



Public Health Data Strategy Milestones for 2026

APR. 30, 2026



For Public Health

AT A GLANCE

The Public Health Data Strategy (PHDS) launched in 2023 and is updated annually. Organized around four public health data goals, the PHDS milestones are designed to deliver faster, more complete, and more secure exchange of data to ensure the public health system is ready to respond to health threats.



Goal 1: Strengthen the core of public health data

Through goal 1, CDC ensures that core data sources are more complete, timely, rapidly exchanged, and available to detect, monitor, investigate, and respond to public health threats. Core data sources:

- Provide essential information for multiple public health purposes, every day and during emergencies.
- Cover many diseases and conditions.
- Support critical capabilities for detecting and forecasting threats, understanding disease burden, and monitoring health and outbreak trends.
- Combine easily with other data to provide new insights for informing action.

Examples of core public health data sources include case reports, laboratory results, emergency department visits, vital statistics, immunization data, hospital bed capacity, and wastewater surveillance data. The list of core data sources continues to evolve as new sources become available.

1.01. Expand real-time access to emergency department (ED) visit data

Expands the geographic coverage of ED visit data and enables more comprehensive situational awareness and early detection of emerging and ongoing public health threats. Learn more about the [National Syndromic Surveillance Program \(NSSP\)](#).

2026: CDC is receiving data from at least 86% of the nation's emergency departments, including data from all 50 states, the District of Columbia (DC), and at least 2 territories.

1.02. Automated hospital bed capacity reporting

Reduces reporting burden on hospitals and state, tribal, local, and territorial (STLT) partners and enables more accurate and timely tracking of hospital bed capacity, leading to timelier and better-informed public health action. Learn more about the [National Healthcare Safety Network \(NHSN\)](#).

2026: At least 17 state and territorial jurisdictions have established automated data feeds and are submitting near-real-time hospital bed capacity data to CDC.

1.03. Increase in automated processing of electronic case reporting (eCR) data by health departments

Reduces burden on STLT health departments to manually ingest case data into disease surveillance systems.

2026: At least 70% (42/59) of Epidemiology and Laboratory Capacity (ELC)-funded health departments connected to the Association for Public Health Laboratories (APHL) Informatics Messaging Services (AIMS) for eCR are processing eCR data into production disease surveillance

systems.

1.04. eCR expansion among hospitals, including critical access hospitals (CAHs)

Enables faster detection of anomalies in health status, particularly among rural communities, at the STLT and national levels.

2026: CAHs in production with eCR increased to 65%, and all hospitals in production with eCR increased to 50%.

1.05. Sustainable and flexible case data transmission methods

Reduces burden and increases timeliness and use of data. This milestone builds on CDC's advancements in defining [minimal data necessary \(MDN\)](#) for emergency response.

2026: Support MDN implementation for all emergency responses and accelerate transmission of case data during emergencies by onboarding at least 3 jurisdictions to HL7® Case Notification MDN.

1.06. Expanded and timely collection of wastewater surveillance results

Enables faster detection of emerging public health threats. Learn more about the [National Wastewater Surveillance System \(NWSS\)](#).

2026: At least 40% of states and DC are submitting data for pathogens (e.g., influenza, SARS-CoV-2 virus, etc.) under national wastewater surveillance and are submitting at least 80% of samples within 7 days of collection.

1.07. Expanded exchange of mortality data using FHIR®

Supports faster sharing of mortality data, enabling more robust national-level situational awareness. Learn more about the [National Vital Statistics System \(NVSS\)](#) and [Fast Healthcare Interoperability Resources \(FHIR\)](#) [PDF](#) [↗](#).

2026: Implement FHIR-based exchange of mortality data between CDC and 6 additional vital records jurisdictions, bringing the total to 23.

1.08. Expanded public health laboratory data exchange

Enables laboratories to share test results faster with facilities and public health authorities.

2026: All CDC infectious disease laboratories are sending laboratory test results to state public health laboratories and health departments via electronic laboratory reporting (ELR). At least 75% of state public health laboratories and health departments are able to accept ELR from CDC infectious disease laboratories.

Goal 2: Accelerate access to analytic and automated solutions to support public health investigations

Through goal 2, CDC provides tools for STLT health departments and decision-makers that enable better use of public health data to address health threats and preventable differences in health outcomes.

The [One CDC Data Platform \(1CDP\)](#) allows public health practitioners and disease experts to more quickly, easily, and effectively generate usable information that can enable better decisions and actions without requiring hours of manual data compilation across siloed systems. 1CDP provides an integrated, scalable, and secure data ecosystem that enables CDC and STLT health departments to prepare for, detect, and respond to public health threats with unprecedented speed, accuracy, and efficiency.

