August 10, 2009 – August 9, 2010

Public Health Emergency Preparedness Cooperative Agreement

Budget Period 10 (BP10) Performance Measures Guidance

December 2009

Contact Information

Key contacts for information regarding the BP10 performance measures can be accessed through the Outcome Monitoring and Evaluation Branch (OMEB) in the Division of State and Local Readiness (DSLR). Feel free to send any questions to OMEB via the following mailbox and the appropriate person will follow-up with you:
omeb@cdc.gov

In addition, project officers will be available to assist with answering and/or clarifying questions related to the BP10 performance measures or this guidance document.

Table of Contents

Introduction and Document Organization

Since 2002, the Centers for Disease Control and Prevention (CDC) has awarded nearly $7 billion to 62 states, territories, and directly funded localities through the Public Health Emergency Preparedness (PHEP) Cooperative Agreement. The Outcome Monitoring and Evaluation Branch (OMEB) within the Division of State and Local Readiness in the Coordinating Office for Terrorism Preparedness and Emergency Response has been charged with developing measures of performance to evaluate and report on how well this federal investment has improved the nation's ability to prepare for and respond to public health emergencies. Working in close collaboration with local, state, and federal partners participating in CDC's PHEP Evaluation Workgroup (see Appendix C), performance measures were developed to enable CDC and its awardees to

- monitor, for *accountability* purposes, the extent to which awardees are able to demonstrate performance on specific preparedness and response capabilities;
- support *program improvement/technical assistance;* and
- report awardees' best demonstration of preparedness and response capabilities in publications such as CDC's Public Health Preparedness: Mobilizing State by State report

This document provides detailed guidance on the **eight** PHEP Cooperative Agreement performance measures developed for **Budget Period 10 (BP10)*, including a new Health and Human Services/Office of Management and Budget (HHS/OMB) High Priority Performance Measure*** which runs from August 10, 2009, to August 9, 2010. The capabilities to be reported during this period include Incident Management (IM), Laboratory, and Crisis and Emergency Risk Communication (CERC) with the Public. The "new" HHS/OMB High Priority Performance Measure will not require any additional performance demonstration or data collection. This "new" HHS/OMB Priority Performance Measure will build upon the current Incident Management- Staff Assembly measure. Unlike the other Incident Management measures, however, this measure *does* have a target associated with it. Background on the "new" HHS/OMB Priority performance measures is located in Appendix A.

Table 1 displays the capability-based performance measures in greater detail.

Table 1. Budget Period 10 Performance Measures

Incident Management (IM)	
IM – Staff Notification	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to acknowledge notification**
Measurement Specifications	Start time**:** Date and time that a designated official began notifying staff to cover activated incident management roles. Stop time: Date and time that the last staff person needed to cover an activated incident management role acknowledged notification.
IM – Staff Assembly	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty**
Measurement Specification	Start time: Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. Stop time: Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
IM - Staff Assembly ***HHS/OMB High Priority Performance Measure***	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty. Performance Target: 60 minutes**
Measurement Specification	Start time: Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. Stop time: Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
IM - IAP	**Production of the approved Incident Action Plan (IAP) before the start of the second operational period**
Measurement Specifications	Was a written Incident Action Plan approved before the start of the second operational period (Yes/No)?
IM - AAR and IP	**Time to complete a draft of an After Action Report and Improvement Plan**
Measurement Specifications	Start time: Date exercise or public health emergency operation completed. (*The exercise or response may have occurred before or during the budget period for which data are being submitted.)* Stop time: Date the draft AAR and IP were submitted for clearance within the public health agency. (*This date must occur during the budget period for which data are being submitted.)*

Table 1. Budget Period 10 Performance Measures (continued)

Laboratory	
Lab – PFGE – *E. coli* O157:H7	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *E. coli* O157:H7 for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *E. coli* O157:H7 reference or clinical isolates for which the state performed PFGE subtyping.
Lab – PFGE – *Listeria monocytogenes*	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *Listeria monocytogenes* submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *L. monocytogenes* for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *L. monocytogenes* reference or clinical isolates for which the state performed PFGE subtyping.
Crisis and Emergency Risk Communication with the Public (CERC)	
CERC – Public Message Dissemination	**Time to issue a risk communication message for dissemination to the public**
Measurement Specifications	Start time: Date and time that a designated official requested that the first risk communication message be developed. Stop time: Date and time that a designated official approved the first risk communication message for dissemination.

Awardees are strongly encouraged to familiarize themselves with all aspects of this guidance document. This document is organized into three main sections:

- General reporting requirements
- Capability-specific reporting requirements for the IM, Laboratory, and CERC performance measures
- Appendices

General Reporting Requirements

This section of the performance measure guidance is organized as follows:

- Reporting criteria:
  - Reporting schedule and requirements by awardee type
  - Data collection methods for each measure
- Best demonstration of a capability: A description of the type of exercise/incident about which data are to be collected and reported.
- Performance targets: Information related to the target expectations for the two laboratory performance measures and the HHS/OMB High Priority Performance Measure as well as the process for establishing targets for those measures that do not yet have targets assigned to them.

Capability-Specific Reporting Requirements: IM, Laboratory, and CERC Performance Measures

This section of the performance measure guidance is organized by public health capability. A separate section is provided for each capability (IM, Laboratory, and CERC) addressed by the performance measures. Each section is organized as follows:

<u>Introduction</u>

- Rationale for inclusion of the capability;
- Definition of the capability;
- Definition of key terms for the capability; and
- Link to the Department of Homeland Security's Target Capabilities List.

<u>Process Map</u> (for IM and CERC only)

- A visual means of describing the capability. Each map presents the key steps needed to execute the capability, including activities and decision points. The maps were developed to identify those components of the capability most important and most feasible to measure.
- In addition, the process maps reveal additional contextual information to support analysis and interpretation of the performance measures. A key is provided for each map in its lower left corner to help with interpretation.

<u>Performance Measures</u>

For each performance measure, a set of measurement specifications and reporting criteria to support data collection are provided. Table 2 on the following page summarizes the reporting elements for each measure.

Table 2. Organization of Budget Period 10 Performance Measures

Performance Measure	The specific PHEP capability being measured
Measurement Specifications	Data points for calculating the performance measure
Intent	The scientific and/or programmatic rationale for the measure
Reporting Criteria	Activity and reporting requirements: what types of exercises and/or real incidents are applicable, frequency of submission, etc.
Reported Data Elements	Specific information documented and reported to understand the conditions under which the time based measure was collected.
Additional Guidance	Additional information, references, or examples that further explain the requirements of the measure

Appendices

The appendices provide supporting documentation and tools to assist with data collection and reporting for the BP10 performance measures (e.g., Appendix G provides a data collection template for each measure).

General Reporting Requirements

Reporting Criteria

Reporting Schedule

Awardees are responsible for collecting the performance measure data throughout the August 10, 2009, to August 9, 2010 reporting period. The deadline for submission of BP10 performance measure data is November 9, 2010.

Awardee Reporting Requirements

Specific reporting requirements vary by type of awardee and are as follows:

- States: All eight measures (IM, CERC, Laboratory)
- Washington, D.C.: Seven measures (IM, excluding the IM-Staff Assembly HHS/OMB High Priority Performance Measure, CERC, Laboratory)
- Other directly funded localities (Chicago, Los Angeles, and New York City): Five measures (IM, excluding the IM-Staff Assembly HHS/OMB High Priority Performance Measure, and CERC)
- Territories and Freely Associated States of the Pacific: Six measures (IM and CERC)

The intent of these performance measures is aimed at collecting demonstrations of a capability for each directly-funded health department. Therefore, awardees are required to report the data collected **from their health department** for each of the required performance measures. **For IM and CERC with the Public performance measures, awardees should only report on responses or exercises during which the awardee served as the lead agency or actively participated as an assisting agency.**

Data Collection Methods

Data for the BP10 performance measures may come from exercises or real incidents, provided they meet the specifications and criteria outlined for each measure. Table 3 below summarizes the acceptable data collection methods for each measure.

Table 3. Budget Period 10 Performance Measures – Data Collection Methods

PERFORMANCE MEASURE	DATA COLLECTION METHOD				
	Tabletop Exercise (TTX)	Drill	Functional Exercise (FE)	Full-Scale Exercise (FSE)	Real Incident
IM – Staff Notification		X	X	X	X
IM – Staff Assembly		X	X	X	X
IM – Staff Assembly *HHS/OMB High Priority Performance Measure*		X	X	X	X
IM - IAP		X	X	X	X
IM – AAR and IP	X	X	X	X	X
Lab – PFGE *E.coli* O157:H7					X
Lab – PFGE *Listeria*					X

Monocytogenes				
CERC – Public Message Dissemination	X	X	X	X

Awardees that report data for the two Laboratory performance measures are expected to report all *E. coli* O157:H7 and *L. monocytogenes* isolates ***received*** by the state public health PFGE laboratory. However, awardees' performance is based on those isolates for which the state ***performed*** PFGE subtyping.

Best Demonstration of a Capability

For the IM and CERC performance measures, awardees are strongly encouraged to submit performance measure data on multiple exercises and real incidents occurring from August 9, 2009, to August 10, 2010. However, **awardees are required to submit performance measure data based on their one best demonstration** of the capability. Awardees are requested to nominate their most comprehensive or challenging example of performing the capability, provided the methods meet the specifications and criteria outlined for the measure. To assist awardees in determining their best demonstration of the capability, CDC has identified the following decision-making elements:

- Scenario-based execution of tasks and activities within an emergency operations plan;
- Conducted with multiple partners at the local, state, regional, or national levels;
- Includes collaboration, cooperation, and interactive decision-making;
- Conducted under complex conditions such as high-stress and real-time constraints of an actual incident;
- Conducted during a comprehensive exercise or response that allows awardees to collect data on many if not all of the performance measures for a given capability; and
- May or may not be the quickest time demonstrated for the particular measure.

CDC recognizes the need for flexibility in identifying what is considered a best demonstration of the capability. The examples on the following page show how two hypothetical awardees were able to provide a best demonstration of reporting requirements as outlined in Table 3.

Performance Targets

Targets have not been set for the BP10 IM and CERC performance measures. Targets for these performance measures will be identified based on analysis of the BP9 and BP10 data and will be implemented in future budget periods. Explanatory and contextual variables for each performance measure will be analyzed in combination with the time-based metric to develop appropriate and realistic targets.

The Laboratory – PFGE performance measures that have been continued from Budget Period 9 specify a target (established by PulseNet) that 90% of all subtyping data results (for *E.coli* O157:H7 and *Listeria monocytogenes*) be submitted to the PulseNet national database within four working days of receiving the isolate at the PFGE laboratory.

The Incident Management – Staff Assembly HHS/OMB High Priority Performance Measure specifies a target of 60 minutes for state public health agencies to convene a team of trained staff that can make decisions about appropriate response and interaction with partners. This team can be convened in-person, virtually, or a combination of both.

Examples of Best Demonstration

Example 1:

- In November 2009, Awardee A conducted a mass-vaccine dispensing exercise that simulated a response to a pandemic influenza outbreak.
- The exercise was conducted in coordination with numerous local health departments.
- Given that the scenario for the incident was a pandemic flu outbreak, Awardee A used the exercise to test their ability to develop and approve a risk communication message to affected populations. Awardee A also simulated a second operational period and completed a written Incident Action Plan (IAP) for that operational period.
- Following the exercise, Awardee A drafted an After Action Report and Improvement Plan.
- Through this exercise, Awardee A met the requirements, and collected and reported data, for the Incident Management measures focusing on the IAP and AAR/IP, as well as the CERC performance measure.
- Since the exercise was conducted during normal business hours and did not require unannounced staff notification or unannounced and immediate staff assembly, Awardee A was not able to report data from this exercise for the staff notification and staff assembly performance measures associated with IM.

Example 2:

- In February 2010, Awardee B responded to a chemical spill on a highway that occurred during a busy holiday weekend.
- Awardee B notified and immediately assembled public health staff with IM functional responsibilities to respond to the incident.
- Response required coordination with other state agencies as well as hospitals and emergency medical services.
- Site monitoring for potentially harmful substances was initiated and required Awardee B to disseminate timely information to the public about potential risks.
- Due to the time required to clean and assess the site, the incident spanned multiple operational periods and therefore Awardee B developed a written IAP before the second operational period.
- Awardee B finalized an AAR and IP following the incident.
- Awardee B was able to capture required data elements during the incident and used them to report on all four IM performance measures as well as the CERC performance measure.

INCIDENT MANAGEMENT

Page intentionally left blank

Incident Management Performance Measures

Introduction

What is the capability and why was it selected?

Incident management (IM) is a capability required to direct and coordinate the implementation of other public health emergency capabilities and is therefore critical to public health emergency preparedness and response. Incident management allows public health agencies to make informed, timely, and effective decisions that direct resources and personnel to adaptively address ongoing and evolving health needs arising from emergencies.

