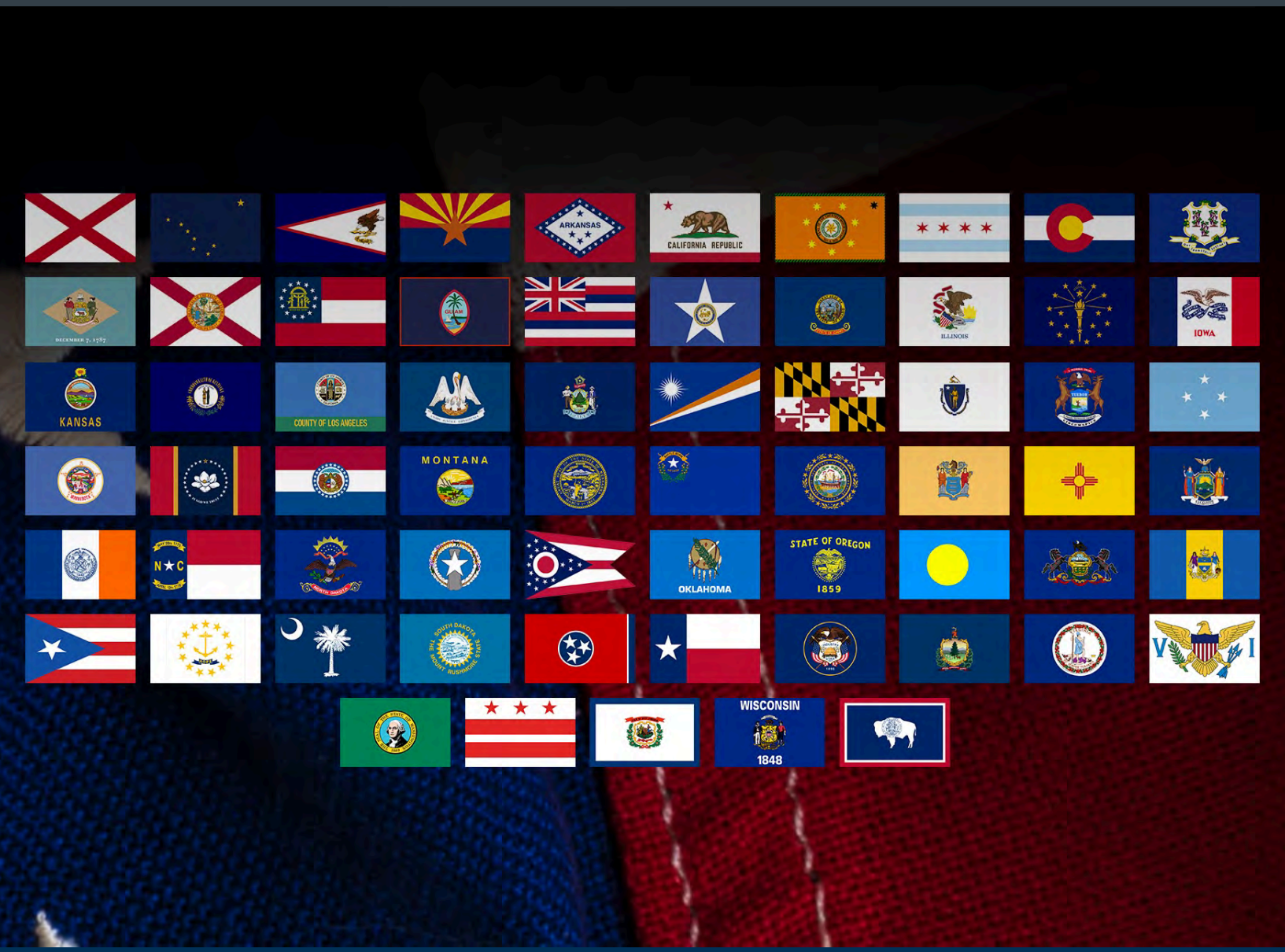
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Division of State and Local Readiness

Notice of Funding Opportunity

**Application due April 24, 2024**




# Public Health Emergency Preparedness (PHEP) Cooperative Agreement

Opportunity number: CDC-RFA-TU24-0137

# Contents

# Before you begin

If you believe you are a good candidate for this funding opportunity, secure your SAM.gov and Grants.gov registrations now. If you are already registered, make sure your registration is active and up-to-date.

### SAM.gov registration (this can take several weeks)

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI).

See Step 2: Get Ready to Apply

### Grants.gov registration (this can take several days)

You must have an active Grants.gov registration. Doing so requires a Login.gov registration as well.

See Step 2: Get Ready to Apply

### Apply by April 24, 2024

Applications are due by 11:59 p.m. Eastern Time on April 24, 2024.

# Step 1: Review the Opportunity

## In this step

# Basic information

**Centers for Disease Control and Prevention (CDC)**

Office of Readiness and Response

Division of State and Local Readiness

Preparing our public health systems to respond to and recover from emergencies

## Summary

This funding program aims to strengthen the capacity and capability of state, tribal, local, and territorial (STLT) public health systems to prepare for, respond to, and recover from public health threats and emergencies.

Our goal is to enhance readiness to save lives and prevent morbidity and mortality during emergencies that exceed the day-to-day capacity of public health agencies.

This funding opportunity provides a roadmap for PHEP recipients to design, develop, and implement strategies and activities that will improve their readiness to execute plans, respond to public health threats and emergencies, and recover from them.

To do this, we use CDC's Response Readiness Framework (RRF), which describes 10 program priorities. These program priorities, along with the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health, provide the framework to support advancement of preparedness, response, and recovery operations.

## Funding details

Type: Cooperative agreement

Total awards: 62

Projected total program funding, subject to the availability of funds, over the five-year performance period: $3,268,693,045

Projected total program funding, subject to the availability of funds, per budget period: $653,738,609

Have questions? See Contacts & Support.

### Key facts

**Opportunity name:**
Public Health Emergency Preparedness (PHEP) Cooperative Agreement

**Opportunity number:**
CDC-RFA-TU24-0137

**Federal assistance listing:**
93.069

### Key dates

**Application deadline:**
April 24, 2024

**Informational webinars:**

- Thursday, February 29, 2024, 2 p.m. to 3:30 p.m. ET
- Thursday, February 29, 2024, 8 p.m. to 9:30 p.m. ET

**Expected award date:**
July 1, 2024

**Expected start date:**
July 1, 2024

## Funding strategy

We will award funding using a statutory formula.

We encourage you to make 75% of Cities Readiness Initiative (CRI) funds available to your CRI jurisdictions within 90 days of the start of the budget period.

To help you find what you need, this NOFO uses internal links. In Adobe Reader, you can go back to where you were by pressing Alt + Left Arrow (Windows) or Command + Left Arrow (Mac).

# Eligibility

**Who can apply**

## Eligible applicants

As defined in section 319C-1 of the Public Health Service Act, the 62 eligible applicants for this funding opportunity are states, a consortium of states, or eligible political subdivisions that prepare and submit sufficient applications compliant with the statutory and administrative requirements described in this document. For the purposes of this announcement, the term "state" may include a state, a territory, or a freely associated state.

### State governments

- 50 state governments
- Eight territorial governments and freely associated states: American Samoa, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Guam, Puerto Rico, Republic of the Marshall Islands, Republic of Palau, and U.S. Virgin Islands

### Local governments

CDC can make awards to up to three political subdivisions that:

- Have a substantial number of residents
- Have a substantial local infrastructure for responding to public health emergencies
- Face a high degree of risk from bioterrorist attacks or other public health emergencies

CDC has determined that Chicago, Los Angeles County, and New York City meet the requirements of this provision.

Eligible recipients for this funding opportunity announcement must be currently funded under CDC-RFA-TP19-1901.

### Other award

The statute also allows CDC to set aside funding to address significant unmet needs or a particularly high degree of risk for public health threats.

CDC has determined that the CRI and Level 1 Laboratory Response Network chemical laboratories meet the requirements of these provisions. In addition, Washington D.C. meets the requirements for one of these awards, per statute.

# Cost sharing and matching funds

This program requires you to contribute $1 for every $10 we award you in federal funds.

To calculate the cost-sharing requirement, divide the federal share by 10.

**For example:** Divide $45,000,000 by 10. Your match would be $4,500,000.

## Cost-sharing exceptions

The match requirement does not apply to Chicago, Los Angeles County, and New York City.

A portion of the requirement, up to $200,000 is waived for American Samoa, Guam, U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands. If your calculated cost-sharing requirement is more than $200,000, then you must contribute that amount minus $200,000. See 48 USC 1469a(d).

## Types of cost sharing

You can meet your match requirement through any combination of:

- Cash or in-kind contributions (non-cash) from your organization
- Cash or in-kind contributions (non-cash) from public or private entities

You must not use federal funds to meet match requirements.

## Cost-sharing commitments

If you receive an award, you are required to contribute the funds you agreed to pay. This applies if you promised an amount more than the required minimum. We put these commitments in your Notice of Award (NOA).

If you do not provide your promised amount, we may decrease your award amount. You will have to report your funds when you fill out your annual Federal Financial Report. This accounting is subject to ongoing monitoring, oversight, and audit.

# Maintaining state funding

If you receive an award, you must maintain at least the same spending level for public health security as the average of the previous two fiscal years before the award. This is a requirement under 42 USC 247d-3a(h)(2). We will enforce these statutory requirements through all available mechanisms. You must provide supporting documentation in your attachments.

Public health security includes:

- Eligible state expenditures specifically designed to support public health emergency preparedness; and
- Other funds — such as general funds or other lines within your operating budget — that support public health emergency preparedness activities, such as costs for related personnel, supplies, or equipment.

You must be able to account for maintaining state funding separate from accounting for:

- Federal funds
- Any matching funds requirements

This accounting is subject to ongoing monitoring, oversight, and audit.

# Program description

## Purpose

Our purpose is to strengthen STLT public health preparedness, response, and recovery capacity and capability through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and implementing corrective actions.

A successful public health response is expected to help prevent or reduce morbidity and mortality from public health threats and emergencies and facilitate the recovery process.

## Approach

### Overview

CDC's Response Readiness Framework describes 10 cross-cutting program priorities to focus efforts on during the federal fiscal years (FY) 2024-2028 period of performance. These priorities inform the PHEP logic model.

Additionally, the Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health describes the 15 capability standards designed to support STLT jurisdictions as you prepare for, respond to, and recover from public health threats and emergencies. These 15 capabilities are foundational to the CDC Response Readiness Framework.

We expect you to show measurable progress toward achieving the outcomes outlined in the logic model during the five-year period of performance. CDC will evaluate you on the strategies and activities outlined in the PHEP logic model to ensure that you show measurable progress in achieving desired outcomes.

### Logic model

The logic model in this section includes the NOFO strategies and activities and outcomes.

