training. Specific improvements that address the AOI should strengthen the technical assistance resource.* • **AHA-G-TRAIN-ADD-TOPICS:** *Describe suggestions for additional topics for future trainings*

	• **AHA-G-TRAIN-REGISTRATION:** *Rate (using a Likert scale) the ease of the registration process and describe any issues encountered.* **The following survey questions are additional for instructor-led or webinar-based trainings.** • **AHA-G-TRAIN-PRESENTER**: *Rate (using a Likert scale) the presenters content knowledge, clarity, and engagement in the training.* • **AHA-G-TRAIN-PRESENTER-OTHER**: *Open-ended narrative for additional feedback about the training presenter.* **The following survey questions are applicable for asynchronous trainings.** • **AHA-G-TRAIN-ASYNCHRONOUS-PLATFORM**: *Rate (using a Likert scale) the usefulness of the platform used for the training and describe any issues encountered.* **The following survey questions are applicable for trainees that agree to provide additional information one to four months after an initial training date.** • **AHA-G-TRAIN-FUP-NAME:** *Select the name of the training.* • **AHA-G-TRAIN-DATE:** *Enter date MM/DD/YYYY.* • **AHA-G-TRAIN-FUP-ROLE:** *Select current job classification.* • **AHA-G-TRAIN-FUP-APPLICATION:** *Describe the relevance, applicability, and frequency of the training content given current job classification.* • **AHA-G-TRAIN-FUP-IMPACT-SELF:** *Rate (using a Likert scale) the impact of the training. information and resources on the ability to perform in the current job classification.* • **AHA-G-TRAIN-FUP-IMPACT-OTHERS:** *Rate (using a Likert scale) the impact of the training information and resources on ability to enhance performance of the participants team, organization, or workplace.* • **AHA-G-TRAIN-FUP-RESOURCES-KNOWLEDGE:** *Rate (using a Likert scale) the utility of the resources provided in the training to further knowledge, understanding, or implementation.* • **AHA-G-TRAIN-FUP-RESOURCES-APPLY:** *Rate (using a Likert scale) the ability to apply the knowledge to a practical situation.* • **AHA-G-TRAIN-FUP-IMPLEMENT:** *Describe how participants implemented or applied the targeted skills, knowledge, or resources since completing the training.* • **AHA-G-TRAIN-FUP-FEEDBACK:** *Open-ended narrative for additional feedback about how the training, skills, knowledge, or resources were used.*
Additional guidance	Trainings are an important component of workforce development and program implementation. Evaluating and providing feedback on PHEP trainings, whether instructor-led, webinars, or asynchronous learning, help CDC ensure that training activities are focused on gaps and needs of PHEP recipients. See also Training and Compliance detail in the PHEP NOFO CDC-RFA-TU-24-0137 (pages 63-64).
How will this data be used?	CDC will use data to identify training gaps and needs, understand how trainings are supporting program reporting and monitoring, activity implementation, knowledge transfer and preparedness and response readiness.
Target (if applicable)	75% of trainees
Recommended data source	Data should be compiled by the recipient while conducting the activity. Data can be stored in any format that is available to the recipient.
Reporting frequency	Training participants will receive an initial evaluation survey following an offered training. CDC will send an additional survey to trainees who volunteer to provide feedback one to four months after an initial training. Training survey responses are voluntary.