Capability Definition

The Incident Management Measurement Subgroup (refer to Appendix D) defined incident management for public health as follows:

> Incident management for public health is a flexible and integrated system that provides a common framework for departments and agencies at all levels of government, the private sector, and nongovernmental organizations to work seamlessly to prepare for, prevent, respond to, recover from, and mitigate the health effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property, and harm to the environment.

This definition is based on the National Incident Management System (NIMS). However, this definition specifies "*health* effects" to strengthen the focus on public health emergencies. The phrase "flexible and integrated system" was also added to emphasize the importance of adaptability in incident management. As with NIMS, the definition emphasizes the importance of a common structure for coordinating the activities of multiple response agencies and levels of government and covers all stages of incidents and events (i.e., "prevent, respond to, recover from, and mitigate").

Definition of key terms for IM capability

Below is a list of terms and definitions that appear throughout the Incident Management performance measures. These terms, when they appear in the performance measure tables, are underlined. Please apply the following definitions when interpreting the guidelines for data collection and reporting on the Incident Management performance measures.

Acknowledgement: Notified staff confirms receipt of notification to designated official. Examples of acknowledgement methods include email, Health Alert Network, or cell phone. Acknowledgement methods may differ from notification methods used.

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

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

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

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

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

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

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

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

Federal agencies: Includes all federal governmental agencies.

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

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

Immediate: Performed with no delay, with an expectation that upon receipt of notification the staff is to report for duty as soon as possible or within 60 minutes of the notification.

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

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

Incident Action Plan Approved: The Incident Commander has signed and dated (including the time) the IAP.

Incident management roles: Refers to the Command Staff (Incident Commander, Public Information Officer, Safety Officer, Liaison Officer, and any additional Command Staff) required to support the command function in an incident and General Staff (Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance / Administration Section Chief) **or their equivalent**, in an awardee health department. ***Not all roles may be activated for a given response, and it is possible that agencies will use different titles for equivalent roles***.

As stated by NIMS (December 2008):

> *"Incident management, by distinction, includes directing specific incident operations; acquiring, coordinating and delivering resources to incident sites; and sharing information about the incident with the public … Overall management includes Command Staff assignments required to support the command function …The General Staff is responsible for the functional aspects of the incident command structure."*
>
> ***Note: The level of complexity of an incident will direct the activation of certain incident management roles. In certain scenarios, incident management staff may cover more than one role at a time.*** Incident management roles include personnel ***required to manage*** the incident such as:
>
> Incident Commander – has overall incident management responsibility including developing incident objectives on which subsequent incident action planning will be based, approve the Incident Action Plan, and all requests pertaining to ordering and releasing incident resources.
>
> Public Information Officer – responsible for communicating with the media, public and other agencies with incident-related information needs.
>
> Safety Officer – monitors operations and advises the Incident Commander on all matters relating to operational safety, including the health and safety of public health responders.
>
> Liaison Officer – designated point of contact for representatives of other governmental agencies, nongovernmental organizations and private organizations to provide input on their agency's policies, resource availability, and other incident-related topics.
>
> Additional Command Staff – Depending on the nature and location(s) of the incident or specific requirements established by Incident Command, additional command staff positions may be necessary. For example, a medical advisor may be required to provide advice and recommendations to Incident Command about medical and mental health services, mass casualty, acute care, vector control, epidemiology, or mass prophylaxis considerations.
>
> Operations Section Chief – Responsibilities include the direct management of all tactical activities.
>
> Planning Section Chief – Responsible for the collection, evaluation and dissemination of incident situation information and intelligence to the incident management personnel.
>
> Logistics Section Chief – Responsible for all service support requirements needed to facilitate an effective and efficient response including, but not limited to, providing facilities, transportation, supplies, and equipment.
>
> Finance / Administration Section Chief – Established when the incident management activities require on-scene or incident-specific finance and other administrative support services. Some of

the functions and responsibilities include recording personnel time, maintaining vendor contracts, administering compensation and claims, and conducting an overall cost analysis for the incident.

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

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

Incident safety analysis: Communicates safety and health issues for emergency responders for a given incident / event and identifies mitigation measures to address those issues (NIMS, 2008). Detailed information is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf.

Incident type: Characterizes the complexity of an incident. If your agency uses a different scheme, please choose the type that is most similar to your exercise/incident for reporting:

Type 5 incidents are characterized as follows:

- The incident can be handled with one or two single resources with up to six personnel;
- Command and General Staff positions (other than the Incident Commander) are not activated;
- No written IAP is required; and
- The incident is contained within the first operational period and often within an hour to a few hours after resources arrive on scene.

Type 4 incidents are characterized as follows:

- Command staff and general staff functions are activated only if needed;
- Several resources (e.g., task force or strike team) are required to mitigate the incident;
- Usually limited to one operational period in the control phase;
- Agency administrator may have briefings, and ensure the complexity analysis and delegation of authority are updated; and
- The role of the agency administrator/official includes completing the operational plans, including objectives and priorities.

Type 3 incidents are characterized as follows:

- Some or all of the Command and General staff positions may be activated, as well as Division/Group Supervisor and/or Unit Leader level positions;
- An Incident Management Team (IMT) or incident command organization manages initial action incidents with a significant number of resources; and
- The incident may extend into multiple operational periods.

Type 2 incidents are characterized as follows:

- May require the response of resources out of area, including regional and/or national resources to effectively manage the operations and command and general staffing;
- Most or all of the Command and General Staff positions are filled;
- Many of the functional units are needed and staffed;
- The incident is expected to go into multiple operational periods; and
- The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority.

Type 1 incidents are the most complex and are characterized as follows:

- Requires national resources to safely and effectively manage and operate;
- All of the Command and General staff positions are activated;
- Branches need to be established;
- The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority;
- Use of resource advisors at the incident base is recommended; and
- There is a high impact on the local jurisdiction, requiring additional staff for office administrative and support functions.

Additional information on incident types is available from the Federal Emergency Management Agency at http://www.training.fema.gov/EMIWeb/IS/ICSResource/assets/IncidentTypes.pdf

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

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

Organization Assignment List: Provides a full accounting of incident management and supervisory staff during a given operational period and is a component of the Incident Action Plan (IAP). This list is typically the second page of the IAP using ICS Form 203 or equivalent documentation.

Further information and guidance on the organization assignment list is available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf (NIMS, 2008).

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

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

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

State agencies: Includes all state governmental agencies.

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

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

Tribal agencies: Includes all tribal governmental agencies.

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

Unannounced*:* Without advanced warning or notice.

Link to the Department of Homeland Security's Target Capabilities List (TCL)

This PHEP capability is aligned with three capabilities identified in the TCL:

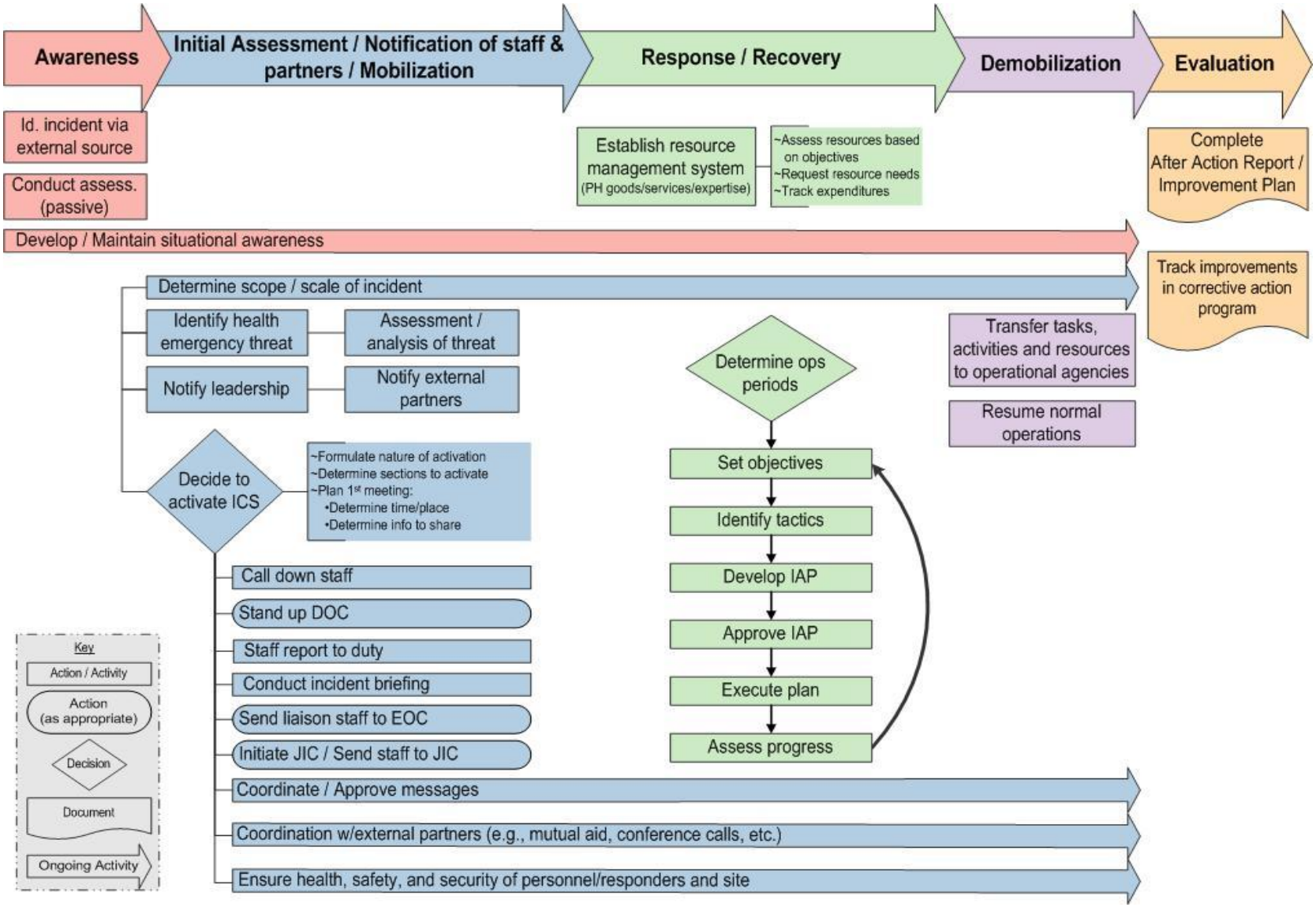
- Onsite incident management
- Emergency operations center management
- Planning

Process Map

The process map on the following page was developed by the Incident Management Measurement Subgroup to capture and illustrate the critical programmatic activities required to implement the incident management capability. While this process map is displayed in a linear fashion, several of the activities are depicted as ongoing and/or iterative processes. In addition, the process map is organized to demonstrate the scalability and dynamic nature of this capability. Figure 1 displays the process map developed by the Incident Management Measurement Subgroup.

Figure 1.

Incident Management Process Map



Performance Measures: Incident Management (IM)

Table 4. IM Performance Measures At-a-Glance

IM – Staff Notification	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to acknowledge notification**
Measurement Specifications	Start time: Date and time that a designated official began notifying staff to cover activated incident management roles. Stop time: Date and time that the last staff person needed to cover an activated incident management role acknowledged notification.
IM – Staff Assembly	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty**
Measurement Specifications	Start time: Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. Stop time: Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
IM – Staff Assembly ***HHS/OMB High Priority Performance Measure***	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty. Performance Target: 60 minutes**
Measurement Specifications	Start time: Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. Stop time: Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
IM - IAP	**Production of the approved Incident Action Plan (IAP) before the start of the second operational period**
Measurement Specifications	Was a written Incident Action Plan approved before the start of the second operational period (Yes/No)?
IM - AAR and IP	**Time to complete a draft of an After Action Report (AAR) and Improvement Plan (IP)**
Measurement Specifications	Start time: Date exercise or public health emergency operations completed. (*The exercise or response may have occurred before or during the budget period for which data are being submitted.)* Stop time: Date the draft AAR and IP were submitted for clearance within the public health agency. (*This date must occur during the budget period for which data are being submitted.)*

Table 5. IM - Staff Notification

IM - Staff Notification	Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to acknowledge notification
Measurement Specifications	**Start time:** Date and time that a designated official began notifying staff to cover activated incident management roles. **Stop time:** Date and time that the last staff person needed to cover an activated incident management role acknowledged notification.
Intent	To ensure a timely and effective response to an incident, awardees must be able to demonstrate the capability both to rapidly notify and to receive acknowledgment from ***their own agency's*** incident management staff covering regardless of time of day. The intent of this measure is to be able to rapidly notify and receive acknowledgement from enough public health staff to cover key incident management roles deemed necessary by the awardee for the real or simulated response that initiated the notification. *Note: This measure does not test staff assembly.*
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are **required to report data collected *from their health department* on their one best demonstration** of staff notification that occurred between 08/10/2009 and 08/09/2010. The demonstration must have occurred during one of the following: ▪ Drill ▪ Functional exercise ▪ Full-scale exercise ▪ Real incident ***The notification must be unannounced AND outside of normal business hours.***
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **operations-based exercises** (drill, functional, or full-scale only) testing staff notification conducted between 08/10/2009 and 08/09/2010 1a. Number of **operations-based exercises** testing *unannounced and outside of normal business* hours staff notification 2. Total number of **real incidents** involving staff notification that occurred between 08/10/2009 and 08/09/2010 2a. Number of **real incidents** involving *unannounced and outside of normal business hours* staff notification ***For each unannounced, outside of normal business hours staff notification being reported:*** 3. Was the staff notification part of a drill, functional exercise, full-scale exercise, or real incident? (select one)