Outcomes are the results that you intend to achieve and usually show the intended direction of change, such as increase or decrease.

Not all outcomes apply to all strategies. The table shows how they apply. Use these outcomes as a guide to plan for performance measurement.

## Program logic model

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

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

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

# Strategies & activities

The 10 Response Readiness Framework program priorities are categorized into three strategies. The following section describes the three strategies, outlined in the PHEP logic model, and the activities to achieve required outcomes. You can find additional resources on how to achieve these outcomes in Ready CAMP, our program management platform.

## NOFO activities, details, and performance measures for quick reference

### Strategy 1

**Table: Activities table 1: All-hazards activities (AHA)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| AHA-A: Complete and submit a risk assessment and data elements | 62 recipients | • Budget Period 1, by January 31, 2025, submit your risk assessment and data elements<br>• Complete a new risk assessment once during the five-year performance period<br>• Submit risk assessment and data elements each time your risk assessment is updated | Recipients must submit a completed risk assessment and required data elements that reflects the needs of the whole jurisdiction | Required |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| AHA-B: Complete and submit multiyear integrated preparedness plans and data elements | 62 recipients | • Budget Period 1, by June 30, 2025<br>• Review multiyear integrated preparedness plan each budget period, update and submit as needed | Recipients must submit a multiyear integrated preparedness plan that addresses plans, training, exercising, and corrective actions for prioritized jurisdictional risks (see AHA-A, AHA-E, and REC-A) | • Required<br>• PHEP benchmark |
| AHA-C: Develop and conduct required exercises | 62 recipients | According to jurisdictional exercise plans | Recipients must complete all required discussion- and operation-based exercises | Required |
| AHA-D: Submit exercise and incident response improvement plan data elements | 62 recipients | Each budget period, 90 days after completing discussion-based, operation-based exercises or incident responses | Recipients must submit updated improvement plans based on all required exercises and corrective actions from incidents | Required |
| AHA-E: Maintain capacity and capability to distribute, dispense, administer medical countermeasures and manage medical materiel | 62 recipients | Each budget period | Recipients must maintain capability to distribute, dispense, and administer medical countermeasures | Required |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| AHA-F: Review and update CHEMPACK plans | 62 recipients | Review each budget period with Administration for Strategic Preparedness and Response/ Strategic National Stockpile and update as needed | Recipients must develop or update CHEMPACK plan | Required |
| AHA-G: Complete training to ensure baseline competency and integration with preparedness requirements | 62 recipients | As appropriate | Recipients must complete preparedness training to support a ready responder workforce (see WKF-B) | Recommended |

**Table: Activities table 2: Public health laboratory capacity activities (LAB)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| LAB-A: Participate in LRN-C specimen packaging and shipping exercises | 50 states, Los Angeles County, New York City, Puerto Rico, and Washington D.C. | Each budget period | Recipients with PHEP funding for LRN-C laboratory capacity must pass specimen packaging and shipping exercise | Required |
| LAB-B: Participate in LRN-B challenge panels | 50 states, Los Angeles County, New York City, Puerto Rico, and Washington D.C. | Each budget period | Recipients with PHEP funding for LRN-B laboratory capacity must pass challenge panel exercises | Required; PHEP benchmark |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| | | | as defined by LRN | |
| LAB-C: Participate in LRN-C proficiency testing | 10 states with LRN-C Level 1 laboratories; 32 states with LRN-C Level 2 laboratories, Los Angeles County, and Washington D.C. | Each budget period | Recipients with PHEP funding for LRN-C laboratory capacity must pass proficiency exercises (core & additional) as defined by LRN | Required; PHEP benchmark for LRN-C Level 1 laboratories |
| LAB-D: Implement specified standards for electronic reporting of LRN-B and LRN-C laboratory data for routine and emergency reporting | 50 states, Los Angeles County, New York City, Puerto Rico, and Washington D.C. | Budget Period 5, by June 30, 2029 | Recipients with PHEP-funded laboratories must implement specified standards for electronic reporting of LRN-B and LRN-C data for routine and emergency reporting | Required |
| LAB-E: Develop surge capacity plans for LRN laboratories and incorporate related surge activities in jurisdictional exercises | 50 states, Los Angeles County, New York City, Puerto Rico, and Washington D.C. | • Budget Period 2, by June 30, 2026<br>• Review each budget period thereafter and update as needed | Recipients with PHEP-funded laboratories must develop and exercise LRN surge plans | Required |
| LAB-F: Maintain LRN program fiscal strategy | 50 states, Los Angeles County, New York City, Puerto Rico, and Washington D.C. | • Budget Period 1, by June 30, 2025<br>• Review each budget period | Recipients with PHEP funded laboratories must demonstrate fiscal responsibility for | Required |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| | | thereafter and update as needed | laboratory maintenance | |

**Table: Activities table 3: Data modernization activities (DM)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| DM-A: Incorporate data systems and data source functionality and infrastructure in public health emergency response plans | 62 recipients | • Budget Period 2, by June 30, 2026<br>• Review each budget period thereafter and update as needed | Recipients must update preparedness plans by incorporating data modernization principles as needed | Required |
| DM-B: Incorporate testing of the functionality and infrastructure of data systems and data sources into jurisdictional exercises | 62 recipients | • Budget Period 3, by June 30, 2027<br>• Report on changes at the end of each subsequent budget period | Recipients must modernize data and data systems by demonstrating improvements through exercising at least three of the six CDC North Star architecture standards | Required |

**Table: Activities table 4: Health equity activity (HE)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| HE-A: Update risk assessment to include people who are disproportionately impacted by public health emergencies | 62 recipients | • Budget Period 1, by January 31, 2025<br>• Review each budget period, update as needed, and submit each budget period if updated | Recipients must complete a risk assessment that identifies the likeliest jurisdictional risks and prioritize populations (that are potentially disproportionately affected or impacted because of access and functional needs given the identified risks); see AHA-A) | • Required<br>• PHEP benchmark |

## Strategy 2

**Table: Activities table 5: Partnerships activity (PAR)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| PAR-A: Include critical response and recovery partners in required plans and exercises | 62 recipients | Review each budget period and update as needed | Recipients must include partners that represent prioritized populations in planning and exercises (see AHA-A and HE-B) | • Required<br>• PHEP benchmark |

**Table: Activities table 6: Risk communications activities (RSK)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| RSK-A: Develop or update crisis and emergency risk communication and information dissemination plans | 62 recipients | Review each budget period and update as needed | Recipients must update Crisis and Emergency Risk Communication and information dissemination plans | Required |
| RSK-B: Identify and implement communication surveillance, media relations, and digital communication strategies in exercises | 62 recipients | Each budget period | Recipients must exercise communication objectives including identifying and addressing mis/ disinformation | • Required<br>• PHEP benchmark |
| RSK-C: Identify and implement specific crisis and emergency risk communication | 62 recipients | Review each budget period and update as needed | Recipients must actively engage in established communities of practice focused on crisis and | Required |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| activities that meet the diverse needs of communities of focus | | | emergency risk communication related preparedness, response, and recovery activities (see PAR-A and WKF-C) | |

**Table: Activities table 7: Recovery activity (REC)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| REC-A: Incorporate recovery operations into public health multiyear integrated preparedness plans | 62 recipients | • Budget Period 1, by June 30, 2025<br>• Review each budget period thereafter and update as needed | Recipients must document and exercise recovery plan objectives in the multiyear integrated preparedness plan (see AHA-B) | Required |

**Table: Activities table 8: Health equity activity (HE)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| HE-B: Engage partners to incorporate health equity principles into preparedness plans and exercises | 62 recipients | Review each budget period and update as needed | Recipients must work with preparedness partners that represent populations with access and functional needs or populations likely to be disproportionately affected during a response to promote health equity and social justice for the whole community (see AHA-A and PAR-A) | Required |

## Strategy 3

**Table: Activities table 9: Administrative and budget preparedness activities (ADM)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| ADM-A: Update administrative preparedness plans using lessons learned from emergency responses | 62 recipients | • Budget Period 1, by June 30, 2025<br>• Review each budget period thereafter and update as needed | Recipients must update administrative preparedness plans | Required |
| ADM-B: Integrate administrative and budget preparedness recommendations into training and exercises | 62 recipients | • Budget Period 2, by June 30, 2026<br>• Review each budget period thereafter and update as needed | Recipients must complete an administrative and budget preparedness discussion-based exercise | Required |
| ADM-C: Improve adherence to guidance related to spending, lapsing of funds, awarding of local contracts, and other administrative and budgetary requirements | 62 recipients | Each budget period | Recipients must award all PHEP funds allocated to local and tribal entities within 90 days (calculation starts one day after the date recipient receives the CDC award; see ADM-E) | Required |
| ADM-D: Reduce the time PHEP-funded positions at the recipient | 62 recipients | Each budget period | • Recipients must reduce PHEP | • Required<br>• PHEP benchmark |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| level remain vacant | | | workforce vacancy rates<br>• Benchmark goal is dependent on jurisdiction vacancy at application<br>• Jurisdictions with 20% or lower vacancy rates must decrease vacancy by 10%<br>• Jurisdictions with greater than 20% vacancy rates must demonstrate a decrease of at least 10% by the end of the five-year period of performance (see WKF-A) | |
| ADM-E: Distribute or award funds to local health departments and tribal entities within 90 days after the start of the budget period | 62 recipients | Each budget period | Recipients must award all PHEP funds allocated to local health departments and tribal entities within 90 days (calculation starts one day after the date | • Required if you distribute funds to local health departments and tribal entities<br>• PHEP benchmark |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| | | | recipient receives the CDC award; see ADM-C) | |

**Table: Activities table 10: Workforce activities (WKF)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| WKF-A: Develop plans, processes, and procedures to hire, recruit, train, and retain a highly qualified and diverse workforce | 62 recipients | • Budget Period 1, by June 30, 2025<br>• Review each budget period thereafter and update as needed | • Recipients must reduce PHEP workforce vacancy rates<br>• Benchmark goal is dependent on jurisdiction vacancy at application<br>• Jurisdictions with 20% or lower vacancy rates must decrease vacancy by 10%<br>• Jurisdictions with greater than 20% vacancy rates must demonstrate a decrease of at least 10% by the end of the five-year period of | • Required<br>• PHEP benchmark |

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| | | | performance (see ADM-D) | |
| WKF-B: Provide guidance, direction, and training to maintain a ready responder workforce across the entire health department | 62 recipients | Each budget period | • Recipients must have PHEP-funded staff complete jurisdiction's minimum training requirements (see AHA-G)<br>• Recipients must have surge staff complete jurisdiction's minimum training requirements (see AHA-G) | Required |
| WKF-C: Actively engage in at least one community of practice that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency | 62 recipients | Each budget period | Recipients must participate in at least one community of practice | • Required for the 50 states, Chicago, Los Angeles County, New York City, Washington, D.C., and Puerto Rico<br>• Recommended for the remaining territories and freely associated states |

**Table: Activities table 11: Local support activities (LOC)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| LOC-A: Engage local jurisdictions, including rural, frontier, and tribal entities, in public health preparedness planning and exercises | 50 states | Review each budget period and update as needed | States must include local planning jurisdictions in preparedness, response, and recovery activities (see AHA-A, (see AHA-C), and REC-A) | Required |
| LOC-B: Provide direct technical assistance and surge support staffing to increase local readiness | 50 states | Review each budget period and update as needed | States must have surge staff complete minimum training requirements (see WKF-B) | Required |
| LOC-C: Include local representation on senior advisory committees | 50 states | Review each budget period and update as needed | States must include at a minimum one local jurisdictional representative on their advisory committees | Required |

**Table: Activities table 12: Health equity activity (HE)**

| Activity | Who | When | Performance Measure | Obligation |
|---|---|---|---|---|
| HE-C: Include health equity representatives on senior advisory committees to increase advocacy for communities of focus | 62 recipients | Each budget period | Recipients must include advisory committee members that promote readiness for health equity and social justice in the whole community (see LOC-C and WKF-C) | Required |

## Strategy 1 (ST1)

Use CDC's national preparedness and response capabilities, as applicable, to augment STLT all-hazards planning to improve readiness, response, and recovery capacity for existing and emerging public health threats; and modernize laboratory and electronic data systems.