2.01. Modernized integrated disease surveillance system to better receive, use, and share data for public health decision making

Improves STLT-level integrated disease surveillance systems. Reduces STLT agency overhead to coordinate hosting and management of CDC-provided disease surveillance systems.

2026: Further modernize the National Electronic Disease Surveillance System Base System (NBS) by delivering 3 modernized system services, progressively replacing legacy components while maintaining system functionality. Six NBS 6 jurisdictions have demonstrated commitment to migrating to NBS 7 by allocating financial, technical, or staff resources toward migration.

2.02. Access to core data sources and reusable capabilities on a central platform

Integrates additional core data sources and tools into a central platform to support both routine public health surveillance and emergency response with speed, efficiency, and transparency. Supports core public health missions such as early detection, trend monitoring, outbreak response, and information dissemination.

2026: 1CDP users (CDC programs, STLT health departments, and federal partners) have access to at least 6 core data sources and 10 reusable tools through the platform.

2.03. 1CDP Partner Workspace

Enables STLT and federal partners to benefit from data assets, reusable capabilities, and cutting-edge innovation developed at CDC.

2026: Begin providing access to the 1CDP Partner Workspace to partners (including STLT health departments, academia, and public health organizations) and continue to iteratively expand and improve functionality.

2.04. Expand use of comprehensive healthcare data

Expands the use of CDC's robust portfolio of electronic health record and administrative healthcare data, which will inform timely and effective public health action, including for emergency response.

2026: Release in 1CDP at least 5 new analytic capabilities or data products for identifying, monitoring, or characterizing public health threats using CDC's healthcare data portfolio.

2.05. Combine core data sources to improve integrated surveillance

Leverages foundational infrastructure improvements within 1CDP that enable easy data access, integration, and reusability, and ultimately simplify data exchange and visualizations to support CDC programs and responses.

2026: To support an integrated monitoring framework, develop a master data cube (which enables flexible and fast querying of data) and a feature set that enables cross data source analysis for at least 3 data sources (ED, lab, case).

2.06. Promote artificial intelligence (AI) integration across public health

Equips STLT health departments with informational resources to develop generative AI guidance and policies for their jurisdictions, enabling safe and secure adoption and encouraging appropriate use of this tool to augment their work. Providing resources with best practices would support STLT health departments in adopting AI, fostering innovation, protecting privacy, and ensuring transparency.

2026: Publish CDC generative AI guidance and other informational resources for STLT health department partners to strengthen AI readiness and promote the safe and secure use of AI in public health, in alignment with [CDC's AI Strategy](#), the [US Department of Health and Human Services AI Strategy](#) [PDF](#) [↗](#), and [America's AI Action Plan](#) [PDF](#) [↗](#).

2.07. Accelerate public health AI adoption through strategic partnerships

Establishes partnerships among CDC, STLT health departments, and private sector AI providers to enable access to and test advanced AI technologies. Through this collaboration, CDC and STLT health departments will be able to explore and evaluate AI tools at no cost, supporting broader adoption and integration of AI solutions. This effort also advances compliance with [CDC's AI Strategy](#), the [US Department of Health and Human Services AI Strategy](#) [PDF](#) [↗](#), and [America's AI Action Plan](#) [PDF](#) [↗](#) by expanding access to frontier language models and conducting market research on state-of-the-art AI capabilities.

2026: Establish and/or foster at least 1 public-private partnership with an AI provider to enable STLT health departments access to AI technology and explore provisioning of AI tools at minimal cost to STLT health departments.

2.08. Expand use of centralized population and community data assets

Expands CDC's portfolio of centralized data to include standardized population and community or "foundational" data assets to minimize redundancy and silos, increase efficiency, and facilitate consistency in analysis and interpretation of data used to inform public health action.

2026: Release in the 1CDP Marketplace at least 3 new population and community (e.g., demographic, geographic, social, and environmental) data assets to enhance and standardize analyses across CDC programs.

2.09. Provide AI-ready analytic features in 1CDP

Improves CDC's ability to leverage features of data in concert with each other to better understand trends and anomalies across data sources and to perform routine surveillance review of these data in a more efficient manner.

2026: In support of an integrated monitoring framework, make AI-ready analytic features available across at least 3 data sources in 1CDP and leverage AI to enable cross comparison of these data sources.

Goal 3: Visualize and share insights to inform public health action

Through goal 3, CDC uses innovative, cutting-edge approaches to create near real-time data visualizations, serving as a trusted source for situational awareness and data-driven decision making. Enhanced, easy-to-understand visualizations and dashboards allow individuals, communities, and policymakers at all levels to better understand risks, make decisions, and direct resources.