Table 5. IM – Staff Notification (continued)

Reported Data Elements (continued)	4. If reporting data from a real incident: What was the incident type: (select one) ▪ Type 4 ▪ Type 3 ▪ Type 2 ▪ Type 1 5. Was the staff notification unannounced? [Yes/No] 6. Did the staff notification occur outside of normal business hours? [Yes/No] 7. Brief description of real incident or event/incident upon which exercise scenario was based (750 character limit) 8. Notification method(s) used: (select all that apply) ▪ Cell phone ▪ Email outside of rapid notification system ▪ Rapid notification system (e.g. Health Alert Network) ▪ Land-line telephone ▪ Pager ▪ Satellite communication system ▪ Other-specify 9. Acknowledgement method(s) used: (select all that apply) ▪ Cell phone ▪ Email outside of rapid notification system ▪ Rapid notification system (e.g. Health Alert Network) ▪ Land-line telephone ▪ Pager ▪ Satellite communication system ▪ Other-specify 10. Incident management roles (or equivalent lead roles) activated at the time of initial notification: (select all that apply) ▪ Incident Commander ▪ Public Information Officer ▪ Safety Officer ▪ Liaison Officer ▪ Operations Section Chief ▪ Planning Section Chief ▪ Logistics Section Chief ▪ Finance / Administration Section Chief ▪ Additional Lead Roles: Specify - 11. Number of pre-identified staff required to cover activated incident management roles (e.g., ICS staff or equivalent) at the time of the initial notification (must be greater than zero) 12. Number of staff notified to cover these activated incident management roles (must be greater than zero) 13. Number of staff who acknowledged notification (must be greater than zero) 14. Start time (see measurement specifications above)

Table 5. IM – Staff Notification (continued)

Reported Data Elements (continued)	15. Stop time (see measurement specifications above) 16. Does this exercise or incident represent the best demonstration of your agency's staff notification capability? [Yes / No] 17. Brief description of why this exercise or incident was chosen as the best demonstration of a staff notification (750 character limit) 18. Was this your quickest time? [Yes/No]
Additional Guidance	**Exercise types:** Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/VolumeI.pdf **Incident management role:** For the purposes of reporting data for this performance measure, the generic term, "incident management role," refers to senior ICS functions or roles, ***or their equivalent***, in an awardee health department including the command and general staff (Operations Section Chief, Public Information Officer, etc.). Not all roles may be activated for a given response, and it is possible that agencies will use different titles for equivalent roles. Awardees may **not** report notification or assembly of staff at other agencies, including local health departments. **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Methods to record response times:** Though a fully automated electronic system is an efficient means to notify staff and document response times, such a system is **not** necessary to meet the requirements of this measure. Awardees may manually record staff notification and acknowledgement times. **Up-to-date contact list for pre-identified staff:** Since rapid notification of staff depends on maintaining accurate contact information for pre-identified staff, awardees should keep a complete list of contact information for all staff with public health agency incident management responsibilities. Awardees should update this list at least once every six months and record the date of each update.

Table 6. IM – Staff Assembly

IM - Staff Assembly	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty**
Measurement Specifications	**Start time:** Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. **Stop time:** Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
Intent	To ensure a timely and effective response to an incident, awardees must demonstrate the capability to immediately assemble public health staff with senior incident management roles.
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are **required to report data from their health department on their one best demonstration** of a staff assembly that occurred between 08/10/2009 and 08/09/20010. The demonstration must have occurred during one of the following: ▪ Drill ▪ Functional exercise ▪ Full-scale exercise ▪ Real incident ***Staff assembly must be unannounced AND immediate.***
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **operations-based exercises** (drill, functional, or full-scale only) testing staff assembly conducted between 08/10/2009 and 08/09/2010 1a. Number of **operations-based exercises** testing *unannounced and immediate* staff assembly; 2. Total number of **real incidents** involving staff assembly that occurred between 08/10/2009 to 08/09/2010 2a. Number of **real incidents** involving *unannounced and immediate* staff assembly ***For each unannounced and immediate staff assembly being reported:*** 3. Was the staff assembly part of a drill, functional exercise, full-scale exercise, or real incident? (select one) 4. If reporting data from a real incident: What was the incident type: (select one) ▪ Type 4 ▪ Type 3 ▪ Type 2 ▪ Type 1 5. Was the staff assembly **unannounced**? [Yes / No] 6. Was the staff assembly **immediate**? [Yes / No]

Table 6. IM – Staff Assembly (continued)

Reported Data Elements (continued)	7. Brief description of real incident or event/incident upon which exercise scenario was based (750 character limit) 8. Was staff assembly virtual, physical, or a combination? (select one) 9. Was the Department Operations Center (DOC) activated? [Yes / No] 10. Incident management roles (or equivalent lead roles) activated at the time of initial notification: (select all that apply) ▪ Incident Commander ▪ Public Information Officer ▪ Safety Officer ▪ Liaison Officer ▪ Operations Section Chief ▪ Planning Section Chief ▪ Logistics Section Chief ▪ Finance / Administration Section Chief ▪ Additional Lead Roles: Specify 11. Number of pre-identified staff required to fill activated incident management roles at the time of the initial notification (must be greater than zero) 12. Number of staff notified to cover activated incident management roles (must be greater than zero) 13. Number of staff who reported for duty to cover activated incident management roles (must be greater than zero) 14. Start time (see measurement specifications above) 15. Stop time (see measurement specifications above) 16. Does this exercise or incident represent the best demonstration of your agency's staff assembly capability? [Yes / No] 17. Brief description of why this exercise or incident was chosen as the best demonstration of a staff assembly (750 character limit)
Additional Guidance	**Exercise types:** Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/VolumeI.pdf **Incident management role:** For the purposes of reporting data for this performance measure, the generic term, "incident management role," refers to senior ICS functions or roles, ***or their equivalent***, in an awardee health department including the command and general staff (Operations Section Chief, Public Information Officer, etc.). Not all roles may be activated for a given response, and it is possible that agencies will use different titles for equivalent roles. Awardees may **not** report notification or assembly of staff at other agencies, including local health departments. **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Methods to record response times:** Though a fully automated electronic system is an efficient means to notify staff and document time of notification and time of reporting for duty, awardees may manually record staff response (assembly) times.

Table 7. IM – Staff Assembly – *HHS/OMB High Priority Performance Measure*

IM - Staff Assembly ***HHS/OMB High Priority Performance Measure***	**Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty.** **Performance Target: 60 minutes**
Measurement Specifications	**Start time:** Date and time that a designated official began notifying staff to report for immediate duty to cover activated incident management roles. **Stop time:** Date and time that the last staff person notified to cover an activated incident management role reported for immediate duty.
Intent	To ensure a timely and effective response to an incident, awardees must demonstrate the capability to immediately assemble public health staff with senior incident management roles.
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are **required to report data from their health department on their one quickest demonstration** of a staff assembly that occurred between 08/10/2009 and 08/09/20010. The demonstration must have occurred during one of the following: ▪ Drill ▪ Functional exercise ▪ Full-scale exercise ▪ Real incident ***Staff assembly must be unannounced AND immediate.*** ***The performance target for this measure is 60 minutes. If demonstration of this measure is more than 60 minutes, report the demonstration time closest to the target of 60 minutes.***
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **operations-based exercises** (drill, functional, or full-scale only) testing staff assembly conducted between 08/10/2009 and 08/09/2010 1a. Number of **operations-based exercises** testing *unannounced and immediate* staff assembly; 2. Total number of **real incidents** involving staff assembly that occurred between 08/10/2009 to 08/09/2010 2a. Number of **real incidents** involving *unannounced and immediate* staff assembly ***For each unannounced and immediate staff assembly being reported:*** 3. Was the staff assembly part of a drill, functional exercise, full-scale exercise, or real incident? (select one)

Table 7. IM – Staff Assembly – HHS/OMB priority performance measure (continued)

Reported Data Elements (continued)	4. If reporting data from a real incident: What was the incident type: (select one) ▪ Type 4 ▪ Type 3 ▪ Type 2 ▪ Type 1 5. Was the staff assembly **unannounced**? [Yes / No] 6. Was the staff assembly **immediate**? [Yes / No] 7. Did this staff assembly meet the performance target of 60 minutes? [Yes / No] 8. Brief description of real incident or event/incident upon which exercise scenario was based (750 character limit) 9. Was staff assembly virtual, physical, or a combination? (select one) 10. Was the Department Operations Center (DOC) activated? [Yes / No] 11. Incident management roles (or equivalent lead roles) activated at the time of initial notification: (select all that apply) ▪ Incident Commander ▪ Public Information Officer ▪ Safety Officer ▪ Liaison Officer ▪ Operations Section Chief ▪ Planning Section Chief ▪ Logistics Section Chief ▪ Finance / Administration Section Chief ▪ Additional Lead Roles: Specify 12. Number of pre-identified staff required to fill the activated incident management roles at the time of the initial notification (must be greater than zero) 13. Number of staff notified to fill the activated incident management roles (must be greater than zero) 14. Number of staff who reported for duty to cover activated incident management roles (must be greater than zero) 15. Start time (see measurement specifications above) 16. Stop time (see measurement specifications above) 17. Was this demonstration your agencies' quickest time for a staff assembly? [Yes / No]

Table 7. IM – Staff Assembly – HHS/OMB priority performance measure (continued)

Additional Guidance	**Exercise types:** Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/VolumeI.pdf **Incident management role:** For the purposes of reporting data for this performance measure, the generic term, "incident management role," refers to senior ICS functions or roles, ***or their equivalent***, in an awardee health department including the command and general staff (Operations Section Chief, Public Information Officer, etc.). Not all roles may be activated for a given response, and it is possible that agencies will use different titles for equivalent roles. Awardees may **not** report notification or assembly of staff at other agencies, including local health departments. **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Methods to record response times:** Though a fully automated electronic system is an efficient means to notify staff and document time of notification and time of reporting for duty, it is not necessary to meet the requirements of this measure. Awardees may manually record staff response (assembly) times.

Table 8. IM – Incident Action Plan (IAP)

IM - IAP	Production of the approved Incident Action Plan (IAP) before the start of the second operational period
Measurement Specifications	Was a written Incident Action Plan approved before the start of the second operational period? (Yes / No)
Intent	To ensure a timely and effective response, awardees must engage in sound, timely planning during the response to guide the incident management decision process. A critical component of this planning is the ability to produce an approved IAP for each operational period. *Note: This is a binary measure where time is judged relative to the beginning of the second operational period. While it is recognized that the quality of an IAP is variable and dependent on many different attributes, the intent of this measure does not include the extent to which an IAP is adequate for a given response.*
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are **required to report data from their health department on their one best demonstration** of a written IAP that occurred between 08/10/2009 and 08/09/2010. The demonstration must have occurred during one of the following: ▪ Drill ▪ Functional Exercise ▪ Full-Scale Exercise ▪ Real Incident The exercise or real incident must include the following characteristics: ▪ The exercise scenario or real incident continues over two or more operational periods; ▪ Command and General staff sections (not necessarily all) are activated; and ▪ The IAP is comprised of the following components: ISC Form 202, "Incident Objectives", ICS Form 203, "Organization Assignment List", ICS Form 204, "Assignment List", ICS Form 215a, "Incident Action Plan Safety Analysis" or equivalent documentation.
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **operations-based exercises** (drill, functional exercise, or full-scale exercise only) conducted between 08/10/2009 and 08/09/2010 that extended two or more operational periods 1a. Total number of **operations-based exercises** (drill, functional exercise, or full-scale exercise only) during which a written IAP was produced **before the start of the second operational period** 2. Total number of **real incidents** extending two or more operational periods that occurred between 08/10/2009 and 08/09/2010 2a. Total number of **real incidents** during which a written IAP was completed **before the start of the second operational period**

Table 8. IM – IAP (continued)

Reported Data Elements (continued)

For each written Incident Action Plan being reported:

3. Did you have any operations-based exercises or real incidents resulting in the production of a written IAP? [Yes / No]
4. Was a written IAP approved before the start of the second operational period? [Yes / No]
5. Was the IAP produced during a drill, functional exercise, full-scale exercise, or real incident? (select one)
6. What was the complexity of the simulated or real incident at the time that the IAP was written? (select one)
    - Type 4
    - Type 3
    - Type 2
    - Type 1
7. Brief description of the real incident or event/incident upon which the exercise scenario was based (750 character limit)
8. Number of federal and state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)
9. Number of local and tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)
10. Did your agency act in a lead or assisting role? (select one)
11. Did you partner with any other public or private sector agencies during this exercise or real incident? [Yes – Private Sector / Yes – Public Sector / No] (Can select No, or one or both Yes options);