ST1 highlights the following Response Readiness Framework program priorities.

- **Develop a risk-based approach to all-hazards planning** to advance risk-based planning; address evolving threats; and support medical countermeasure distribution, dispensing, and administration and medical materiel management.
- **Advance capacity and capability of public health laboratories** to characterize emerging public health threats through testing and surveillance.
- **Modernize data collection and systems** to improve situational awareness and information sharing with health care systems and other partners.
- **Integrate health equity practices** to enhance preparedness, response, and recovery support for populations experiencing health disparities.

### Risk-based approach to all-hazards planning (AHA)

When used together with the exercise framework, the all-hazards approach (AHA) is designed to improve your response and recovery readiness. It offers a cohesive and structured process that includes:

- Identifying and planning for hazards based on identified risks
- Exercising all-hazard plans
- Recognizing opportunities for improvement
- Refining plans to further improve response capacity

You, along with your CRI local planning jurisdictions must maintain the capacity and capability to manage, distribute, dispense, and administer medical countermeasures according to the Administration for Strategic Preparedness and Response/Strategic National Stockpile (ASPR/SNS) requirements and guidelines. Requirements on validating receipt, stage, and storage (RSS) sites and testing inventory data exchange, along with SNS guidance on developing capacity and capability to receive, distribute, dispense, and administer medical countermeasures (MCM) can be found of SNS's Technical Assistance SharePoint site.

## Activity details

### AHA-A: Complete and submit a risk assessment (RA) and data elements (RADE)

Who: 62 recipients

When:

- Budget Period 1, by January 31, 2025, submit your RA and RADE
- After that:
  - Complete a new RA once during the five-year performance period
  - Submit RA and RADE each time your risk assessment is updated

Obligation: Required

- Conduct RAs and identify the top five risks based on public health consequences.
- At a minimum, an RA must be coordinated with and include all CRI funded local planning jurisdictions. You have autonomy to organize local planning.
- In your application, you must confirm CRI local planning jurisdiction organization. Indicate how many RAs you will report to us based on your planning structure. We expect either:
  - A single RA coordinated between you and your CRI local planning jurisdictions
  - Separate risk assessments coordinated by you and your CRI local planning jurisdictions
- We expect you to coordinate with:
  - The point of contact(s) responsible for completing the Threat and Hazard Identification and Risk Assessment (THIRA) for Federal Emergency Management Agency (FEMA) preparedness grants
  - The point of contact(s) responsible for completing the Health Care Coalition (HCC) Hazard Vulnerability Assessment (HVA) for the ASPR Hospital Preparedness Program (HPP) cooperative agreement
- We will provide you with the RADE template for submission.
  - You must submit your most recent RA and RADE by January 31, 2025.
  - Recipients whose most recent RA occurred in Budget Periods 2, 3, 4, or 5 of the previous NOFO (CDC-RFA-TP19-1901) performance period should submit that RA and the RADE based on elements addressed at that time.

    - Recipients who conduct an RA during Budget Period 1 will submit the RA and RADE.
- We expect that all CDC-identified data elements outlined in the RADE are incorporated in the RA.
- Consider updating your RA as recipient jurisdictions change or events necessitate. Examples of such changes or events include new:
    - Risks or hazards
    - Population change
- Each time your RA is updated, submit both:
    - RADE
    - RA

**AHA-B: Complete and submit multiyear integrated preparedness plans (MYIPP) and data elements**

Who: 62 recipients

When:

- Budget Period 1, by June 30, 2025
- After that: Review MYIPP and data elements each budget period, update and submit as needed

Obligation: Required; PHEP benchmark

- In Budget Period 1, conduct an integrated preparedness planning workshop (IPPW) and produce a five-year MYIPP informed by:
    - Risk priorities identified in activity AHA-A
    - Lessons learned through previous exercises or responses
    - Exercise priorities for you and your CRI local planning jurisdictions
- Your MYIPP must include planning, training, and exercising priorities and integrate PHEP exercise framework requirements.
    - MYIPP must address your pandemic influenza plan as required by statute
    - At a minimum, coordinate MYIPPs with CRI funded local planning jurisdictions and frontier, rural, and tribal entities as relevant.
    - The MYIPP data elements summarizes your current MYIPP, regardless of when it was performed.

### AHA-C: Develop and conduct required exercises

Who: 62 recipients

When: Varies depending on timelines of jurisdictional exercise plans

Obligation: Required

- Implement jurisdictional exercise programs in alignment with the PHEP exercise framework.
    - Plan for and conduct discussion-based and operation-based exercises outlined in the PHEP exercise framework and associated supplemental guidance.
- Complete at least one operation-based exercise each budget period throughout the performance period.
- Use the Homeland Security Exercise and Evaluation Program (HSEEP) methodology when organizing exercise plans.
- You must engage and exercise with local planning jurisdictions and federally recognized American Indian and Alaska Native tribes within applicable PHEP jurisdictions.
- You must account for your jurisdictional risks and scenarios in exercises; we will provide mandatory objectives within exercise supplemental guidance to assist planners.
- You must develop exercise scenarios that meet your priority jurisdictional risks and complete the capstone exercise, based on one of your top five risks with public health consequences identified in your RA, during the period of performance.
- Submit required exercise data elements, which will include required mandatory objective(s), corrective actions, improvement plan data elements, and MYIPP. Submission of after-action reports (AAR) are required when requested.

### AHA-D: Submit exercise and incident response improvement plan data elements

Who: 62 recipients

When: Each budget period, 90 days after completing discussion-based and operation-based exercises or incident responses

Obligation: Required

- We will provide you with improvement plan data elements for submission.

- Upon request you must submit (on behalf of the recipient or CRI local planning jurisdictions):
  - Improvement plans (IPs)
  - AARs

**AHA-E: Maintain capacity and capability to distribute, dispense, administer medical countermeasures (MCMs) and manage medical materiel**

Who: 62 recipients

When: Each budget period

Obligation: Required

- Maintain capacity and capability to dispense, distribute, and administer MCMs according to Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health and ASPR/SNS guidelines.
  - Work with your CRI local planning jurisdictions to ensure they maintain these capabilities.
  - Work with SNS to understand the MCM request process, as needed.
- Conduct or participate in activities to test ASPR systems and tools to order, distribute, track local inventory, report utilization and other operational data for federally procured resources and supplies for public health threats, as needed.
- Identify and provide receipt, stage, and storage (RSS) site information to ASPR/SNS as applicable.
  - Identify primary and alternate RSS sites.
  - Coordinate new RSS site validation with ASPR/SNS and U.S. Marshals Service senior inspectors within a year of identification.
  - Revalidate existing previously validated sites at least once every three years.
  - Confirm that existing, validated RSS site information is current each year.

**AHA-F: Review and update CHEMPACK plans**

Who: 62 recipients

When: Review each budget period with ASPR/SNS and update as needed

Obligation: Required

- Conduct CHEMPACK sustainment activities as needed per ASPR/SNS guidelines.

**AHA-G: Complete training to ensure baseline competency and integration with preparedness requirements**

Who: 62 recipients

When: As appropriate

Obligation: Recommended

Consider the following trainings to ensure baseline competency and integration with preparedness requirements. Following are recommendations for recipients and local jurisdictions based on staff designations. These courses are meant to build upon each other.

- Public health preparedness and recovery staff, including exercise planning staff:
  - Incident Command System (ICS) 100: Introduction to ICS
  - ICS 700: An Introduction to the National Incident Management System (NIMS)
  - ICS 706: NIMS Intrastate Mutual Aid
  - ICS 800: National Response Framework, An Introduction
  - IS-120.C: An Introduction to Exercise
  - IS-2900.A: National Disaster Recovery Framework (NDRF) Overview
  - Homeland Security Exercise and Evaluation Program
  - Emergency Management Assistance Compact (EMAC) Pre-Event Preparation for Resource Providers
- Health Department supervisory positions:
  - ICS 200: Basic ICS for Initial Response
  - Independent Study (IS)-2200: Basic Emergency Operations Center Functions
- Staff with designated response roles:
  - ICS 300: Intermediate ICS for Expanding Incidents (In Person)
  - EMAC Just-in-Time Training for Deploying Personnel
  - Crisis and Emergency Risk Communication (CERC)
- Senior staff who support the management of large/complex responses (incidents across multiple locations or over a large area):
  - ICS 400: Advanced ICS (In Person)

## Public health laboratory capacity (LAB)

Public health laboratories (PHLs) must advance their capacity and capability to respond to emerging public health threats through initial detection and rapid electronic results sharing.

State and territory PHLs that are members of CDC's Laboratory Response Network (LRN) must:

- Meet specified standards for electronic laboratory reporting
- Maintain and exercise surge plans
- Maintain longer term fiscal strategies for the Laboratory Response Network for Biological Threats (LRN-B) and Laboratory Response Network for Chemical Threats (LRN-C)

We may provide additional funding, if available, to support these efforts:

- A Laboratory Response Network for Radiological Threats (LRN-R)
- Public health LRN-B advanced laboratories to support assay development and may assist CDC with or generate their own regulatory submissions to the U.S. Food and Drug Administration (FDA) during this period of performance
- Laboratory equipment updates and technology transfers for LRN-C level 1 and level 2 laboratories

### Activity details

**LAB-A Participate in LRN-C specimen packaging and shipping (SPaS) exercises**

Who: 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.