The PHDS advances open and effective data dissemination by promoting accessible, repeatable, and scalable technical capabilities across CDC and STLT health departments. Through 1CDP, CDC enables transparent nationwide sharing of actionable public health insights with partners and the public. This approach is intended to transform data accessibility, empowering all Americans with timely, comprehensive information.

3.01. Streamline agency-level communication with STLT health departments on data dissemination

Increases consistency of data shared between CDC and external partners (such as STLT health departments, national organizations, or other federal agencies) by enabling partners to see a common operating picture before data are disseminated. Improves transparency and speed of communication.

2026: Share pre-dissemination data with external partners (such as STLT health departments, national organizations, or other federal agencies) for at least 3 projects for collaborative development, review, or approval to improve consistency and speed of public health communications.

3.02. Sophisticated outbreak analytical tools available to CDC, STLT health departments, and federal partners

Allows CDC programs, STLT health departments, and federal partners to apply sophisticated analytical tools to their private data that estimate the number and timing of disease cases under a variety of scenarios in a secure environment without needing specialized computing resources. This can help decision makers pinpoint the most effective resource allocation for their response.

2026: Deploy a proof-of-concept infectious disease outbreak modeling tool on CDC enterprise platforms for use by CDC programs, STLT health departments, and federal partners.

3.03. Disseminate integrated data and visualizations

Supports public health decision-making by providing timely, transparent data on public health threats.

2026: Expand public access to data visualization products for 4 of the nation's most urgent public health threats.

3.04. Support tribes with tribally-determined data modernization projects

Tribes, Tribal Epidemiology Centers, or tribal consortia participating in the Tribal Data Modernization Implementation Program will have improved workforce and technical capacity that enables better access to, and improved use of, public health data to drive public health resources.

2026: With support from CDC and the Data Modernization Tribal Implementation Center program, at least 20 tribes, Tribal Epidemiology Centers, and tribal consortia are implementing public health data modernization projects aimed at improving data access and use to better protect tribal communities.

3.05. Transition ED data ingest processing to 1CDP

Leverages foundational infrastructure on 1CDP to support dataflow, reduce dependencies on external systems, and make use of reusable components within 1CDP.

2026: Move ED data processing to 1CDP to consolidate platforms and reduce cloud footprint, without reducing surveillance quality.

Goal 4: Advance more open and interoperable public health data

Through goal 4, CDC enhances the interoperability of systems and the accessibility of data so that healthcare organizations, STLT health departments, federal agencies, and CDC programs can access and use the data they need, when they need it, to improve health.

The consistent use of standards and policies for data exchange is crucial to ensure interoperability, reduce the burden of data management and sharing, and increase the quality and utility of data to support public health decisions and actions.

4.01. Support adoption of minimal data necessary (MDN) for public health emergency response

Reduces data reporting burden on CDC's partners, including STLT health departments and laboratories, particularly during public health emergencies.

2026: Building on the success of the [MDN initiative](#), ensure that data elements are incorporated into the 1CDP Data Element Repository to support adoption of MDN in CDC data collections. In 2026, implement data governance policy and procedures for at least 4 of the 6 core data sources.

4.02. FHIR adoption for National Healthcare Safety Network

Reduces reporting burden on hospitals and enables faster sharing of critical healthcare data. Learn more about the [National Healthcare Safety Network](#).

2026: At least 15 healthcare facilities are submitting critical hospital data to CDC through automated FHIR-based exchange.

4.03. FHIR adoption for birth data

Reduces reporting burden on vital records offices and enables faster sharing of critical vital statistics data.

2026: Test FHIR-based exchange of birth data between CDC and at least 6 additional vital records jurisdictions, bringing the total to 13.

4.04. Reduce data agreement burden

Reduces administrative and legal burden for jurisdictions and CDC programs by replacing fragmented, program-specific data use and sharing agreements with a single jurisdictional data use agreement (DUA) that enables faster, more consistent, and more transparent sharing of critical public health data.

2026: Obtain compliance with a single jurisdictional DUA with 10 STLT health departments.

4.05. Expand partnerships between public health agencies and data intermediaries, such as health data utilities (HDUs), to increase efficiency and effectiveness of data exchange

Advances the production, exchange, and enrichment of standardized public health data at scale and efficiently addresses critical gaps in public health surveillance and longitudinal population health impacts.

2026: CDC will establish minimum functional requirements and standards for public health intermediaries, such as HDUs, and pilot their application in at least 5 jurisdictions.

1. FHIR® is a registered trademark of Health Level Seven International and use of this trademark is for informational purposes only and does not constitute an endorsement by HL7®.

SOURCES

CONTENT SOURCE:
[Office of Public Health Data, Surveillance, and Technology](#)