    11a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise / real incident? (select all that apply)
        - Business(es)
        - Hospital(s)
        - Media
        - Nonprofit / community-based organizations
        - Universities
        - Volunteer health professionals
        - Other-specify

    11b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise / real incident? (select all that apply)
        - Agriculture
        - Education
        - Emergency Management
        - Emergency Medical Services
        - Environmental Health / Protection
        - Fire Service
        - Indian Health Service
        - Law Enforcement
        - National Guard
        - Public Health (excluding awardee)
        - Other-specify

Table 8. IM – IAP (continued)

Reported Data Elements (continued)	12. Did the IAP include "Incident Objectives" documented on ICS Form 202 or equivalent documentation? [Yes / No] 13. Did the IAP include an "Organization Assignment List" on ICS Form 203 or equivalent documentation? [Yes / No] 14. Did the IAP include an "Assignment List" on ICS Form 204 or equivalent documentation? [Yes / No] 15. Did the IAP include an Incident Safety Analysis? [Yes / No] 16. Incident management roles (or equivalent lead roles) activated **during the *first* operational period**: (select all that apply) ▪ Incident Commander ▪ Public Information Officer ▪ Safety Officer ▪ Liaison Officer ▪ Operations Section Chief ▪ Planning Section Chief ▪ Logistics Section Chief ▪ Finance / Administration Section Chief ▪ Additional Lead Roles - Specify 17. Number of staff who covered activated incident management roles **during the *first* operational period.** (must be greater than zero) 18. Does this exercise or incident represent the best demonstration of your agency's capability to complete a written IAP? [Yes / No] 19. Brief description of why this exercise or incident was chosen as the best demonstration of a written IAP (750 character limit)
Additional Guidance	**Exercise types:** Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/VolumeI.pdf **ICS forms:** Descriptions and templates for the ICS Forms can be found in National Incident Management System, available at http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf **Maintenance of records:** Awardees are required to maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Methods to record data:** Though a fully automated electronic system is an efficient means to maintain documentation of data for this measure, such a system is *not* necessary to meet the requirements of this measure. Awardees may manually record all data elements.

Table 9. IM – After Action Report and Improvement Plan (AAR / IP)

IM – AAR and IP	Time to complete a draft of an After Action Report (AAR) and Improvement Plan (IP)
Measurement Specifications	**Start time:** Date exercise or public health emergency operations completed. (*The exercise or response may have commenced before or during the budget period for which data are being submitted.)* **Stop time:** Date the draft AAR and IP were submitted for clearance within the public health agency. (*This date must fall within the budget period for which data are being submitted.)*
Intent	Through the use of after-action reporting and improvement planning, awardees must demonstrate the capability to analyze real or simulated response actions, describe needed improvements, and prepare a plan for making improvements within an acceptable timeframe.
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are ***required to report data from their health department on their one best demonstration*** of an AAR and IP that were drafted between 08/10/2009 and 08/09/2010. This AAR and IP must have been drafted as a result of one of the following: ▪ Tabletop exercise ▪ Drill ▪ Functional exercise ▪ Full-scale exercise ▪ Real incident ***The date of AAR/IP submitted for clearance MUST fall within the budget period (August 10, 2009 – August 9, 2010).***
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **exercises** (tabletop, drill, functional, or full-scale exercise, only) that resulted in the completion of a draft AAR and IP between 08/10/2009 and 08/09/2010 2. Total number of **real incidents** that resulted in the completion of a draft of an AAR and IP between 08/10/2009 and 08/09/2010 ***For each example of the completion of a draft AAR and IP being reported:*** 3. Was the AAR and IP the result of a tabletop exercise, drill, functional exercise, full-scale exercise, or real incident? (select one) 4. If reporting data from a real incident: What was the incident type: (select one) ▪ Type 4 ▪ Type 3 ▪ Type 2 ▪ Type 1

Table 9. IM – AAR / IP (continued)

Reported Data Elements (continued)

5. Brief description of real incident or event/incident upon which exercise scenario was based (750 character limit)
6. Number of federal and state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)
7. Number of local and tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)
8. Did your agency act in a lead or an assisting role? (select one)
9. Did you partner with any other public or private sector agencies during this exercise or real incident? [Yes – Private Sector / Yes – Public Sector / No] (Can select No, or one or both Yes options);

    8a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise / real incident? (select all that apply)
    - Business(es)
    - Hospital(s)
    - Media
    - Non-profit/community-based organizations
    - Universities
    - Volunteer health professionals
    - Other-specify

    8b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise / real incident? (select all that apply)
    - Agriculture
    - Education
    - Emergency Management
    - Emergency Medical Services
    - Environmental Health / Protection
    - Fire Service
    - Indian Health Service
    - Law Enforcement
    - National Guard
    - Public Health (excluding awardee)
    - Other-specify

10. Start time (see measurement specifications above)
11. Stop time (see measurement specifications above)
12. Date AAR and IP were approved by the public health agency (MM/DD/YY)
13. Does this exercise or incident represent the best demonstration of your agency's capability to complete an AAR and IP? [Yes / No]
14. Brief description of why this exercise or incident was chosen as the best demonstration of the completion of an AAR and IP (750 character limit)
15. Was this your quickest time? [Yes / No]

Table 9. IM – AAR / IP (continued)

Additional Guidance	**Exercise types:** Additional information about exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/Volume1.pdf **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Methods to record data:** Though a fully automated electronic system is an efficient means to maintain documentation of data for this measure, such a system is *not* necessary to meet the requirements of this measure. Awardees may manually record all data elements.

LABORATORY

Page intentionally left blank

Laboratory Performance Measures

Introduction

What is the capability and why was it selected?

The laboratory performance measures were identified and developed in collaboration with the PulseNet program at the Centers for Disease Control and Prevention (CDC). Participants of PulseNet perform standardized molecular subtyping of foodborne disease-causing bacteria through pulsed filed gel electrophoresis (PFGE). To allow for rapid comparison of the patterns, an electronic, dynamic database at the CDC is available on demand to participants. Please visit the PulseNet website at http://www.cdc.gov/PULSENET/ for a complete description of this national network of public health and food regulatory agency laboratories

Definition of key terms for Laboratory capability

Below is a list of terms and definitions that appear throughout the laboratory performance measures. These terms, when they appear in the performance measure tables, are underlined. Please apply the following definitions when interpreting the guidelines for data collection and reporting on the Laboratory Testing performance measures.

Receipt of isolate: The time when the PFGE laboratory has a pure culture of a viable organism with know identification.

Working days: This term is equivalent to "business days"

Link to the Department of Homeland Security's Target Capabilities List (TCL).

The laboratory performance measures are aligned with the following capabilities identified in the DHS Target Capabilities List (TCL):

- Laboratory testing
- Information gathering and recognition of indicators and warning

Performance Measures: Laboratory

Table 10. Laboratory Performance Measures At a Glance

Lab – PFGE – *E. coli* O157:H7	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *E. coli* O157:H7 for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *E. coli* O157:H7 reference or clinical isolates for which the state performed PFGE subtyping.
Lab – PFGE – *Listeria monocytogenes*	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *Listeria monocytogenes* submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *Listeria monocytogenes* for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *Listeria monocytogenes* reference or clinical isolates for which the state performed PFGE subtyping.

Table 11. Laboratory – PFGE – *E. coli* O157:H7

Lab – PFGE – *E. coli* O157:H7	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *E. coli* O157:H7 submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *E. coli* O157:H7 for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *E. coli* O157:H7 reference or clinical isolates for which the state performed PFGE subtyping.
Intent	Awardees need to be able to inform local, state, and national laboratorians and epidemiologists of disease occurrences in a timely manner to determine the extent and scope of potential outbreaks and to minimize the effects of these outbreaks. Performing PFGE subtyping and submitting data results to the PulseNet electronic database in a timely manner indicates the public health laboratory's ability to subtype specific bacteria and share results quickly.
Reporting Criteria	Self-report data submitted annually. State awardees and Washington, D.C., are required to report on this performance measure.
Target	90% of PFGE subtyping data results during the budget period are submitted to the PulseNet database within four working days.
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Did the state public health laboratory receive any *E.coli* O157:H7 reference or clinical isolates between 08/10/2009 and 08/09/2010? [Yes/ No] 2. If YES to question #1, how many *E.coli* O157:H7 reference or clinical isolates did the state public health PFGE laboratory receive between 08/10/09 and 08/09/10? 3. If YES to question #1, of the *E.coli* O157:H7 reference or clinical isolates that the state public health PFGE laboratory received, how many were sent to another laboratory/laboratories between 08/10/2009 and 08/09/2010? 3a. For the *E.coli* O157:H7 reference or clinical isolates that were sent to another laboratory/laboratories between 08/10/2009 and 08/09/2010, name the laboratory/laboratories, the city, and the state that performed PFGE subtyping. 4. If YES to question #1, for how many *E.coli* O157:H7 reference or clinical isolates did the state public health PFGE laboratory perform PFGE subtyping between 08/10/2009 and 08/09/2010? 5. How many of the PFGE results for *E. coli* O157:H7 reference or clinical isolates for which the state public health PFGE laboratory performed PFGE subtyping from 08/10/2009 to 08/09/2010 were **submitted** to the PulseNet database **within four working days**?

Table 11. Laboratory – PFGE – *E.coli* O157:H7 *(continued)*

Reported Data Elements (continued)	6. If Percentage* <90%, why were fewer than 90% of the state's *E.coli* O157:H7 PFGE laboratory subtyping results submitted to PulseNet within four working days? **Percentage = (Number of PFGE results submitted to PulseNet within four working days / Number of isolates for which laboratory performed PFGE subtyping)*100*
Additional Guidance	**Submission of results within four working days:** The target for this measure is the submission of PFGE subtyping results to PulseNet within four working days from the date that the PFGE laboratory has a pure culture of a viable organism with know identification. **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Duplicate isolates**: If PFGE laboratory does not subtype duplicate isolates received do not count the duplicate isolates in the number of isolates received.

Table 12. Laboratory – PFGE – *Listeria Monocytogenes*

Lab – PFGE – *Listeria monocytogenes*	**Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results for *Listeria monocytogenes* submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.**
Measurement Specifications	Numerator: Number of reference or clinical isolates that were identified as *Listeria monocytogenes* for PFGE subtyping and submitted to CDC's PulseNet database within four working days of receipt of isolate at the PFGE laboratory. Denominator: Total number of *Listeria monocytogenes* reference or clinical isolates for which the state performed PFGE subtyping.
Intent	Awardees need to be able to inform local, state, and national laboratorians and epidemiologists of disease occurrences in a timely manner to determine the extent and scope of potential outbreaks and to minimize the effects of these outbreaks. Performing PFGE subtyping and submitting data results to the PulseNet electronic database in a timely manner indicates the public health laboratory's ability to sub-type specific bacteria and share results quickly.
Reporting Criteria	Self-report data submitted annually. State awardees and Washington, D.C., are required to report on this performance measure.
Target	90% of PFGE subtyping data results during the budget period are submitted to the PulseNet database within four working days.
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Did the state public health laboratory receive any *Listeria monocytogenes* reference or clinical isolates between 08/10/2009 and 08/09/2010? [Yes / No] 2. If YES to question #1, how many *Listeria monocytogenes* reference or clinical isolates did the state public health PFGE laboratory receive between 08/10/2009 and 08/09/2010? 3. If YES to question #1, of the *Listeria monocytogenes* reference or clinical isolates that the state public health PFGE laboratory received, how many were sent to another laboratory/laboratories between 08/10/2009 and 08/09/2010? 3a. For the *Listeria monocytogenes* reference or clinical isolates that were sent to other laboratory/laboratories between 08/10/2009 and 08/09/2010, name the laboratory/laboratories, the city, and the state that performed PFGE subtyping. 4. If YES to question #1, for how many *Listeria monocytogenes* reference or clinical isolates did the state public health PFGE laboratory perform PFGE subtyping between 08/10/2009 and 08/09/2010? 5. How many of the PFGE results for *Listeria monocytogenes* reference or clinical isolates for which the state public health PFGE laboratory performed PFGE subtyping from 08/10/2009 to 08/09/2010 were **submitted** to the PulseNet database within four working days?

Table 12. Laboratory – PFGE – *Listeria Monocytogenes*

Reported Data Elements (continued)	6. If Percentage* <90%, why were fewer than 90% of the state's *Listeria monocytogenes* PFGE laboratory subtyping results submitted to PulseNet within four working days? **Percentage = (Number of PFGE results submitted to PulseNet within four working days / Number of isolates for which laboratory performed PFGE subtyping)*100*
Additional Guidance	**Submission of results within four working days:** The target for this measure is the submission of PFGE subtyping results to PulseNet within four working days from the date that the PFGE laboratory has a pure culture of a viable organism with know identification. **Maintenance of records:** Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits. **Duplicate isolates**: If PFGE laboratory does not subtype duplicate isolates received do not count the duplicate isolates in the number of isolates received.

CRISIS AND EMERGENCY RISK COMMUNICATION (CERC) WITH THE PUBLIC

Page intentionally left blank

CERC with the Public Performance Measure

Introduction

What is the capability and why was it selected?