When: Each budget period

Obligation: Required

- Demonstrate proficiency in specimen shipping and packaging through the LRN-C SPaS exercises for chemical threat agents.
    - SPaS annual exercise evaluates the ability of a laboratory to collect clinical samples for chemical laboratory analysis and to ship those samples in compliance with International Air Transport Association regulations.
    - You must ensure that at least one PHEP-funded LRN-C laboratory in your jurisdiction participates in the LRN-C SPaS exercise with a minimum score of 90% each budget period.

### LAB-B: Participate in LRN-B challenge panels

Who: 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.

When: Each budget period

Obligation: Required; PHEP benchmark

- Demonstrate proficiency in public health laboratory testing for biological agents through participation in annual challenge panels.
    - Challenge panels consist of a variety of mock clinical and environmental matrices that test a laboratory's ability to:
        - Successfully identify biothreat agents
        - Demonstrate understanding of LRN agent-specific testing procedures and algorithms
        - Ensure a laboratory maintains appropriate levels of testing supplies and reagents
    - PHEP-funded LRN-B laboratories cannot fail more than one challenge panel associated with standard laboratory requirements during the budget period. The LRN-B challenge panel policy defines successful demonstration of this capability.
- CDC's LRN-B program requires public health laboratories in the 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C., to participate in all available challenge panels specific to each laboratory's testing capability. If a laboratory has testing capability for a specific agent and that agent is included in a challenge panel being offered, the PHEP-funded laboratory must participate in that challenge panel.
- We do not expect LRN-B labs that are offline for three months or more due to renovations, moving, or other special circumstances to participate in challenge panels during that time. Report offline status to the LRN-B program office and project officer for awareness.

### LAB-C: Participate in LRN-C proficiency testing

Who: 10 states with LRN-C Level 1 laboratories; 32 states with LRN-C Level 2 laboratories, Los Angeles County, and Washington D.C.

When: Each budget period

Obligation: Required; PHEP benchmark for LRN-C Level 1 laboratories

- Demonstrate proficiency in public health laboratory testing for chemical threat agents through the participation in LRN-C proficiency testing panels.

- We will evaluate LRN-C Level 1 and Level 2 laboratories on sample results, reporting accuracy, and timeliness via the LRN secure data portal.
- You must ensure that LRN-C Level 1 laboratories in your jurisdiction participate in all LRN-C proficiency testing events for all LRN-C core and additional methods as defined by the LRN-C program office.
  - This activity is a PHEP benchmark for LRN-C Level 1 laboratories.
- You must ensure that LRN-C Level 2 laboratories in your jurisdiction participate in LRN-C proficiency testing events for all LRN-C core methods as defined by the LRN-C program office. Additional methods are optional for Level 2 laboratories.
  - This activity is not a PHEP benchmark for LRN-C Level 2 laboratories.
- CDC's LRN-C quality assurance policy guidelines define successful demonstration of this capability.

**LAB-D: Implement specified standards for electronic reporting of LRN-B and LRN-C laboratory data for routine and emergency reporting**

Who: 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.

When: Budget Period 5, by June 30, 2029

Obligation: Required

- Ensure that LRN-B and LRN-C laboratories implement CDC specified standards for electronic reporting of laboratory data for routine and emergency reporting.
- By the end of the performance period on June 30, 2029:
  - Report results of all LRN-B-distributed assays to us using specific CDC standards for electronic reporting.
    - Contact the LRN-B program office for the most current standards and requirements for specific members.
  - Report all Level 1 LRN-C methods to us using specific CDC standards for electronic reporting.
  - Report all Level 2 LRN-C core methods to us using specific CDC standards for electronic reporting.
    - Contact the LRN-C program office for the most current standards.

**LAB-E: Develop surge capacity plans for public health LRN laboratories and incorporate related surge activities in jurisdictional exercises**

Who: 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.

When:

- Budget Period 2, by June 30, 2026
- Review each budget period thereafter and update as needed

Obligation: Required

- By the end Budget Period 2, PHEP-funded state public health LRN-B and LRN-C laboratories must develop surge plans that include essential elements for LRN-B and LRN-C activities:
  - Surge staffing
  - Surge equipment and resources
  - Sentinel laboratory and external laboratory coordination and communication
  - Biosafety protocols
  - Sample management (triage, prioritization, testing, and referral)
  - Data exchange, reporting, and management
  - Training and exercising
- Incorporate activities into jurisdictional exercises through a phased, progressive exercise approach.
- LRN-B laboratories must exercise surge plans in:
  - A jurisdictional discussion-based exercise at least once during the five-year performance period
  - A functional exercise at least once during the five-year period of performance
- LRN-C laboratories must exercise surge plans in:
  - A jurisdictional discussion-based exercise at least once during the five-year performance period
- Test, at a minimum:
  - Surge coordination, including surge staff notification and coordination with sentinel laboratories
  - Continuity of operations (COOP) planning capability
  - Electronic reporting of laboratory data
  - Receiving and testing of samples

- Jurisdictions must include laboratory capability in their MYIPPs (AHA-C).

**LAB-F: Maintain LRN program fiscal strategies**

Who: 50 states, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.

When:

- Budget Period 1, by June 30, 2025
- Review each budget period thereafter and update as needed

Obligation: Required

- In Budget Period 1, determine a five-year fiscal strategy to support LRN-B and LRN-C capacity and capability.
  - Diversify laboratory funding sources to ensure that LRN-B and LRN-C activities are funded to achieve laboratory standards and requirements. This includes replacing obsolete instrumentation and obtaining maintenance agreements on necessary instrumentation for the five-year performance period.
  - Work together with jurisdictional epidemiology leads, public health laboratory directors or their designated representatives to determine the fiscal strategy in Budget Period 1. Continue to meet each year throughout the remainder of the performance period to update laboratory fiscal strategies.

## Data modernization (DM)

We designed the following data modernization activities to improve situational awareness and information sharing by ensuring that data systems and sources are incorporated into plans and tested with exercises.

### Activity details

**DM-A: Incorporate data systems and data source functionality and infrastructure into public health emergency response plans**

Who: 62 recipients

When:

- Budget Period 2, by June 30, 2026
- Review each budget period thereafter and update as needed

Obligation: Required

- By the end of Budget Period 2, you must:

    - Identify the resources and infrastructure necessary for data systems and sources to meet jurisdictional needs during an emergency response
    - Document this information in public health emergency response plans
- Consider what data systems and data sources are essential for an emergency response in your jurisdictions. We advise you to use:
    - The data systems modernization assessment you completed as an activity under Epidemiology and Laboratory Capacity (ELC) Health Information Systems (HIS) awards
    - The six CDC data capabilities listed in the North Star Architecture: scalable, flexible, interoperable, sustainable, reusable, and intuitive.
    - Other priority capabilities identified by the jurisdiction to assess the response readiness of data systems and data sources
- If you receive ELC Program Accelerating Data Modernization funding, coordinate with the data modernization leads in your geographic regions who are responsible for coordinating or leading the assessment process. Learn more in the Epidemiology and Laboratory Capacity (ELC) C2 Public Health Data Modernization Assessment.
- Reference the CDC Public Health Data Strategy for examples of data sources.

**DM-B: Incorporate testing of the functionality and infrastructure of data systems and data sources into jurisdictional exercises**

Who: 62 recipients

When:

- Budget Period 3, by June 30, 2027
- Report on changes at end of each subsequent budget period

Obligation: Required

- By the end of Budget Period 3 you must:
    - Identify at least one of the six data capabilities listed in the North Star Architecture or one of the priorities identified by your jurisdiction to focus on for improvement that is critical to improve response readiness.
    - Prioritize improving data systems and data sources that are the most essential for effective response.
    - Establish a baseline of performance for the selected capability(s).

    - Incorporate the testing of the selected capability(s) into an exercise during the budget period.
    - By the end of each subsequent budget period, report on changes from the baseline assessment of the capability(s) for the data systems and data sources.
- Over the course of the five-year period of performance, you must exercise at least three different capabilities.
    - CDC defines a modern public health information system as possessing the following six core capabilities aligned with the North Star Architecture.
        - Scalable: Able to receive, send, and process unpredictable volumes of data
        - Flexible: Supports rapidly changing data, workflows, end users, and end user needs
        - Interoperable: Can easily exchange data with other systems used for public health action
        - Sustainable: System is designed to ensure that continuous development, maintenance, and operations costs can be covered by the jurisdiction's routine funding sources
        - Reusable: Usable for both daily and emergent public health action across multiple disease areas and types of public health threats
        - Intuitive: Can be quickly understood and used effectively by new staff, whether for purposes of routine public health action or emergency response

## Health equity (HE)

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. We incorporate the health equity activities across all three PHEP strategies. These strategies improve inclusion and support for disproportionately affected populations and those with accessibility and functional needs that affect their ability to prepare for, respond to, and recover from public health emergencies.

You will help establish the necessary infrastructure so that disproportionately affected populations with health disparities, access needs, or functional needs compared with others in the same jurisdiction are prepared to appropriately respond to threats with public health consequences. See the CDC Access and Functional Needs Toolkit.

You will include these communities of focus when identifying jurisdictional risks, developing preparedness plans, and exercising those plans to improve preparedness for people who are disproportionately impacted by public health emergencies.

## Activity details

**HE-A: Update RA to include people who are disproportionately impacted by public health emergencies**

Who: 62 recipients

When:

- Budget Period 1, by January 31, 2025
- Review each budget period thereafter, update as needed, and submit each budget period if updated

Obligation: Required; PHEP benchmark

- Recipients and CRI local planning jurisdictions must update RAs with relevant input from partners to ensure communities of focus are included in MYIPPs.
- Ensure RAs reflect health equity
    - Include disproportionally impacted populations or communities projected to be adversely impacted by the public health consequences of risks.
    - Include populations with limited English proficiency.
    - Consider how social determinants of health may affect health outcomes during an emergency.
    - Use data sources, such as CDCs Social Vulnerability Index (SVI) and PLACES, to inform how you prioritize populations that are potentially disproportionately affected or impacted because of access and functional needs given the identified risks of your jurisdiction.
        - For example, if you use SVI, prioritize communities with an overall SVI score greater than 25% (labeled high).
- Over the five-year period of performance, identify impacted communities and implement actions to understand how public health emergency response plans and exercises can be developed or updated to address unique preparedness, response, and recovery needs of the communities.

# Strategy 2 (ST2)

Use CDC's Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health, as applicable, to improve whole community readiness, response, and recovery through enhanced partnerships and improved communication systems for timely situational awareness and risk communication.

ST2 highlights the following Response Readiness Framework program priorities.