Appendix G: Monitoring and Technical Assistance

Strategy 1–3: Monitoring and Technical Assistance	Technical assistance (TA) aims to support recipient's implementation of program activities and requirements. PHEP TA resources are made available to recipients or recipients can directly requests specific TA.
Activity	TAS: Technical Assistance Survey TAF: Technical Assistance Feedback
Who must report	Recipients requesting technical assistance from CDC or recipients using CDC technical assistance tools. TAS and TAF responses are voluntary.
Rationale	TA and training are important capacity-building components of this cooperative agreement and supports implementation of program activities and requirements. The TAS and TAF survey and feedback tools provide a mechanism to evaluate process and the degree to which recipients are receiving timely, useful, and clear TA to implement program activities and requirements.
Data elements	CDC collects data to evaluate program impact and address national preparedness, readiness, and response. TAS and TAF responses are voluntary. Technical Assistance Survey (TAS) CDC will send TA recipients a voluntary survey to measure value of provided TA. Responses are optional for all questions. • **TAS-SATISFACTION**: *Rate (using a Likert scale) overall satisfaction about the TA process, recommended actions, and resources provided.* • **TAS-PROCESS**: *Rate (using a Likert scale) the ease of the TA request process.* • **TAS-APPLY**: *Rate (using a Likert scale) confidence for implementing and applying recommended actions or resources.* • **TAS-ENGAGMENT**: *Rate (using a Likert scale) satisfaction with engagement from CDC to resolve the request.* • **TAS-FEEDBACK**: *Describe additional feedback about the TA or resources provided.* Technical Assistance Feedback (TAF) CDC will send TA recipients using CDC resources will be sent a voluntary survey about the resources. Responses are optional for all questions. • **TAF-JURISDICTION**: *Enter jurisdiction name (optional).* • **TAF-FUNDED:** *Select PHEP funding source type (recipient, sub-recipient, contractor, other)* • **TAF-ROLE**: *Select PHEP position or emergency preparedness role.* • **TAF-RESROUCE-NAME:** *Enter the resource provided.* • **TAF-ACTIVITY:** *Multiselect or specify the PHEP activity the resource supported.* • **TAF-RESOLVE:** *Rate (using a Likert scale) if the resource helped resolve a need, issue, or gap and describe how the resource helped to resolve the need, issue, or gap or implement a preparedness and response capability or a PHEP activity.* • **TAF-ADAPT:** *Indicate if the resource was adapted and describe what was changed or updated to meet the needs of the jurisdiction for implementation.* • **TAF-AUDIENCE:** *Multiselect the appropriate audience for the resource (federal, state, local, tribal, territorial, municipal, partners, other).* • **TAF-JOB:** *Multiselect the appropriate job classification for the resource application.* • **TAF-CQI-ACCURACY:** *Rate (using a Likert scale) the accuracy of the resource.* • **TAF-CQI-CLARITY:** *Rate (using a Likert scale) the clarity of the resource.* • **TAF-CQI-COMPLETE:** *Rate (using a Likert scale) the completeness of the resource.* • **TAF-CQI-RELEVANCE:** *Rate (using a Likert scale) the relevance of the resource.*

	• **TAF-CQI-ORG:** *Rate (using a Likert scale) the organization of the resource.* • **TAF-CQI-TIME:** *Rate (using a Likert scale) the timeliness of the resource.* • **TAF-CQI-VALUE:** *Describe the most valuable attributes of the resource.* • **TAF-CQI-AOI: Area of Improvement:** *Describe an area of improvement for the resource by creating an observation statement that addressed an area of improvement for the resource. The statement should clearly describe the problem or gap; it should not include a recommendation or corrective action.* • **TAF-CQI-Update:** *Describe the improvement or update suggested for this resource. Analyzing the root cause of the identified AOI will inform the focus of the improvement or update. Specific improvements that address the AOI should strengthen the technical assistance resource and its ability to support preparedness and response capability and activity implementation.* • **TAF-CQI-COMMENT:** *Open-ended narrative for additional feedback about the resource content or use.* • **TAF-FG**: *Willingness to participate in a focus group about the resource (yes/no).* • **TAF-BESTPRACTICE:** *Describe a best or promising practice or impact that resulted from using the resource. Create an observation statement focused on an aspect of the practice that conveys a successful action or attribute adopted by the jurisdiction.*
Additional guidance	TA is an important component of workforce development and program implementation. Evaluating and providing feedback on TA resources help CDC ensure that TA resources and activities are focused on gaps and needs of PHEP recipients and are useful for improving preparedness and response capabilities and support implementing PHEP cooperative agreement activities. CDC requests that those who use using CDC-developed TA resources provide feedback on the resources and their use. See also Training and Compliance detail in the PHEP NOFO CDC-RFA-TU-24-0137 (pages 63-64).
How will this data be used?	CDC will use data to assess the satisfaction, timeliness, and provision of TA to PHEP recipients by surveying two areas, the technical request process, and the specific resources. CDC will use the data to help identify gaps and improve knowledge transfer to support response readiness. TAS will assess if CDC met the needs of the requestor and identify if further TA is needed to support the request. TAF will assess how well certain tools are meeting the needs of recipients to implement PHEP activities and meet PHEP reporting and monitoring requirements. Additionally, CDC will combine this information with other data to identify gaps in PHEP resources and improvement to TA processes and resources.
Target (if applicable)	60% of CDC TA resource users
Recommended data source	Recipients should compile data while conducting the activity. Recipients can store data in any format that is available to them.
Reporting frequency	Recipients will receive a survey after technical assistance is delivered or a technical assistance resource is used. Additionally, CDC will ask recipients if they are willing to participate in a voluntary focus group to further clarify responses to survey and help clarify potential improvements for TA resources. Responses are voluntary.

Appendix H: Key Terms

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