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

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

Note: CERC with the public is distinguished from tactical communication, which involves communication *among responders*. For more information on CERC, including training curricula and tools, go to http://emergency.cdc.gov/cerc/index.asp.

Capability Definition

The CERC Measurement Subgroup (refer to Appendix E) defined crisis and emergency risk communication with the public as follows:

> Crisis and emergency risk communication is the capability to provide accurate, credible, actionable, and timely information to the public in culturally and linguistically appropriate ways to inform decision making and reduce uncertainty before, during, and after a public health emergency. It involves an iterative process of developing, coordinating, and disseminating information to the public, responding to inquiries and reactions from the public, and evaluating the effectiveness of the information provided and the delivery channels utilized.

In developing this definition, the CERC Measurement Subgroup emphasized that, during emergencies, information must flow both to and from the public; thus, the definition includes responding to inquiries from the public as well as pushing messages out to the public. The group also emphasized the need for messages to have certain characteristics, including accuracy, credibility, actionability, and timeliness. Finally, the subgroup emphasized the importance of ongoing evaluation of the effectiveness of the delivery channels used to disseminate risk communication messages.

Definition of key terms

Below is a list of terms and definitions that appear throughout the Incident Management performance measures. These terms, when they appear in the performance measure tables, are underlined. Please apply the following definitions when interpreting the guidelines for data collection and reporting on the CERC with the public performance measures.

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

Acting in a lead role: When the public health agency assumes primary responsibility for managing the response and recovery to an incident, either simulated or real, including the coordination of resources in order to respond to an incident in an efficient manner, the public health agency is acting in a lead role. For example, if the awardee participated in an exercise led by the State emergency management agency,

and the awardee had responsibility for drafting either its own risk communication message on the public-health related aspects of the scenario (lead role) or a portion of a broader risk communication message (assisting role), the public health agency can report either for this measure.

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

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

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

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

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

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

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

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

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

Incident type: Characterizes the complexity of an incident. If your agency uses a different scheme, please choose the type that is most similar to your exercise/incident for reporting:

Type 5 incidents are characterized as follows:

- The incident can be handled with one or two single resources with up to six personnel;
- Command and General Staff positions (other than the Incident Commander) are not activated;
- No written IAP is required; and
- The incident is contained within the first operational period and often within an hour to a few hours after resources arrive on scene.

Type 4 incidents are characterized as follows:

- Command staff and general staff functions are activated only if needed;
- Several resources (e.g., task force or strike team) are required to mitigate the incident;
- Usually limited to one operational period in the control phase;
- Agency administrator may have briefings, and ensure the complexity analysis and delegation of authority are updated; and
- The role of the agency administrator/official includes completing the operational plans, including objectives and priorities.

Type 3 incidents are characterized as follows:

- Some or all of the Command and General staff positions may be activated, as well as Division/Group Supervisor and/or Unit Leader level positions;
- An Incident Management Team (IMT) or incident command organization manages initial action incidents with a significant number of resources; and
- The incident may extend into multiple operational periods.

Type 2 incidents are characterized as follows:

- May require the response of resources out of area, including regional and/or national resources to effectively manage the operations and command and general staffing;
- Most or all of the Command and General Staff positions are filled;
- Many of the functional units are needed and staffed;
- The incident is expected to go into multiple operational periods; and
- The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority.

Type 1 incidents are the most complex and are characterized as follows:

- Requires national resources to safely and effectively manage and operate;
- All of the Command and General staff positions are activated;
- Branches need to be established;
- The designated official is responsible for the incident complexity analysis, administrator briefings, and written delegation of authority;
- Use of resource advisors at the incident base is recommended; and
- There is a high impact on the local jurisdiction, requiring additional staff for office administrative and support functions.

Additional information on incident types is available from the Federal Emergency Management Agency at http://www.training.fema.gov/EMIWeb/IS/ICSResource/assets/IncidentTypes.pdf

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

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

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

- Print media release refers to any communication that is disseminated through printed material such as newspapers, magazines, direct mail, signs and billboards.
- Radio
- Spokesperson refers to any message delivered through an appearance on Television news release, at a conference, community meeting, or any other in-person appearance (whether delivered by health department personnel, spokesperson, or news anchor).
- Web release refers to any publication or posting of a message on a public website.
- Other captures any alternative delivery method.

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

State agencies: Includes all state governmental agencies.

Tribal agencies: Includes all tribal governmental agencies.

Link to the Department of Homeland Security's Target Capabilities List (TCL).

This PHEP capability draws upon a subset of the activities covered under the TCL:

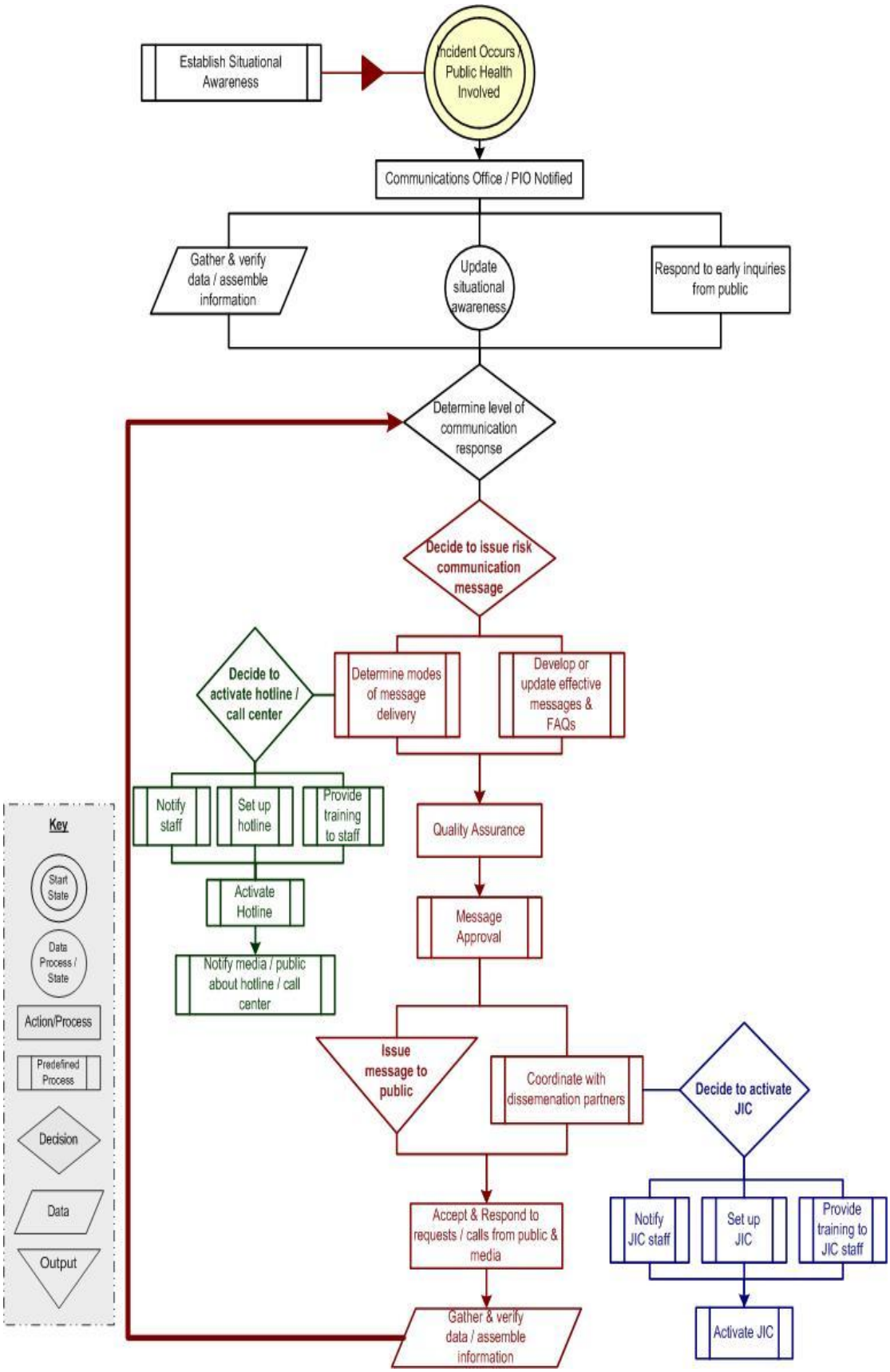
- Emergency public information and warning

Process Map

The process map was developed by the CERC with the Public Measurement Subgroup to illustrate critical programmatic activities. While several activities (i.e., activate joint information center) are displayed on the process map, it is recognized that not all health departments exert full control and / or authority over such activities. However, these activities are considered critical components to the process and are included in the process map accordingly. Figure 2 displays the process map developed by the CERC with the Public Measurement Subgroup.

Figure 2.

Crisis and Emergency Risk Communication (CERC) with the Public



Performance Measure: CERC with the Public

Table 13. CERC – Public Message Dissemination

CERC - Public Message Dissemination	Time to issue a risk communication message for dissemination to the public
Measurement Specifications	Start time: Date and time that a designated official requested that the ***first*** risk communication message be developed. Stop time: Date and time that a designated official approved the ***first*** risk communication message for dissemination.
Intent	To inform decision making by the public and reduce uncertainty before, during, and after a public health emergency, awardees must demonstrate the ability to develop, coordinate, and disseminate timely information to the public about the public health emergency. It is critical that a public health agency be able to disseminate the first risk communication message to the public during a public health emergency to ensure that the public is first made aware of the incident and necessary actions in a timely manner and from a credible source (see http://emergency.cdc.gov/cerc/pdf/CERC-SEPT02.pdf for additional information).
Reporting Criteria	Self-report data submitted annually. Awardees may report data from multiple exercises and / or real incidents. However, awardees are **required to report data from their health department on their one best demonstration** of the development and dissemination of a risk communication message that occurred between 08/10/2009 and 08/09/2010. This demonstration must have occurred during one of the following: ▪ Drill ▪ Functional exercise ▪ Full-scale exercise ▪ Real incident This measure pertains specifically to the ***first*** CERC message disseminated in the context of an emergency. The focus is on the first measure because research has shown that the first message is critical as it sets the stage for comparison of all subsequent messages on a topic.
Reported Data Elements	The following information will be collected in support of the performance measure: 1. Total number of **operations-based exercises** (drill, functional exercise, or full-scale exercise only) occurring between 08/10/2009 and 08/09/2010 that tested the process of risk communication message dissemination to the public 2. Total number of **real incidents** occurring between 08/10/2009 and 08/09/2010 that involved risk communication message dissemination to the public

Table 12. CERC –Public Message Dissemination (continued)

Reported Data Elements (continued)	***For each example of the development of a risk communication message for dissemination to the public being reported:***

3. Was the message dissemination part of a drill, functional exercise, full-scale exercise, or real incident? (select one)
4. If reporting data from a real incident: What was the incident type when the first message was approved for dissemination: (select one)
    - Type 4
    - Type 3
    - Type 2
    - Type 1
5. Brief description of real incident or event / incident upon which exercise scenario was based (750 character limit)
6. Number of federal and state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)
7. Number of local or tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)
8. Did your agency act in a lead or an assisting role? (select one)
9. Did you partner with any other public or private sector agencies during this exercise or real incident? [Yes – Private Sector / Yes – Public Sector / No] (Can select No, or one or both Yes options)

    8a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise/real incident? (select all that apply)
        - Business(es)
        - Hospital(s)
        - Media
        - Nonprofit/community-based organizations
        - Universities
        - Volunteer health professionals
        - Other-specify

    8b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise/real incident? (select all that apply)
        - Agriculture
        - Education
        - Emergency Management
        - Emergency Medical Services
        - Environmental Health / Protection
        - Fire Service
        - Indian Health Service
        - Law Enforcement
        - National Guard
        - Public Health (excluding awardee)
        - Other-specify

Table 12. CERC –Public Message Dissemination (continued)

Reported Data Elements (continued)	10. Was the message developed from a pre-drafted template? [Yes / No] 11. Was the message written at or below a 6th grade reading level? [Yes / No / Not Assessed] 12. Who was the intended audience of the message? (General Population, Population(s) with special needs – specify) 13. In which language(s) was the message developed? (List all) 14. What was the intended method of delivery of the message? (select all that apply) ▪ Print media release ▪ Radio ▪ Spokesperson (TV or in-person appearance) ▪ Web release ▪ Other-specify 15. Who was the immediate recipient of the approved message? (select all that apply) ▪ Clearance or dissemination authority beyond the public health agency ▪ Dissemination partner – specify ▪ Public information line ▪ Public information website ▪ Other-specify 16. Start Time (see measurement specifications above) 17. Stop Time (see measurement specifications above) 18. If reporting data from a real incident: Approximate date / time that message was disseminated to the public. 19. Does this exercise or incident represent the best demonstration of your agency's capability to develop a CERC message? [Yes / No] 20. Brief description of why this exercise or incident was chosen as the best demonstration of the development of a risk communication message for dissemination to the public (750 character limit) 21. Was this your quickest time? (Yes/No)
Additional Guidance	**Exercise types**: Additional information on exercise types is available from the Homeland Security Exercise and Evaluation Program at https://hseep.dhs.gov/support/VolumeI.pdf **First CERC message**: This measure pertains specifically to the first CERC message released in the context of an emergency. The focus is on the first measure because research has shown that first message is critical as it sets the stage for comparison of all subsequent messages on a topic. (see http://emergency.cdc.gov/cerc/pdf/CERC-SEPT02.pdf for additional information). **Methods to record data**: Though a fully automated electronic system is an efficient means to maintain documentation of data for this measure, such a system is not necessary to meet the requirements of this measure. Awardees may manually record all data elements. **Maintenance of records**: Please maintain paper and/or electronic log(s) or other documentation of all data reported for this performance measure. Data submitted may be verified by an independent party during scheduled site visits.