- **Enhance partnerships** with federal and non-governmental organizations to effectively support community preparedness efforts
- **Strengthen risk communication activities** to improve proficiency in disseminating critical public health information and warnings and address misinformation or disinformation
- **Prioritize community recovery efforts** to support health department reconstitution and incorporate lessons learned from public health emergency responses
- **Integrate health equity practices** to enhance preparedness, response, and recovery support for communities experiencing differences in health status due to structural barriers

## Partnerships (PAR)

We designed the following partnerships activity to improve your support of community preparedness efforts by:

- Further integrating partners into preparedness planning
- Conducting exercises to align roles and strengthen responses to public health emergencies

### Activity details

**PAR-A: Include critical response and recovery partners in required plans and exercises**

Who: 62 recipients

When: Review each budget period and update as needed

Obligation: Required; PHEP benchmark

- Include critical infrastructure and critical response and recovery partners who have roles in required plans and exercises.
- At a minimum, consider including the following partners in planning and exercises.

    - Local government officials, local health departments, and health board members
    - Public health communication professionals
    - Volunteer and human resource managers
    - Contract and procurement managers
    - Health care and community health care coalitions
    - Environmental health and environmental management programs
    - Emergency management officials
    - Rural, frontier, and tribal organizations
    - Non-governmental organizations
    - K-12 schools, colleges, and universities
    - Community and faith-based organizations that work with disproportionately impacted populations including people with access and functional needs and those with limited English proficiency
- Assess your ability to address the unique needs of community members through exercises.
- Maintain response affiliations with private industry partners to include large employers, pharmacies, academia, and others.

## Risk communications (RSK)

We intend these risk communications activities to improve proficiency in disseminating critical public health information and warnings.

You will refine communication strategies and engage community-based messengers to promote the development and timely receipt of accurate information across jurisdictions and within communities of focus.

### Activity details

**RSK-A: Develop or update crisis and emergency risk communication (CERC) and information dissemination plans**

Who: 62 recipients

When: Review each budget period and update as needed

Obligation: Required

- Incorporate lessons learned from exercises and responses into CERC and information dissemination plans.

    - Use information dissemination plans and experiences from recent exercises and responses that communicated information to staff, partners, and the public to identify gaps and incorporate solutions into information dissemination plans.
- Incorporate strategies to monitor and combat misinformation and disinformation into CERC and information dissemination plans.
    - Identify and ensure appropriate staffing and information technology (IT) resources in media monitoring plans that include communication surveillance and social listening activities to identify and combat misinformation and disinformation.
    - Identify and engage partners, such as key influencers, as part of overall strategies for combatting misinformation and disinformation.

**RSK-B: Identify and implement communication surveillance, media relations, and digital communication strategies in exercises**

Who: 62 recipients

When: Each budget period

Obligation: Required; PHEP benchmark

- Work with your CRI local jurisdictions to complete the following activities:
    - Conduct media monitoring and communication surveillance activities
    - Develop or update approaches for regular media outreach
    - Identify opportunities to build trust and address misinformation and disinformation during responses
- Exercise CERC plans and principles to ensure risk communication and staff activities simulate actions that will be taken during an emergency.
- Provide training opportunities, tools, and resources to public health leaders, staff, partners, CRI local planning jurisdictions, and other interested groups about strategies and best practices for engaging with the media and combatting misinformation and disinformation.

**RSK-C: Identify and implement specific CERC activities that meet the diverse needs of communities of focus**

Who: 62 recipients

When: Review each budget period and update as needed

Obligation: Required

- Use lessons learned from COVID-19, mpox, and other recent responses to identify and address gaps in CERC activities that support communities of focus.
- Identify program personnel to support CERC planning and implementation efforts, conduct communication surveillance activities, and coordinate with the jurisdiction's health department communication staff to identify and address misinformation and disinformation.
- Collaborate with partners that represent prioritized populations to develop culturally, linguistically, and accessible appropriate risk messages for populations with access needs, functional needs, and health disparities.
- Actively engage in established communities of practice focused on CERC-related preparedness, response, and recovery activities.
    - Any community of practice that includes discussion of gaps, strengths, and barriers and improves CERC can fulfill this requirement.

## Recovery (REC)

We intend this recovery activity to support health departments in reconstitution and reflection on lessons learned from previous public health emergency responses to improve community-based recovery efforts.

You will incorporate recovery operations into planning to address needs and meet recovery objectives.

### Activity details

**REC-A: Incorporate recovery operations into public health MYIPPs**

Who: 62 recipients

When:

- Budget Period 1, by June 30, 2025
- Review each budget period thereafter and update as needed

Obligation: Required

- During Budget Period 1, ensure that recovery and planning operations are incorporated into MYIPPs:
    - Identify community partners who aid in recovery and engage in discussions regarding their potential roles and their resources.
    - Identify roles and responsibilities for staff designated to support recovery operations.

    - Identify and establish methods for collecting data and sharing information with staff assigned to recovery operations to aid in tracking progress toward meeting recovery objectives.
    - Develop or enhance processes that support the restoration and continuity of operation and service for public health programs, especially for those serving displaced communities.
- Establish methods for determining community recovery priorities and communicating the status of recovery operations with relevant partners, interested groups, and the public.
- Participate each year in emergency management recovery and mitigation committees.

## Health equity (HE)

You will build on previous efforts in support of disproportionately affected populations and expand partner engagement efforts to reach more communities of focus.

### Activity details

**HE-B: Engage partners to incorporate health equity principles into preparedness plans and exercises**

Who: 62 recipients

When: Review each budget period and update as needed

Obligation: Required

Work with your CRI local planning jurisdictions to complete the following activities.

- Engage community or nontraditional partners, such as faith-based organizations and private industry each year to support communities of focus identified in the RADE health equity section.
    - Prioritize engagement with communities that you identified in HE-A to have a greater percentage of populations that are disproportionately affected by the public health impact of one or more of the top five jurisdictional risks identified in your RADE.
    - Ensure preparedness plans and exercises incorporate community of focus needs and priorities identified through partnerships.
- Establish or join communities of practice or partner advisory groups to continue collaboration and coordination for communities of focus.

## Strategy 3 (ST3)

Use CDC's established national preparedness and response capabilities to expand:

- Capacity and capability to meet jurisdictional administrative, budget, and public health response and recovery workforce priorities
- Local support to ensure that public health emergencies are effectively coordinated and executed

ST3 highlights the following RRF program priorities.

- **Improve administrative and budget preparedness systems** to ensure timely access to resources for supporting jurisdictional responses
- **Build workforce capacity** to meet jurisdictional surge management needs and support staff recruitment, retention, resilience, and mental health
- **Expand local support** to improve jurisdictional readiness to effectively manage public health emergencies
- **Integrate health equity practices** to enhance preparedness and response support for communities experiencing differences in health status due to structural barriers

### Administrative and budget preparedness (ADM)

We intend the following ADM activities to improve mechanisms and processes that support timely jurisdictional responses.

You will update plans and ensure compliance with guidelines to enhance administrative operations and capacity to achieve response readiness.

#### Activity details

**ADM-A: Update administrative preparedness plans using lessons learned from emergency responses**

Who: 62 recipients

When:

- Budget Period 1, by June 30, 2025
- Review each budget period thereafter and update as needed

Obligation: Required

- During Budget Period 1, analyze administrative and budget preparedness (ADM) plans and activities from CDC-RFA-TP19-1901 to identify the time it

takes to hire staff, execute contracts, and request, receive, and distribute federal funds.

- Analyze and update ADM plans that reflect improved hiring and contracting procedures and address legal barriers to receive and distribute funds.
- Review and analyze existing financial management and tracking systems and identify ways to improve monitoring and accurate reporting on spending. This includes your systems and those used by local health departments, federally recognized tribes, and partners.
- Compare hiring, contracting, and distribution of federal funds during nonresponse and emergency response events, identify efficiencies, and update ADM plans accordingly.

**ADM-B: Integrate ADM recommendations into training and exercises**

Who: 62 recipients

When:

- Budget Period 2, by June 30, 2026
- Review each budget period thereafter and update as needed

Obligation: Required

- By the end of Budget Period 2, develop and update contact lists of ADM planning and response decision makers, staff such as legal, procurement, and human resources personnel, and partners, which may include local officials and emergency management agencies, for inclusion in administrative preparedness training and exercises.
- Provide training and educational opportunities for ADM planning and response personnel and partners, such as conferences, exercises, integrated preparedness planning meetings, seminars, and workshops.
  - Use them to help participants understand CDC's ADM requirements and relevant roles and responsibilities during public health emergencies. Integrate ADM procedures into training for new personnel.
- Develop and conduct planning meetings with ADM personnel and partners to review objectives, identify topics, and coordinate injects for trainings and exercises.
  - Include personnel and partners in development of AARs, corrective action plans (CAPs), or IPs.
- Update ADM plans each year, using AAR findings, and implement changes as part of subsequent training and exercise planning.

**ADM-C: Improve adherence to guidance related to spending, lapsing of funds, awarding of local contracts, and other ADM requirements**

Who: 62 recipients

When: Each budget period

Obligation: Required

- Ensure adherence to and compliance with PHEP NOFO and CDC budget guidelines in developing and executing contractual agreements with subrecipients such as local health departments.
    - Advise subrecipients, such as local health departments and contractors, to comply with federal regulations as stated in the NOFO and terms and conditions of the funding awards for appropriate use of federal funds including restrictions, tracking, and reporting requirements.
    - Collect, review, and maintain quarterly spend plans from subrecipients to identify spending challenges early in the budget period.
- Identify spending challenges and provide technical assistance to subrecipients which may include strategies to mitigate lapsing funds.
    - Explore the feasibility of using flexible General Services Administration (GSA) contracting or other mechanisms such as blanket purchase agreements or blanket order agreements.

**ADM-D: Reduce the time PHEP-funded positions at the recipient level remain vacant**

Who: 62 recipients

When: Each budget period

Obligation: Required; PHEP benchmark

- Identify existing vacant positions, such as laboratorians, grant managers, or MCM coordinators, and establish baseline projections to fill these roles during routine periods.
    - Identify and document factors that impact the time it takes to fill vacancies as well as challenges in coordinating with human resource offices to improve hiring practices and policies.
- Include provisions in subrecipient monitoring plans that require local health departments to report vacancies through required reporting mechanisms.

- Develop strategies to mitigate staffing challenges and workforce retention and include in ADM plans.

**ADM-E: Distribute or award funds to local health departments and tribal entities within 90 days after the start of the budget period**

Who: 62 recipients

When: Each budget period

Obligation: Required if you distribute funds to local and tribal entities; PHEP benchmark

- Identify and document in PHEP five-year work plan factors that contribute to delays in distributing PHEP funds.
- Include strategies to mitigate challenges and reduce delays in distributing funding to local health departments in ADM plans.
- Include provisions in subrecipient monitoring plans that require local health departments and tribal entities to document challenges or delays in receiving funds and date funds were received in routine progress reports.

## Workforce (WKF)

We intend these workforce activities to improve workforce capacity to meet jurisdictional surge management needs and increase support for public health emergency preparedness staff.

You will develop plans, coordinate with and train staff, and implement procedural improvements to maintain a qualified, response-ready workforce.

### Activity details

**WKF-A: Develop plans, processes, and procedures to hire, recruit, train, and retain a highly qualified and diverse workforce**

Who: 62 recipients

When:

- Budget Period 1, by June 30, 2025
- Review each budget period thereafter and update as needed

Obligation: Required; PHEP benchmark

- By the end of Budget Period 1, conduct or update a landscape analysis that includes key jurisdictional emergency response positions, considering critical staffing needs identified during the COVID-19 pandemic and lessons learned from other recent responses.

    - During subsequent budget periods, continue to monitor and mitigate existing or developing staffing vacancies and develop strategies for surge staffing to support a range of emergency responses.
- Designate key response roles or their equivalent in response plans. At a minimum, include ICS 100 positions:
    - Incident Commander
    - Finance Section Chief
    - Administration Section Chief
    - Logistics Section Chief
    - Operations Section Chief
    - Planning Section Chief
- Designate support roles or equivalent for response command staff based on incident requirements that include:
    - Public Information Officer
    - Safety Officer
    - Data Liaison (lead)
- Designate responsibility within the incident command structure to address plans for responders and the public, given the scope of the response, that considers these functions:
    - Diversity, equity, inclusion, accessibility, and belonging (DEIAB)
    - Health equity
    - Responder and workforce safety
    - Responder mental and behavioral health

**WKF-B: Provide guidance, direction, and training to maintain a ready responder workforce across the entire health department**

Who: 62 recipients

When: Each budget period

Obligation: Required

- Include health department preparedness staff and surge staff outside the preparedness program who fill key incident command roles in preparedness training and periodic exercises. Primary response staff must participate in exercises on a rotational basis as determined by the health department.

- During small responses, such as local outbreak investigations, periodically include surge staff who may fill roles during major responses. You can establish surge staffing through various mechanisms including redirected health department staff, contract staff, National Guard, and community teams.
- PHEP-funded health department staff must participate in jurisdictionally defined annual training and national-level exercises to bolster response and resilience competencies and to demonstrate operational readiness. We encourage surge staff outside the preparedness program who fill key response roles to participate in both training and exercises.
- PHEP staff and surge STLT staff must participate in full-scale exercises involving federal agencies.

**WKF-C: Actively engage in at least one community of practice that identifies problems, solutions, and best practices in workforce recruitment, hiring, training, retention, or resiliency**

Who: 62 recipients

When: Each budget period

Obligation: Required for the 50 states, Chicago, Los Angeles County, New York City, Puerto Rico, and Washington, D.C.; recommended for the remaining territories and freely associated states

- Actively engage — either as a leader or a participant — when establishing or joining a community of practice for a public health workforce. Share ideas, processes, protocols, and promising or best practices.
    - Any community of practice that includes discussion of gaps, strengths, barriers and improves PHEP workforce capacity and resiliency can fulfill this requirement.
    - These practices should foster a resilient public health workforce readily equipped to implement best practices and interventions that support or remedy workforce recruitment, hiring, training, retention, or resiliency.
- Make systemic changes to support health and well-being across the preparedness workforce and response cycle by adapting interventions to reduce trauma, stress, and burnout and foster a resilient public health workforce.

## Local support (LOC)

We intend these local support activities to improve jurisdictional readiness to effectively manage public health emergencies.

States must support local readiness efforts and include local jurisdictional representatives in key advisory forums to advance the ability of local entities to prepare for, respond to, and recover from public health emergencies.

The local support activities pertain to PHEP subrecipients, tribal entities, and other partners within PHEP recipients' geographic boundaries. Input from these partners about response plans can prevent illness, injury, and death during a public health emergency.

### Activity details

**LOC-A: Engage local jurisdictions, including rural, frontier, and tribal entities, in public health preparedness planning and exercises**

Who: 50 states

When: Review each budget period and update as needed

Obligation: Required

- States should engage meaningfully with all local and tribal jurisdictions, as appropriate, during the period of performance.
  - Enhance engagement by providing technical assistance to local jurisdictions, including rural and frontier jurisdictions, to improve operational readiness.
  - Support local jurisdictions, including rural and frontier jurisdictions, in evaluating programmatic and ADM processes and provide examples of promising and best practices.
  - Maintain flexibility when developing work plans, exercises, and mitigation strategies for specific hazards to account for gaps and risks of local and tribal jurisdictions, as appropriate.
- Improve jurisdictional readiness and community preparedness by identifying, creating, and facilitating opportunities for local engagement within and outside of the CRI local planning jurisdictions, including rural, frontier, and tribal entities.
  - Opportunities can include risk assessments, threat prioritization, roles and responsibilities, direct technical assistance, training, staffing, peer-to-peer connections, and funding.

- Work collaboratively with subrecipients, tribes, and other partners within your geographic boundaries to identify activities based on local needs and priorities to improve operational readiness. Do this before you submit your PHEP funding application and annual updates to PHEP work plans and budgets throughout the performance period.
- Provide opportunities for local jurisdictions to review PHEP work plans and provide input and feedback prior to submission.
- You must demonstrate meaningful engagement by providing technical assistance to local jurisdictions, completing the required concurrence process, and maintaining local representation on your senior advisory committees (SACs).

**LOC-B: Provide direct technical assistance and surge support staffing to increase local readiness**

Who: 50 states

When: Review each budget period and update as needed

Obligation: Required

- Ensure that all local jurisdictions, including rural and frontier jurisdictions, can identify threats or hazards with public health implications, communicate risks to the public, and request additional assistance when emergencies exceed local capacity.
  - All 50 states must ensure all local jurisdictions can perform these baseline readiness activities.
  - All 50 states must have surge staffing plans that support local public health emergency responses if needed.

**LOC-C: Include local representation on senior advisory committees**

Who: 50 states

When: Review each budget period and update as needed

Obligation: Required

- Include local jurisdiction representation on your SAC.
- Include federally recognized tribes and rural and frontier jurisdictions, as appropriate.
- Coordinate with local jurisdictions, including rural and frontier jurisdictions, to align on public health emergency preparedness strategies and activities.

### Health equity (HE)

You will improve representation of, and increase advocacy for, communities of focus in key advisory forums to further include them in planning-based efforts.

#### Activity detail

**HE-C: Include health equity representatives on SACs to increase advocacy for communities of focus**

Who: 62 recipients

When: Each budget period

Obligation: Required

- SACs should include representatives dedicated to addressing health inequities and advocating for communities of focus to minimize disparities throughout the jurisdiction.
- Health equity must be a prioritized objective for the SAC to improve readiness and response for the whole community.
- Collaborate with health equity representatives when completing health equity sections of RA (HE-A).
- Collaborate with health equity representatives when engaging community or nontraditional partners (HE-B).

## Exercise framework requirements

Exercises are essential to ensure that jurisdictions are prepared and ready to respond when needed. You will address CDC's Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health and Response Readiness Framework program priorities through the exercise requirements and objectives.

All exercise requirements have supporting objectives to ensure you meet the intent. HSEEP provides the guiding principles for the development, execution, and evaluation of all PHEP-funded exercises. You will find additional guidance, including objectives, and orientation resources in Ready CAMP.

The following tables describe the exercise requirements and frequency for states, CRI local planning jurisdictions, directly funded localities (DFL), and territories and freely associated states (TFAS).

The exercise framework allows for flexibility in how you complete exercise requirements.

**Table: Exercise table 1: Discussion-based exercise requirements**

| Exercise Requirements | When | Who |
|---|---|---|
| **Administrative preparedness**<br>• Discuss the various fiscal, legal, and administrative authorities and practices governing funding, procurement, contracting, and hiring<br>• Discuss how these authorities can be modified, accelerated, and streamlined during an emergency to support public health preparedness, response, and recovery efforts at state, territorial, local, and tribal levels of government | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Rural, frontier, and tribal coordination**<br>• Discuss response coordination and operations between state and rural, frontier, and tribal public health jurisdictions | Once during the period of performance | • State |
| **Biological incident (100)**<br>• Bring first responder partners together with public health and public health biological laboratories, emergency management, environmental health programs, and hospital preparedness staff to discuss potential public health roles, functions, and countermeasures when responding to a large-scale biological incident including pandemic influenza | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Chemical incident**<br>• Bring first responder partners together with public health, public health chemical laboratories, emergency management, environmental health programs, and hospital preparedness staff to discuss potential public health roles, functions, and countermeasures when responding to large-scale chemical incident | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Radiological/nuclear incident**<br>• Discuss the various aspects of public health response operations during a radiological/nuclear incident within your jurisdiction<br>• Discuss potential public health roles, functions, and countermeasures when responding to a large-scale radiological incident | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |

| Exercise Requirements | When | Who |
|---|---|---|
| **Natural disasters**<br>• Discuss the various aspects of public health response operations during potential natural disasters and climate- related public health impacts within your jurisdiction<br>• Discuss potential public health roles and functions when responding to and recovering from a natural disaster | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Capstone (100)**<br>• Discuss the various aspects associated with conducting the capstone (full-scale) exercise during this period of performance<br>• The capstone exercise may focus on biological, chemical, radiological/nuclear, natural disasters, or other jurisdictional risks identified within your risk assessment | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |

**Table: Exercise table 2: Operation-based exercise requirements**

| Exercise Requirements | When | Who |
|---|---|---|
| **Drill – Capstone (200)**<br>• Select and test one, specific operation or function critical to the success of your full-scale exercise. | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Drill – Critical contacts**<br>• Test and validate your critical contact information provided to CDC on the critical contact sheet. | Each budget period | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Drill – Inventory data exchange**<br>• Test your jurisdiction's ability to provide MCM inventory counts with ASPR/SNS. | Each budget period | • State<br>• DFL<br>• TFAS |
| **Functional – Biological incident (200)**<br>• Validate and evaluate the various aspects of a public health response to a biological incident. Exercise dispensing, administration (throughput), distribution, partnerships, and biological laboratory participation. | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Functional – Capstone (300)**<br>• Validate and evaluate multiple response capabilities critical to the success of your capstone exercise | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• TFAS |
| **Full-scale exercise – Capstone (400)**<br>• Test your jurisdiction's ability to fully operationalize your response plans to the risk selected during the risk assessment process. | Once during the period of performance | • State<br>• CRI<br>• DFL<br>• Optional for TFAS except for Puerto Rico |

# Administrative and federal requirements

For the FY 2024 to 2028 performance period, PHEP recipients must comply with the following administrative and federal requirements. In your project narrative, describe how you will address them.

To remain in good standing for this award, you must comply with reporting requirements and monitoring. If we are not satisfied with the progress toward meeting requirements, additional technical support will be provided. This increased support may include, but is not limited to, increased calls or site visits from your project officers or other CDC staff.

## Reporting requirements and monitoring

Include these requirements in the evaluation and performance measurement plan section of your project narrative.