APPENDICES

Page intentionally left blank

Appendix A: HHS/OMB High Priority Performance Goal

In June 2009, the Office of Management and Budget (OMB) disseminated a memorandum to heads of federal departments and agencies providing an overview for the President's Fiscal Year 2011 Budget and Performance Plans. As stated by OMB, "our goal is to build a transparent, high-performance government capable of addressing the challenges of the 21st century…" To this end, "identification of agency high-priority performance goals is a first step toward developing the President's agenda for building a high-performing government." Departments and agencies were instructed by OMB to identify a limited a number of high-priority goals and begin to define the strategies and means to achieve them. Regular reviews of the progress agencies are making to improve performance in priority areas including problems they encountered and plans to address those problems will be conducted.

A number of high-priority performance goals were submitted by HHS to OMB for consideration. One CDC PHEP-related measure, the "Incident Command Assembly" measure (included in this guidance), was selected for inclusion in the President's Fiscal Year 2011 Budget and Performance plan. The HHS/OMB High Priority Performance Goal: Incident Command Structure Target is as follows:

> *By 2011, increase the percentage of state public health agencies that can convene within 60 minutes of notification a team of trained staff that can make decisions about appropriate response and interaction with partners to 90 percent.* (CDC, 2009 Baseline: 70 percent)

CDC will be responsible for collecting and reporting information related to the progress toward this HHS/OMB high priority performance goal: Incident Command Assembly Target. The readiness of public health agencies to implement Incident Command functions will be collected from the Public Health and Emergency Preparedness (PHEP) Cooperative Agreement funding recipients via the PERFORMS system. Specifically, data currently collected and submitted for the Incident Management – Staff Assembly *HHS/OMB High Priority Performance Measure* performance measure associated with CDC's PHEP funding will support this effort. Please note that this measure is required only of the 50 states and sets a target for the states of convening staff within *60 minutes*.

Appendix B: Background on the PHEP Measurement Project

The Budget Period 10 performance measures were developed following an extensive process of stakeholder engagement and program prioritization activities. The Outcome Monitoring and Evaluation Branch (OMEB) in the Division of State and Local Readiness (DSLR), Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) at the Centers for Disease Control and Prevention (CDC) worked with CDC's PHEP Evaluation Workgroup to identify high priority PHEP capabilities for which measures should be developed. This workgroup is composed of representatives from federal agencies, national partner organizations, state and local public health agencies, and nonprofit organizations (see Appendix C). Using the Department of Homeland Security's Target Capabilities List (TCL) as a starting point, the Workgroup (a) identified the capabilities most critical to public health's role in preparedness and (b) adapted the TCL capabilities slightly to make them more relevant to public health. The Workgroup identified the following capabilities as priorities for immediate measure development:

- Incident management
- Crisis and emergency risk communication (CERC) with the public
- Biosurveillance (including, but not limited to, laboratory, epidemiology, and surveillance and investigation)
- Countermeasure delivery (including distribution and dispensing)
- Community mitigation strategies (including, but not limited to, isolation and quarantine)

While there are many other critical capabilities involved in PHEP, these five capabilities were selected as core to public health's role in preparedness and are aligned with relevant policy mandates (e.g., HSPD-21). The intent is to identify and measure a manageable number of discrete components of the PHEP program as indicators of preparedness and response capabilities.

Incident Management and CERC with the Public were identified by CDC as the first capabilities for which performance measures would be developed. Topic-specific measurement subgroups, comprised of local and state public health department content and/or measurement experts, were convened in April 2008 to identify and develop performance measures for each of these capabilities (see Appendices C and D, respectively). The subgroups used process mapping to identify components of each capability that met the following criteria:

- most important to the achievement of that capability,
- measurable,
- feasible to collect and report, and
- relevant in multiple context.

Appendix C: PHEP Evaluation Workgroup Membership 2008/2009

- Torrance Brown, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
- Rebecca Hathaway, Office of Health Emergency Management, New York State Department of Health
- Rebecca A. Head, Monroe County Public Health Department (Michigan) / NACCHO Public Health Preparedness Essential Services Committee - Metrics Workgroup
- Lisle Hites, Mel and Enid Zuckerman College of Public Health, The University of Arizona
- Vicki Johnson, National Association of County and City Health Officials
- Lara Lamprecht, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services
- Susan Lance, Georgia Division of Public Health / Council of State and Territorial Epidemiologists
- David Kim, Career Epidemiologist Field Officer Program, COTPER / CDC
- Amy Nevel, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services
- Gianfranco Pezzino, Kansas Health Institute
- Marisa Raphael, New York City Department of Health and Mental Hygiene
- Bonnie D. Rubin, University of Iowa Hygienic Laboratory / Association of Public Health Laboratories
- Cathy Slemp, West Virginia Bureau for Public Health / Public Health Preparedness Priorities Workgroup, ASTHO - Directors of Public Health Preparedness
- Karen Smith, Napa County Public Health (California) / NACCHO Public Health Preparedness Essential Services Committee
- Lee Smith, ASTHO Preparedness Policy Committee, Directors of Public Health Preparedness
- Christopher A. Williams, New York City Department of Health and Mental Hygiene
- William Windle, Department of Homeland Security – National Exercise Division

Appendix D: Incident Management Measurement Subgroup Membership

- Beth Bacon, Michigan Department of Community Health – Office of Public Health Preparedness
- Lisle Hites, Mel and Enid Zuckerman College of Public Health, The University of Arizona
- Molly Jo Lamb, Logan County Department of Public Health
- James E. Pate, Orange County Health Department, Florida Department of Health
- Marisa Raphael, New York City Department of Health and Mental Hygiene
- Rocaille Roberts, Harris County Public Health & Environmental Services (Texas)
- Joseph Roth, American Samoa Department of Health / Career Epidemiology Field Officer Program, COTPER / CDC
- Lee Smith, ASTHO Preparedness Policy Committee, Directors of Public Health Preparedness
- Lori Van de Wege, Washington State Department of Health
- Steve Wagner, Ohio Department of Health

Appendix E: Crisis and Emergency Risk Communications Measurement Subgroup Membership

- Bret M. Atkins, Ohio Department of Health
- Laura Blaske, Washington State Department of Health
- Lisle Hites, Mel and Enid Zuckerman College of Public Health, The University of Arizona
- Kimberley Conrad Junius, Cook County Department of Public Health (Illinois)
- Sheryl Tirol Goodwin, New York City Department of Health & Mental Hygiene, Press Office
- J. Royden Saah, North Carolina State Laboratory of Public Health
- Lori Van de Wege, Washington State Department of Health

Page intentionally left blank

Appendix F: Preliminary Data Review Project –Budget Period 9 Performance Measures

During Budget Period 9 (BP9), the Incident Management and CERC with the public performance measures were considered to be developmental and will not be used to make any funding decisions Budget Period 11 (BP11). Although awardees are required to submit data for each of these performance measures by November 9, 2009, this deadline prevented a review and analysis of these new (developmental) performance measures by OMEB prior to the start of BP10 (August 10, 2009). Therefore, a separate project to collect preliminary data on these new performance measures was conducted in order to revise the measures for implementation during BP10. Five awardees representing a variety of geographical and organizational health departments participated in this project and reported data collected from August 10, 2008, to May 30, 2009:

1. Kansas Department of Health and Environment,
2. Los Angeles County Department of Health,
3. New Hampshire Department of Health and Human Services – Department of Safety,
4. Ohio Department of Health, and
5. Oklahoma State Department of Health.

The purpose of this review was to inform revisions to the BP9 developmental performance measures for implementation during BP10. The goals of this preliminary data review were multi-faceted:

- Inform revisions of the BP9 developmental performance measures for implementation during BP10,
- Inform revisions and improvements for the Performance Measures Guidance document,
- Identify areas for improvement in data collection tools and systems, and
- Inform the development of a training and technical assistance program for the performance measures.

Method

For this project, awardees were asked to input/enter preliminary data (consisting of all relevant exercises and real incidents) through PERFORMS by May 30, 2009, and included all data collected for the four Incident Management and the one Crisis and Emergency Risk Communication with the Public performance measures from August 10, 2008, to May 30, 2009. However, due to the system specifications of PERFORMS during BP9, grantees were not able to enter their selection of a "best demonstration" for a given measure during this project. In order to collect this information on the preliminary data entered, grantees were asked to select and submit their best demonstration for each measure using the "Best Demonstration Reporting Template" at the conclusion of the project (May 30, 2009). In addition, follow-up conference calls were conducted in June 2009 with each of the awardees in order to identify any issues encountered with the collection, reporting and/or submission of data on the BP9 performance measures. An interview/discussion protocol was distributed prior to the call and framed the discussion of the conference call. Qualitative data from these follow-up interviews was collected and analyzed for themes on the following topic areas:

- Performance Measure Guidance document,
- Implementation of the Performance Measures,
- Data Sources and Application,
- Training and Technical Assistance, and
- Data collection and reporting system (PERFORMS).

Data for each performance measure was culled from PERFORMS and analyzed descriptively with an emphasis on the variability and outliers observed. Information collected on the selection of best demonstration was collected and reported descriptively while the qualitative data from the follow-up interviews was analyzed for themes. Based on the performance measure data provided and the information collected through follow-up interviews, a number of recommendations were implemented for BP10:

Overall Implementation - Guidance Document

1. OMEB will send the guidance document out to awardees as an Adobe pdf and Word document as it is easier to print/copy the sections needed for different staff members.
2. Definitions provided for each performance measure was removed from the tables of measurement specifications and included in the introductory section for each capability.

Incident Management – Staff Notification

3. Language and definitions for the following terms were revised or clarified:
    a. The term "incident management functional responsibilities" was revised to "incident management roles" and the definition was clarified and
    b. The term "pre-identified staff" was clarified.
4. The following questions for Incident Management – Staff Notification were added in PERFORMS for the BP10 reporting period:

    "Incident management roles (or equivalent lead roles) activated at the time of the initial notification"

    "Number of staff who acknowledged notification"

Incident Management – Staff Assembly

5. Language and definitions for the following term was revised or clarified:
    a. The definition for the term "immediate" was revised.
6. The following question for Incident Management – Staff Assembly was added in PERFORMS for the BP10 reporting period:

    "Incident management roles (or equivalent lead roles) activated at the time of the initial notification"

Incident Management – Incident Action Plan

7. Language and definitions for the following terms were revised or clarified:
    a. The definition for the term "operational period" was clarified,
    b. The term "incident management functional responsibilities" was revised to "incident management roles" and the definition was clarified, and
    c. The term "jurisdiction" was removed from the language of the performance measure and supporting data elements. The following questions and related definitions capturing the relevant data elements were added:
        i. Number of federal and state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)
        ii. Number of local or tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)
8. The following question for Incident Management – Incident Action Plan was added in PERFORMS for the BP10 reporting period:

    "Incident management roles (or equivalent lead roles) activated at the time of the initial notification"

9. Filter questions will be added to PERFORMS to reflect the reporting criteria of Incident Objectives, Organization Assignment List, and Division / Group Assignment List.

Incident Management – After Action Report / Improvement Plan

10. The term "jurisdiction" was removed from the language of the performance measure and supporting data elements. The following questions and related definitions capturing the relevant data elements were added:
    a. Number of state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)

b. Number of local or tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)

11. Included "Fire Service" as a public partner option for question #8b for IM-AAR/IP in PERFORMS to be consistent with the other Incident Management performance measures collecting the same information as well as with the guidance provided.

Crisis and Emergency Risk Communications with the Public

12. The term "jurisdiction" was removed from the language of the performance measure and supporting data elements. The following questions and related definitions capturing the relevant data elements were added:
    a. Number of state agencies involved in the exercise or real incident. (Include your health department if awardee is a state agency)
    b. Number of local or tribal agencies involved in the exercise or real incident. (Include your health department if awardee is a directly-funded city)
13. Definitions for the following terms were added:
    a. General population,
    b. Population with special needs,
    c. Method of delivery, and
    d. Immediate recipient.