- Comply with reporting requirements:
  - Submit documents and deliverables according to program instructions and timelines.
  - Ensure proper data management for accurate data verification and validation.
  - Ensure appropriate documentation is preserved for audits.
- Describe the fiscal and programmatic accountability systems you have in place that document annual improvement.
- Submit required program progress reports and financial data.
  - Include progress you have made in achieving evidence-based benchmarks and objective standards.
  - Work with your project officers to update your work plan and budget, as needed.
- Document how you maintain funding and provide matching funds.
  - This accounting is subject to ongoing monitoring, oversight, and audit.
- Submit an independent audit report of PHEP expenditures every two years to the Federal Audit Clearinghouse within 30 days of when you receive the report.
- Participate in program monitoring activities.
  - Participate in program monitoring calls with project officers every two months, at a minimum. Requirements for additional calls will be based on jurisdictional progress toward meeting program requirements and other jurisdictional needs and requests.

    - Adherence to routine communication is expected. Promptly notify us if meetings need to be rescheduled.
    - Actively and cooperatively plan and participate in at least one site visit per five-year period of performance.
- Site visit frequency will be based on jurisdictional progress toward meeting program requirements and other jurisdictional needs and requests.
- Site visits may be in person or virtual based on availability of funds.
- A reverse site visit for recipients may be held during the five-year period of performance. Adequate advance notice will be provided to all recipients for planning purposes.

## Partnerships and coordination

Include these requirements in the collaborations part of your project narrative.

- Work with relevant public and private partners as appropriate, including:
    - Public health agencies with specific expertise that may be relevant to public health security, such as environmental health agencies.
    - Health care organizations — including hospitals, nursing homes, and other long-term care facilities, and medical transport — to promote and improve public health emergency preparedness, response, and recovery.
    - Critical infrastructure partners, such as utility companies, to help ensure that infrastructure will function during a public health emergency or return to normal functioning as soon as possible.
    - Hospitals and health care coalitions to inform them about their public health emergency preparedness and response roles in MYIPPs and to ensure they use National Incident Management System (NIMS) principles.
- Improve enrollment and coordination of health care professionals who want to provide medical services during public health emergencies.
- Describe, as applicable, how you will enhance cross-border public health emergency preparedness and response capabilities at the United States-Canada border or the United States-Mexico border. Include activities for:
    - Disease detection, identification, investigation, and data sharing.
    - Reporting related to infectious disease outbreaks or chemical, biological, or radiological-nuclear events, whether naturally occurring, accidental, or intentional.

- Describe how you will use the Emergency Management Assistance Compact (EMAC), if applicable, or other mutual aid agreements to support coordinated activities and to share resources, facilities, services, and other support required when responding to emergencies with public health impacts.
- Describe the process you used to consult with local public health departments to reach consensus, approval, or concurrence on the approaches, priorities, and funding approach.
- Describe plans for establishing or maintaining SACs comprised of senior officials from governmental and non-governmental partners to integrate preparedness efforts across jurisdictions and to leverage funding streams. Membership should include senior representatives from multiple disciplines and partner organizations to coordinate jurisdictional preparedness efforts.
    - Integrate disciplines involved in homeland security, health care, public health, behavioral health, environmental health, and emergency management to ensure coordination of federal assets and reduce duplication of efforts.
    - Include jurisdictional health department representatives from the Epidemiology and Laboratory Capacity (ELC) cooperative agreement, Public Health Infrastructure Grant (PHIG), Preventive Health and Health Services Block Grant (PHHS Block Grant), and immunization programs, at a minimum.
    - Invite participation from:
        - State administrative agency (SAA)
        - State office on aging or equivalent
        - Local health department governing board representative, local jurisdictions and associations, or regional working groups
        - Community-based and other nongovernmental organization partners representing communities of focus to coordinate preparedness planning and foster engagement
        - The community
- Describe provisions for using other jurisdictional personnel who are reassigned to preparedness and response activities during public health emergencies.
- Provide a letter signed by the jurisdiction's lead health official confirming that the PHEP director, the environmental health lead, the epidemiology lead, and the public health laboratory director have provided input into

plans, strategies, and investment priorities for epidemiology, surveillance, and laboratory work plans.

- Describe plans to engage and exercise with federally recognized American Indian and Alaska Native tribes within applicable PHEP jurisdictions.
- Summarize the strengths and weaknesses you identified through exercises and what corrective actions you took to address these weaknesses when updating your annual work plan.

## Preparedness plans

Include these requirements in the approach part of your project narrative.

- Develop, maintain, and share with project officers upon request, current versions of these plans, (which may be included as annexes or components in larger plans):
  - All-hazards preparedness and response plan to ensure a jurisdiction is prepared for chemical, biological, radiological, or nuclear threats, whether naturally occurring, unintentional, or deliberate
  - Infectious disease response plan
  - Pandemic influenza plan or integrated respiratory pathogen pandemic plan
  - MCM distribution and dispensing plan
  - COOP plan
  - Chemical, biological, radiological, and nuclear (CBRN) threat response plan
  - Plans that support volunteer management
  - CERC and information dissemination plans
- Develop and coordinate plans with Hospital Preparedness Program and other relevant partners for at-risk populations that include:
  - People with behavioral health needs
  - People with access and functional needs such as:
  - Children
    - Ensure coordination with state educational and childcare lead agencies and Hospital Preparedness Program to plan for pediatric populations.
    - Coordinate messages and plans for reuniting children with their family.

        - Identify the public health role in addressing children's mental health needs following emergencies.
    - Older adults
        - Engage the state office on aging or an equivalent office in addressing the public health emergency preparedness, response, and recovery needs of older adults.
    - People who are pregnant
    - People with disabilities
    - Minorities and other diverse populations with a disproportionate burden of disease and disability
    - People from underserved populations, including rural and frontier populations
    - People with limited English proficiency and non-English speaking populations
- Provide public health situational awareness data to enhance early detection of, rapid response to, and management of, potentially catastrophic infectious disease outbreaks, novel emerging threats, and other public health emergencies.
- Describe plans to analyze real-time clinical specimens for pathogens of public health or bioterrorism significance, including use of poison centers.
- Comply with current SAFECOM guidance.

## Public involvement and consultation

Include these requirements in the collaborations part of your project narrative.

- Describe the process used to obtain public comment on the jurisdiction's all-hazards preparedness and response plan and its implementation.
- Use existing advisory committees or a similar mechanism
    - Ensure continuous input from the public and other state, local, and tribal partners

## Training and compliance

Include these requirements in the collaborations part of your project narrative.

- Participate in essential preparedness meetings or training sessions in person or online.

    - Annual budgets should include detailed travel information for appropriate staff to attend the following essential meetings:
        - Annual Preparedness Summit sponsored by National Association of County and City Health Officials (NACCHO); required each year for states, four directly funded localities, Puerto Rico, and U.S. Virgin Islands; every other year Pacific islands can alternate with the Pacific Islands Preparedness and Emergency Response Summit
        - Directors of Public Health Preparedness Annual Meeting sponsored by the Association of State and Territorial Health Officials (ASTHO)
        - LRN-B and LRN-C meetings sponsored by the Association of Public Health Laboratories (APHL) and CDC.
- Actively participate in PHEP community of practice and, when requested, share with us the tools and resources developed using PHEP funds.

## Outcomes

This section includes outcomes we expect you to report progress on and achieve within the period of performance.

You must build, refine, and sustain program strategies and activities in accordance with expectations and requirements within this funding opportunity. You must achieve the PHEP logic model's outcomes during the five-year performance period.

## Focus populations

This NOFO covers, in broad terms, the United States population and the public health systems within the United States and its territories and freely associated states.

We intend funds to ensure that public health systems are ready and capable of keeping their communities safe and reduce the impacts of any public health emergency.

In this NOFO, we place a special focus on recipient support of:

- Federally recognized American Indian and Alaska Native tribes
- Rural and frontier populations
- Disproportionally affected populations

The Health Equity (HE-A, HE-B, and HE-C) activities found in the Strategies and Activities section and the partnerships and coordination and preparedness

plans sections of the administrative and federal requirements section provide more detail.

## Health disparities

The goal of health equity is for everyone to have a fair and just opportunity to attain their highest level of health. Health disparities are often caused by social determinants that influence which populations are most disproportionately affected by health conditions.

A health disparity is a difference in health burdens between groups of people with differing social determinants of health.

Social determinants of health are conditions in the environments where people are born, live, learn, work, play, worship, and age. These determinants affect a wide range of health, functioning, and quality-of-life outcomes and risks.

You must integrate the access and functional needs of at-risk populations in your plans and exercises. In your MYIPP, describe the structure or processes in place to support their needs. Examples of populations are found in the preparedness plans section.

Find ways to integrate the access and functional needs of at-risk people into public health, health care, and behavioral health response strategies. You must also identify and address these strategies in your work plans.

## Equal opportunities

This NOFO, including funding and eligibility, is not limited based on, and does not discriminate on the basis of race, color, national origin, disability, age, sex (including gender identity, sexual orientation, and pregnancy) or other constitutionally protected statuses.

# Organizational capacity

You must address your ability to implement the requirements and expectations in the program description section.

You should have public health organizational capacity to implement the National Response Framework, which is built on scalable and adaptable concepts and coordinating structures identified in NIMS. These structures are designed to be flexible, so they meet the needs of communities across the country.

The National Response Framework promotes a tiered response system. This means that when an incident occurs, the response starts at the lowest level of government that can effectively handle it.

## Collaborations

We expect you to establish, build, and sustain strategic and meaningful collaborative partnerships during the period of performance for this cooperative agreement. The strategies and activities section and the partnerships and coordination section of the administrative and federal requirements section outline the expected collaborations with CDC programs, CDC-funded organizations, and organizations not funded by CDC.

As mentioned in Administrative and federal requirements section, we expect you to coordinate with other CDC programs. They include at a minimum, Epidemiology and Laboratory Capacity (ELC) cooperative agreement, Public Health Infrastructure Grant (PHIG), Preventive Health and Health Services Block Grant (PHHS Block Grant), and immunization programs.

In addition, we expect states to work together across jurisdictional lines. You should engage meaningfully with all local health departments and jurisdictions during the five-year period of performance.

- Meaningful engagement is the process you use to work collaboratively with subrecipients, tribes, and other interested groups within your geographic boundaries.
- Collaboratively means to provide an opportunity for local health departments and jurisdictions to review the PHEP work plan and budget and provide input and feedback prior to submitting final documents.

Consistent with FEMA's whole-community approach to preparedness, you should actively work with and engage community leaders outside of public health. Engagement with community members with lived experience creates

a greater awareness of the public health's role in emergency preparedness activities and promotes community resilience.

Additionally, strong collaboration with Emergency Support Function #8 partners and interested groups within your geographic boundaries will improve emergency response outcomes.