In addition to these revisions for BP10, the following recommendations have been identified for implementation in the near future (tentatively scheduled for BP11):

Overall Implementation - Guidance Document, Data Collection and Reporting

14. Provide a shorter version of the guidance document. OMEB should develop and provide a reference manual / quick reference guide with a list of the data collection points and sources for each capability,
    a. OMEB will develop a one-page matrix for the purposes of collecting and tracking data. Current efforts are focused on identifying similar tools currently implemented by awardees.
15. Data provided from awardees about why a given example was chosen as their best demonstration of a capability will be used to inform and refine the considerations section of the best demonstration guidance.
16. The Performance Measures Guidance document should be provided to awardees along with the grant RFP. In addition, share a draft of the guidance document with NACCHO by February for their review to solicit additional feedback prior to distributing to PHEP awardees.
17. Open the PERFORMS system for entering the performance data at the beginning of the budget period. Since the reporting periods for two budget years will overlap by 3 months, it is suggested that a filter question requesting the date of the exercise or incident be displayed in order to verify that the correct budget period for entering this data has been selected.
18. Enhance PERFORMS by including key references or links within each measure.
19. Enhance PERFORMS by changing the label for the "Assessment" module to "Performance Measures".

Overall Implementation – Training and Technical Assistance

20. Training and Technical Assistance program for BP10 will include the following topics:
    a. Explanation and description of each performance measure. Specifically, the training should include:
        i. The context of the performance measures, intent of the measures and why it's important
        ii. The components for each performance measure

iii. Information about the on-going development of the performance measures

b. Data Collection and Reporting. Specifically, the training should include best practices and strategies for gathering required data at every incident, a review of possible data points and sources of data, and an explanation of what data are being collected by CDC and why. In addition, training and technical assistance should include the sharing of results of the performance measures as well as the findings and interpretations.

c. Evaluation. Specifically, topics should include how to use the performance measure data collected for program improvement and developing/modifying a work plan, how the performance measures fit into a broader evaluation program, and how to use historical data and trends to track performance and demonstrate improvement.

d. General training. Specifically, training related to communicating expectations and encouraging performance improvement as well as how to work with outside partners were recommended by participating awardees.

21. Training venues to consider include on-line downloadable training programs, regional meetings and webinars.

22. Additional resources that should be developed and provided to awardees include:

    a. Guidance for local jurisdictions,

    b. A shorter version of the guidance document that can serve as the reference manual, and

    c. A quick reference list or one pager of the performance measures for data collection.

Appendix G: Performance Measures Data Collection Template

PHEP Cooperative Agreement
Budget Period 10 (August 10, 2009 – August 9, 2010)

Table 14. Incident Management Performance Measures Data Collection Template

Incident Management
Staff Notification: Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to acknowledge notification

1. How many operations-based exercises (drill, functional, or full-scale) testing staff notification were conducted between August 10, 2009, and August 9, 2010? _____
2. How many operations-based exercises testing **unannounced and outside normal business hours** staff notification were conducted between August 10, 2009, and August 9, 2010? _____
3. How many real incidents involving staff notification occurred between August 10, 2009 and August 9, 2010? ____
4. How many real incidents involving **unannounced and outside normal business hours** staff notification occurred between August 10, 2009, and August 9, 2010? _____

Please complete the questions below for the unannounced, outside of normal business hours staff notification that occurred during Budget Period 10 (August 10, 2009, to August 9, 2010) being reported.

5. Was this staff notification part of a drill, functional exercise, full-scale exercise, or real incident? (select one)
   - _____ Drill
   - _____ Functional exercise
   - _____ Full-scale exercise
   - _____ Real incident

   5a. If reporting data from a real incident, what was the incident type? (select one)
   - _____ Type 4
   - _____ Type 3
   - _____ Type 2
   - _____ Type 1

6. Was the staff notification **unannounced**?
   - _____ Yes
   - _____ No
7. Did the staff notification occur **outside of normal business hours**?
   - _____ Yes
   - _____ No
8. Provide a brief description of the real incident or event / incident upon which exercise scenario was based (750 character limit)

   _____
   _____

Table 14. IM Performance Measures Data Collection Template (continued)

Staff Notification (continued)

9. What notification method(s) were used? (select all that apply)
   - _____ Cell phone
   - _____ Email outside of rapid notification system
   - _____ Land-line telephone
   - _____ Pager
   - _____ Rapid notification system (e.g. Health Alert Network)
   - _____ Satellite communication system
   - _____ Other-specify:_____
10. What acknowledgement method(s) were used? (select all that apply)
   - _____ Cell phone
   - _____ Email outside of rapid notification system
   - _____ Land-line telephone
   - _____ Pager
   - _____ Rapid notification system (e.g. Health Alert Network)
   - _____ Satellite communication system
   - _____ Other-specify:_____
11. What incident management roles (or equivalent lead roles) were activated at the time of initial notification: (select all that apply)
   - _____ Incident Commander
   - _____ Public Information Officer
   - _____ Safety Officer
   - _____ Liaison Officer
   - _____ Operations Section Chief
   - _____ Planning Section Chief
   - _____ Logistics Section Chief
   - _____ Finance / Administration Section Chief
   - _____ Additional Lead Roles – specify:_____
12. How many pre-identified staff was required to fill the activated incident management roles at the time of initial notification? _____
13. How many staff was notified to cover the activated incident management roles? ____
14. How many staff acknowledged the notification? _____
15. Date and time that a designated official began notifying pre-identified staff (start time).

    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)
16. Date and time that the last staff person needed to fill activated incident management roles acknowledged notification (stop time).

    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)

Table 14. IM Performance Measures Data Collection Template (continued)

Staff Notification (continued)

17. Does this exercise or incident represent the best demonstration of your agency's staff notification capability?

    _____ Yes

    _____ No

17a. If yes, please provide a brief description of why this exercise or incident was chosen as the best demonstration of a staff notification (750 character limit)

_____

_____

18. Was this your quickest time for an unannounced and outside of normal business hours staff notification?

    _____ Yes

    _____ No

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

1. How many operations-based exercises (drill, functional, or full-scale) testing staff assembly were conducted between August 10, 2009, and August 9, 2010? _____
2. How many operations-based exercises testing **unannounced and immediate** staff assembly were conducted between August 10, 2009, and August 9, 2010? _____
3. How many real incidents involving staff assembly occurred between August 10, 2009, and August 9, 2010? ____
4. How many real incidents involving **unannounced and immediate** staff assembly occurred between August 10, 2009, and August 9, 2010? _____

Please complete the questions below for the unannounced, immediate staff assembly that occurred during Budget Period 10 (August 10, 2009, to August 9, 2010) being reported.

5. Was this staff assembly part of a drill, functional exercise, full-scale exercise, or real incident? (select one)

    _____ Drill

    _____ Functional exercise

    _____ Full-scale exercise

    _____ Real incident

5a. If reporting data from a real incident, what was the incident type? (select one)

    _____ Type 4

    _____ Type 3

    _____ Type 2

    _____ Type 1

Table 14. IM Performance Measures Data Collection Template (continued)

Staff Assembly (continued)

6. Was the staff assembly **unannounced**?
   _____ Yes
   _____ No
7. Was the staff assembly **immediate**?
   _____ Yes
   _____ No
8. Provide a brief description of the real incident or event/incident upon which exercise scenario was based (750 character limit)
   _____
   _____
9. Was staff assembly virtual, physical, or a combination? (select one)
   _____ Virtual only
   _____ Physical only
   _____ Combination (Virtual and Physical)
10. Was the Department Operations Center (DOC) activated?
    _____ Yes
    _____ No
11. What incident management roles (or equivalent lead roles) were activated at the time of initial notification: (select all that apply)
    _____ Incident Commander
    _____ Public Information Officer
    _____ Safety Officer
    _____ Liaison Officer
    _____ Operations Section Chief
    _____ Planning Section Chief
    _____ Logistics Section Chief
    _____ Finance / Administration Section Chief
    _____ Additional Lead Roles – specify:_____
12. How many pre-identified staff was required to fill the activated incident management roles at the time of initial notification? _____
13. How many staff was notified? _____
14. How many staff reported for duty to fill the activated incident management roles? _____
15. Date and time that a designated official began notifying pre-identified staff (start time).
    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)
16. Date and time that the last staff person needed to fill activated incident management roles reported for duty (stop time).
    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)

Table 14. IM Performance Measures Data Collection Template (continued)

Staff Assembly (continued)

17. Does this exercise or incident represent the best demonstration of your agency's staff assembly capability?
    _____ Yes
    _____ No

    17a. Please provide a brief description of why this exercise or incident was chosen as the best demonstration of a staff assembly (750 character limit)

    _____
    _____

18. Was this your quickest time for an unannounced, immediate staff assembly?
    _____ Yes
    _____ No

Staff Assembly − HHS/OMB Priority Performance Measure: Time for pre-identified staff covering activated public health agency incident management roles (or equivalent lead roles) to report for immediate duty.
Performance Target: 60 minutes

1. How many operations-based exercises (drill, functional, or full-scale) testing staff assembly were conducted between August 10, 2009, and August 9, 2010? ___
2. How many operations-based exercises testing ***unannounced and immediate*** staff assembly were conducted between August 10, 2009, and August 9, 2010? ___
3. How many real incidents involving staff assembly occurred between August 10, 2009, and August 9, 2010? ___
4. How many real incidents involving ***unannounced and immediate*** staff assembly occurred between August 10, 2009, and August 9, 2010? ___

Please complete the questions below for the unannounced, immediate staff assembly that occurred during Budget Period 10 (August 10, 2009, to August 9, 2010) being reported.

5. Was this staff assembly part of a drill, functional exercise, full-scale exercise, or real incident? (select one)
    _____ Drill
    _____ Functional exercise
    _____ Full-scale exercise
    _____ Real incident

    5a. If reporting data from a <u>real incident</u>, what was the incident type? (select one)
    _____ Type 4
    _____ Type 3
    _____ Type 2
    _____ Type 1

6. Was the staff assembly **unannounced**?
    _____ Yes
    _____ No
7. Was the staff assembly **immediate**?
    _____ Yes
    _____ No

Table 14. IM Performance Measures Data Collection Template (continued)

Staff Assembly − HHS/OMB Priority Performance Measure (continued)

8. Did this staff assembly meet the performance target of 60 minutes?
   _____ Yes
   _____ No
9. Provide a brief description of the real incident or event/incident upon which exercise scenario was based (750 character limit)
   _____
   _____
10. Was staff assembly virtual, physical, or a combination? (select one)
    _____ Virtual only
    _____ Physical only
    _____ Combination (Virtual and Physical)
11. Was the Department Operations Center (DOC) activated?
    _____ Yes
    _____ No
12. What incident management roles (or equivalent lead roles) were activated at the time of initial notification: (select all that apply)
    _____ Incident Commander
    _____ Public Information Officer
    _____ Safety Officer
    _____ Liaison Officer
    _____ Operations Section Chief
    _____ Planning Section Chief
    _____ Logistics Section Chief
    _____ Finance / Administration Section Chief
    _____ Additional Lead Roles – specify:_____
13. How many pre-identified staff was required to fill the activated incident management roles at the time of initial notification? _____
14. How many staff was notified? _____
15. How many staff reported for duty to fill the activated incident management roles? _____
16. Date and time that a designated official began notifying pre-identified staff (start time)
    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)
17. Date and time that the last staff person needed to fill activated incident management roles reported for duty (stop time).
    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)_
18. Was this your agency's quickest time for the staff assembly capability?
    _____ Yes
    _____ No

Table 14. IM Performance Measures Data Collection Template (continued)

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

1. How many operations-based exercises (drill, functional, or full-scale) extending two or more operational periods or longer (extended operational periods may be simulated) were conducted between August 10, 2009, and August 9, 2010? _____
2. How many operations-based exercises (drill, functional, or full-scale) extending over two operational periods or longer (extended operational periods may be simulated) were conducted between August 10, 2009, and August 9, 2010 during which a written IAP was produced before the start of the second operational period? _____
3. How many real incidents extending two or more operational periods or longer occurred between August 10, 2009, and August 9, 2010? _____
4. How many real incidents extending two operational periods or longer occurred between August 10, 2009, and August 9, 2010 during which a written IAP was produced before the start of the second operational period? _____

Please complete the questions below for the exercise or real incident demonstrating the completion of an Incident Action Plan that occurred during Budget Period 10 (August 10, 2009 to August 9, 2010) being reported.

5. Did this operations-based exercise or real incident result in the production of a written Incident Action Plan (IAP)?
   _____ Yes
   _____ No
6. Was the IAP the result of a drill, functional exercise, full-scale exercise, or real incident? (select one)
   _____ Drill
   _____ Functional exercise
   _____ Full-scale exercise
   _____ Real incident
7. What was the complexity of the simulated or real incident at the time that the IAP was written? (select one)
   _____ Type 4
   _____ Type 3
   _____ Type 2
   _____ Type 1
8. Was the written IAP approved before the start of the second operational period?
   _____ Yes
   _____ No
9. Provide a brief description of the real incident or event/incident upon which exercise scenario was based (750 character limit)

   _____
   _____

Table 14. IM Performance Measures Data Collection Template (continued)

IAP (continued)

10. How many federal and state agencies were involved in the exercise or real incident? ____
11. How many local and tribal agencies were involved in the exercise or real incident? _____
12. Did your agency act in a lead or an assisting role? (select one)
    - _____ Lead Role
    - _____ Assisting Role
13. Did you partner with any other public or private sector agencies during this exercise or real incident (can select No, or one or both Yes options)
    - _____ Yes – Private Sector
    - _____ Yes – Public Sector
    - _____ No

13a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise / real incident? (select all that apply)
- _____ Business(es)
- _____ Hospital(s)
- _____ Media
- _____ Non-profit/Community-based Organization(s)
- _____ Universities
- _____ Volunteer Health Professionals
- _____ Other-Specify: _____

13b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise / real incident? (select all that apply)
- _____ Agriculture
- _____ Education
- _____ Emergency Management
- _____ Emergency Medical Services
- _____ Environmental Health / Protection
- _____ Fire Service
- _____ Indian Health Service
- _____ Law Enforcement
- _____ National Guard
- _____ Public Health (excluding awardee)
- _____ Other-specify:_____

14. Did the IAP include incident objectives (ICS Form 202 or equivalent)?
    - _____ Yes
    - _____ No
15. Did the IAP include an organization assignment list (ICS Form 203 or equivalent)?
    - _____ Yes
    - _____ No
16. Did the IAP include an assignment list (ICS Form 204 or equivalent)?
    - _____ Yes
    - _____ No

Table 14. IM Performance Measures Data Collection Template (continued)

IAP (continued)

17. Did the IAP include an Incident Safety Analysis?
    _____ Yes
    _____ No
18. What incident management roles (or equivalent lead roles) were activated **during the *first* operational period**? (select all that apply)
    _____ Incident Commander
    _____ Public Information Officer
    _____ Safety Officer
    _____ Liaison Officer
    _____ Operations Section Chief
    _____ Planning Section Chief
    _____ Logistics Section Chief
    _____ Finance / Administration Section Chief
    _____ Additional Lead Roles – specify:_____
19. How many staff filled the activated incident management roles **during the *first* operational period**? _____
20. Does this exercise or incident represent the best demonstration of your agency's capability to complete a written IAP before the start of the second operation period?
    _____ Yes
    _____ No

    20a. If yes, please provide a brief description of why this exercise or incident was chosen as the best demonstration of a written IAP (750 character limit):
    _____
    _____

Table 14. IM Performance Measures Data Collection Template (continued)

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

1. How many exercises (tabletop, drill, functional, or full-scale) resulted in the completion of a draft AAR and IP between August 10, 2009, and August 9, 2010? _____
2. How many real incidents resulted in the completion of a draft AAR and IP between August 10, 2009 and August 9, 2010? _____

Please complete the questions below for the exercise or real incident demonstrating the completion of a draft After Action Report and Improvement Plan that occurred during Budget Period 10 (August 10, 2009, to August 9, 2010) being reported.

3. Were the AAR and IP the result of a tabletop exercise, drill, functional exercise, full-scale exercise, or real incident? (select one)
   - _____ Tabletop exercise
   - _____ Drill
   - _____ Functional exercise
   - _____ Full-scale exercise
   - _____ Real Incident

   3a. If reporting data from a real incident, what was the incident type? (select one)
   - _____ Type 4
   - _____ Type 3
   - _____ Type 2
   - _____ Type 1
4. Provide a brief description of the real incident or event/incident upon which exercise scenario was based (750 character limit)

   _____
   _____
5. How many federal and state agencies were involved in the exercise or real incident? ____
6. How many local and tribal agencies were involved in the exercise or real incident? _____
7. Did your agency act in a lead or an assisting role? (select one)
   - _____ Lead Role
   - _____ Assisting Role
8. Did you partner with any other public or private sector agencies during this exercise or real incident (can select No, or one or both Yes options)
   - _____ Yes – Private Sector
   - _____ Yes – Public Sector
   - _____ No

Table 14. IM Performance Measures Data Collection Template (continued)

AAR/ IP (continued)

8a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise / real incident? (select all that apply)

_____ Business(es)
_____ Hospital(s)
_____ Media
_____ Non-profit/Community-based Organization(s)
_____ Universities
_____ Volunteer Health Professionals
_____ Other-Specify: _____

8b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise / real incident? (select all that apply)

_____ Agriculture
_____ Education
_____ Emergency Management
_____ Emergency Medical Services
_____ Environmental Health / Protection
_____ Fire Service
_____ Indian Health Service
_____ Law Enforcement
_____ National Guard
_____ Public Health (excluding awardee)

_____ Other-specify:_____

9. Date exercise or public health emergency operations completed (start time).

Date: __/__/__ (MM/DD/YY)

10. Date the draft AAR and IP were <u>submitted for clearance</u> within the public health agency (stop time).

Date:__/__/__ (MM/DD/YY)

11. What was the date that the AAR and IP were <u>approved</u> by the public health agency?

Date:__/__/__ (MM/DD/YY)

12. Does this exercise or incident represent the best demonstration of your agency's capability to complete a draft AAR and IP?

_____ Yes
_____ No

12a. If yes, please provide a brief description of why this exercise or incident was chosen as the best demonstration of the completion of an AAR and IP (750 character limit)

_____
_____

13. Was this your quickest time for the submission of a draft AAR and IP for clearance?

_____ Yes

_____ No

Page intentionally left blank

Table 15. Laboratory Performance Measures Data Collection Template

Laboratory – Pulsed Field Gel Electrophoresis (PFGE)	
Lab - PFGE *E. coli* O157:H7:	Percentage of pulsed field gel electrophoresis (PFGE) subtyping data results **for *E. coli* O157:H7** submitted to the PulseNet national database within four working days of receiving isolate at the PFGE laboratory.
Please complete the questions below related to Lab-PFGE: E.coli O157:H7 for Budget Period 10 (August 10, 2009, to August 9, 2010).	

1. Did the state public health laboratory receive any *E.coli* O157:H7 reference or clinical isolates between 08/10/09 and 08/09/010?

   _____Yes

   _____No

2. If YES to question #1, how many *E.coli* O157:H7 reference or clinical isolates did the state public health PFGE laboratory receive between 08/10/09 and 08/09/10? _____

3. If YES to question #1, of the *E.coli* O157:H7 reference or clinical isolates that the state public health PFGE laboratory received, how many were sent to another laboratory / laboratories for PFGE subtyping between 08/10/09 and 08/09/10? _____

   3a. For the *E.coli* O157:H7 reference or clinical isolates that were sent to another laboratory / laboratories between 08/10/09 and 08/09/10, name the laboratory / laboratories, the city, and the state that performed PFGE subtyping.

   _____

4. If YES to question #1, for how many *E.coli* O157:H7 reference or clinical isolates did the state public health PFGE laboratory perform PFGE subtyping between 08/10/09 and 08/09/10? _____

   4a. How many of the PFGE results for *E. coli* O157:H7 reference or clinical isolates for which the state public health PFGE laboratory performed PFGE subtyping from 08/10/09 to 08/09/2010 were **submitted** to the PulseNet database within four working days?_____

   4b. If Percentage* <90%, why were fewer than 90% of the state's *E.coli* O157:H7 PFGE subtyping results submitted to PulseNet within four working days?

   _____

   **Percentage = (Number of PFGE results submitted to PulseNet within four working days / Number of isolates for which laboratory performed PFGE subtyping)*100*

Table 15. Laboratory Performance Measures Data Collection Template (continued)

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

Please complete the questions below related to Lab-PFGE: Listeria monocytogenes for Budget Period 10 (August 10, 2009, to August 9, 2010).

1. Did the state public health laboratory receive any *Listeria monocytogenes* reference or clinical isolates between 08/10/09 and 08/09/0?
   _____Yes
   _____No
2. If YES to question #1, how many *Listeria monocytogenes* reference or clinical isolates did the state public health PFGE laboratory receive between 08/10/09 and 08/09/10? _____
3. If YES to question #1, of the *Listeria monocytogenes* reference or clinical isolates that the state public health PFGE laboratory received, how many were sent to another laboratory/laboratories for PFGE subtyping between 08/10/09 and 08/09/10? _____

   3a. For the *Listeria monocytogenes* reference or clinical isolates that were sent to other laboratory/laboratories between 08/10/09 and 08/08/10, name the laboratory/laboratories, the city, and the state that performed PFGE subtyping.
   _____
4. If YES to question #1, for how many *Listeria monocytogenes* reference or clinical isolates did the state public health PFGE laboratory perform PFGE subtyping between 08/10/09 and 08/09/10? _____

   4a. How many of the PFGE results for *Listeria monocytogenes* reference or clinical isolates for which the state public health PFGE laboratory performed PFGE subtyping from 08/10/09 to 08/09/2010 were **submitted** to the PulseNet database within four working days? _____

   4b. If Percentage* <90%, why were fewer than 90% of the state's *Listeria monocytogenes* subtyping results submitted to PulseNet within four working days?
   _____

**Percentage = (Number of PFGE results submitted to PulseNet within four working days / Number of isolates for which laboratory performed PFGE subtyping)*100*

Table 16. CERC Performance Measure Data Collection Template

Crisis and Emergency Risk Communication (CERC) with the Public

CERC – Public Message Dissemination: Time to issue a risk communication message for dissemination to the public

1. How many operations-based exercises (drill, functional, or full-scale) testing risk communication message dissemination to the public were conducted between August 10, 2009, and August 9, 2010? _____
2. How many real incidents involving risk communication message dissemination to the public occurred between August 10, 2009, and August 9, 2010? _____

Please complete the questions below for the exercise or real incident demonstrating the development of a risk communication message for dissemination to the public that occurred during Budget Period 10 (August 10, 2009, to August 9, 2010) being reported.

3. Was the message dissemination part of a drill, functional exercise, full-scale exercise, or real incident? (select one)
   - _____ Drill
   - _____ Functional exercise
   - _____ Full-scale exercise
   - _____ Real incident

   3a. If reporting data from a real incident, what was the incident type when the first message was approved for dissemination?
   - _____ Type 4
   - _____ Type 3
   - _____ Type 2
   - _____ Type 1
4. Provide a brief description of the real incident or event/incident upon which exercise scenario was based (750 character limit)
   _____
   _____
5. How many federal and state agencies were involved in the exercise or real incident? _____
6. How many local and tribal agencies were involved in the exercise or real incident? _____
7. Did your agency act in a lead or an assisting role? (select one)
   - _____ Lead Role
   - _____ Assisting Role
8. Did you partner with any other public or private sector agencies during this exercise or real incident [can select No, or one or both Yes options]
   - _____ Yes – Private Sector
   - _____ Yes – Public Sector
   - _____ No

Table 16. CERC Performance Measures Data Collection Template (continued)

Public Message Dissemination (continued)

8a. If responded Yes – Private Sector: Which of the following private sector partner(s) participated in the exercise / real incident? (select all that apply)

_____ Business(es)
_____ Hospital(s)
_____ Media
_____ Non-profit/Community-based Organization(s)
_____ Universities
_____ Volunteer Health Professionals
_____ Other-Specify: _____

8b. If responded Yes – Public Sector: Which of the following public sector partner(s) participated in the exercise / real incident? (select all that apply)

_____ Agriculture
_____ Education
_____ Emergency Management
_____ Emergency Medical Services
_____ Environmental Health / Protection
_____ Fire Service
_____ Indian Health Service
_____ Law Enforcement
_____ National Guard
_____ Public Health (excluding awardee)
_____ Other-specify:_____

9. Was the message developed from a pre-drafted template?

_____ Yes
_____ No

10. Was the message written at or below a 6^{th} grade reading level?

_____ Yes
_____ No
_____ Not Assessed

11. Who was the intended audience of the message? Please select all that apply

_____ General Population
_____ Population with special needs (specify): _____

12. In which language(s) was the message developed? Please list all:

_____
_____

13. What was the intended <u>method of delivery</u> of the message? Please select all that apply.

_____ Print media release
_____ Radio
_____ Spokesperson
_____ Web release
_____ Other – Specify: _____

Table 16. CERC Performance Measures Data Collection Template (continued)

Public Message Dissemination (continued)

14. Who was the immediate recipient of the approved message? Please select all that apply.

    _____ Clearance or dissemination authority beyond the public health agency

    _____ Dissemination Partner – specify_____

    _____ Public information line

    _____ Public information website

    _____ Other – Specify: _____

15. Date and time that a designated official requested that the first risk communication message be developed (start time).

    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)

16. Date and time that a designated official approved the first risk communication message for dissemination (stop time).

    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)

17. If reporting data from a real incident: Approximate date / time that message was disseminated to the public

    Date: __/__/__ (MM/DD/YY) Time: __:__ (hr:min)

18. Does this exercise or incident represent the best demonstration of your agency's capability to develop a crisis and emergency risk communication message for dissemination to the public?

    _____ Yes

    _____ No

    18a. If yes, please provide a brief description of why this exercise or incident was chosen as the best demonstration of the development of a risk communication message for dissemination to the public (750 character limit)

    _____

    _____

19. Was this your quickest time for the development and approval of a risk communication message for dissemination to the public?

    _____Yes

    _____No