Federal agencies actively coordinate guidance and technical assistance. We encourage you to actively coordinate preparedness activities for your jurisdiction.

Health care coalitions are essential public health partners. You should work with ASPR's Office of Health Care Readiness (OHCR), which administers the HPP cooperative agreement, and with the HCC(s) in your jurisdiction to ensure coordination in preparing, responding, and recovering from public health emergencies.

Emergency management is fundamental to emergency response planning, response, and recovery. You should work with your colleagues in FEMA's Homeland Security Grant Program and Emergency Management Performance Grant to ensure coordination in preparing for, responding to, and recovering from public health emergencies.

# Data, monitoring, & evaluation

## Required performance measures

Review activities tables 1-12 for the performance measures you will need to report on after award. We will notify you of any performance measure changes before we require you to submit any data.

Section 319C-1(g) of the PHS Act requires you to meet benchmark requirements and report complete and accurate performance data. Benchmarks are indicated in activities tables 1-12.

You must also submit your pandemic influenza plan as required by statute.

### Financial penalty

What happens if you do not meet requirements?

We can withhold a percentage of your award if we determine you do not submit your pandemic influenza plan, required by this NOFO, or substantially meet the following PHEP benchmarks: AHA-B, LAB-B and LAB-C, HE-A, PAR-A, RSK-B, ADM-D and ADM-E, and WKF-A.

This amount is set by law and considers failures in the two immediately preceding federal fiscal years, which align with your budget periods.

Each failure counts as a separate penalty. The penalty amount is based on the fiscal year in which the failure occurs.

For example, if you:

- Do not substantially meet the benchmarks (one or more) **or** do not submit your pandemic influenza plan, we can withhold **10% of your award**
- Do not substantially meet the benchmarks (one or more) **and** do not submit your pandemic influenza plan, we can withhold **20% of your award**

If you fail to substantially meet the benchmarks (one or more) or submit a plan for three consecutive federal fiscal years, the penalty increases to 15% for each failure and 30% for failure to do both.

Prior to withholding funds, we will notify you of the specific failure and offer a chance to correct the failure and provide technical assistance.

## Evaluation and performance measurement plan

You must provide an evaluation and performance measurement plan. Use the measures required under the required performance measures.

Include the following elements.

### Methods

Describe:

- How you will:
  - Collect performance measure data
  - Respond to the evaluation questions
  - Use evaluation findings for continuous program quality improvement
  - Use findings to reduce or eliminate health disparities, if relevant
  - Incorporate evaluation and performance measurement into planning, implementation, and reporting of project activities
- How key program partners will participate in the evaluation and performance measurement process
- How you will share evaluation findings with communities and populations of interest in a way that meets their needs

### Data management

For all public health data you plan to collect, describe:

- The data you plan to collect and their available data sources
- The feasibility of collecting appropriate evaluation and performance data
- A data management plan (DMP) that includes:
  - The data you will collect or generate
  - Who can access data and how you will protect it
  - Data standards that ensure released data have documentation that describes collection methods, what the data represent, and data limitations
  - Archival and long-term data preservation plans
  - How you will update the DMP as new information is available over the life of the project
    - You will provide updates to the DMP in annual reports
    - For more information about CDC's policy on the DMP, see the Data Management and Access Requirement on CDC's website
- Other relevant data information, such as performance measures you propose

For a definition of "public health data" and other key information, see AR 25: Data Management and Access on our website.

### Evaluation activities

You may choose to take on specific evaluation activities. Describe:

- The type of evaluations, such as process, outcome, or both
- Key evaluation questions addressed by these evaluations
- Other information such as measures and data sources

An initial draft of your evaluation and performance measurement plan, including the DMP, should be submitted with your application. You must submit a final, detailed plan within the first six months of the award. See reporting.

## Work plan

You will create a five-year work plan. The work plan connects your period of performance budget, outcomes, strategies and activities, and performance measures. It provides more detail about how you will measure outcomes and processes.

## Paperwork Reduction Act

Any activities involving information collections from 10 or more individuals or organizations, may require you to follow the Paperwork Reduction Act (PRA). This requires review and approval by the White House Office of Management and Budget. For further information about CDC's requirements under PRA see CDC Paperwork Reduction Act Compliance. Collections include items like surveys and questionnaires.

# Funding policies & limitations

You must comply with the following funding policies and limitations. Further guidance, which you must also comply with, will be available in Ready CAMP.

## Use of funds

- We intend PHEP cooperative agreement funding to support preparedness activities that help ensure STLT public health departments are prepared to prevent, detect, respond to, mitigate, and recover from a variety of public health threats. You must receive approval from CDC to use PHEP funds during a response for new activities not previously approved as part of your annual funding applications or subsequent budget change requests.
    - The approval process may include a budget redirection or a change in the scope of activities.
    - You may use PHEP funds, on a limited, case-by-case basis, to support response activities to the extent they are used for their primary purposes: to strengthen public health preparedness and enhance the capabilities of state, local, and tribal governments to respond to public health threats.
    - Some PHEP planning activities may have immediate benefit when conducted or performed simultaneously with an actual public health emergency. It is acceptable to spend PHEP funds on PHEP planning activities that benefit the response effort if the activities demonstrably support progress toward achieving CDC's 15 public health preparedness and response capabilities, the Response Readiness Framework priorities, and demonstrate related operational readiness and response.
- We require prior approval by the CDC grants management officer (GMO) for a change in scope under any award. This is regardless of whether there is an associated budget revision. Any change in scope must also be consistent with the PHEP cooperative agreement's underlying statutory

authority, applicable cost principles, this notice of funding opportunity, and your application, including the jurisdictional all-hazard plan.

## General guidance

- Your five-year budget is arranged in eight categories outlined in the budget narrative.
- You may use funds only for reasonable program purposes consistent with the award, its terms and conditions, and federal laws and regulations that apply to the award. If you have questions about this determination, ask the grants management specialist.
- Generally, you may not use funds to purchase furniture or equipment. If you plan to, clearly identify and justify any such proposed costs in the budget.
- You may use funds to meet national standards or seek health department accreditation or reaccreditation through the Public Health Accreditation Board (PHAB) and Project Public Health Ready (PPHR) for recognition or re-recognition. This applies only to STLT government agencies within the United States and its territories. Include the proposed activities and a description of the connection to national standards or accreditation achievement in the budget narrative.
- You may use funds to:
  - Support your jurisdiction's vital records office (VRO) to build its capacity through partnerships
  - Provide technical or financial assistance to improve vital records timeliness, quality, or access
  - Support vital records improvement efforts
- You may use funds to ensure STLT employees funded by CDC grant or cooperative agreement awards are adequately trained and prepared to participate in jurisdictional emergency response activities effectively.
- You may supplement but not supplant existing state or federal funds for activities described in the budget.

## Unallowable costs

You may not use funds for:

- Research
- Clinical care except as allowed by law
- Pre-award costs unless CDC gives you prior written approval
- Anything outside of normal and recognized executive-legislative relationships, such as:
  - Publicity or propaganda purposes, including preparing, distributing, or using any material designed to support or defeat the enactment of legislation before any legislative body
  - Using the salary or expenses of any grant or contract recipient — or agent acting for such recipient— for any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or executive order proposed or pending before any legislative body

See Guidance on Lobbying for CDC Recipients.

## Indirect costs

Indirect costs are those for a common or joint purpose across more than one project and that cannot be easily separated by project. Learn more at 45 CFR 75.414, Indirect Costs and CDC Budget Preparation Guidelines.

To charge indirect costs you can select one of two methods:

**Method 1 – Approved rate.** You currently have an indirect cost rate approved by your cognizant federal agency. Justification: Provide a summary of the rate. Enclose a copy of the current approved rate agreement in the Attachments.

**Method 2 – De minimis rate.** Per 45 CFR 75.414(f), if you have never received a negotiated indirect cost rate, you may elect to charge a de minimis rate. If you are awaiting approval of an indirect cost proposal you may also use the de minimis rate. If you choose this method, costs included in the indirect cost pool must not be charged as direct costs.

This rate is 10% of modified total direct costs (MTDC). See 45 CFR 75.2 for the definition of MTDC. You can use this rate indefinitely.

### Other indirect cost policies

- As described in 45 CFR 75.403(d), you must consistently charge items as either indirect or direct costs and may not double charge.
- Indirect costs may include the cost of collecting, managing, sharing, and preserving data.

# National public health priorities and strategies

## Healthy People 2030

- Emergency Preparedness

Other national priorities and strategies

- Center for Medicare & Medicaid Services Emergency Preparedness Rule (CMS-3178-F)
- Homeland Security Exercise and Evaluation Program (HSEEP)
- Homeland Security Presidential Directive (HSPD) 5
- Homeland Security Presidential Directive (HSPD) 21
- National Biodefense Strategy 2022
- National Health Security Strategy Implementation Plan
- National Incident Management System (NIMS)
- National Pandemic Influenza Plans
- National Preparedness Goal (NPG)
- National Response Framework (NRF)
- Presidential Policy Directive 8 (PPD-8): National Preparedness
- Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health

# Statutory authority

Section 319C-1 of the Public Health Service (PHS) Act (title 42 United States Code (USC) § 247d-3b), as amended.

# Step 2:
# Get Ready to Apply

## In this step

# Get registered

While you can review the requirements and get started on developing your application before your registrations are complete, you must be registered in both SAM.gov and Grants.gov to apply.

## SAM.gov

You must have an active account with SAM.gov. This includes having a Unique Entity Identifier (UEI). SAM.gov registration can take several weeks. Begin that process today.

To register, go to SAM.gov Entity Registration and click Get Started. From the same page, you can also click on the Entity Registration Checklist for the information you will need to register.

## Grants.gov

You must also have an active account with Grants.gov. You can see step-by step instructions at the Grants.gov Quick Start Guide for Applicants.

## Find the application package

The application package has all the forms you need to apply. You can find it online. Go to Grants Search at Grants.gov and search for opportunity number CDC-RFA-TU24-0137.

If you cannot use Grants.gov to download application materials or have other technical difficulties, including issues with application submission, contact grants.gov for assistance. The grants.gov Contact Center is available 24 hours a day, 7 days a week, except federal holidays. The Contact Center is available by phone at 1-800-518-4726 or by email at support@grants.gov.

To get updates on changes to this NOFO, select Subscribe from the View Grant Opportunity page for this NOFO on Grants.gov.

# Help applying

For help on the application process and tips for preparing your application see How to Apply on our website. For other questions, see Contacts & Support.

# Join an informational call

Join one of our webinars about this opportunity.

Thursday, February 29, 2024, at either:

- 2:00 to 3:30 p.m. ET
- 8 to 9:30 p.m. ET

Zoom:

- Join the webinar
- Webinar ID: 160 898 3560
- Passcode: Yir9!&x*

One-tap mobile:

- +16692545252,,1608983560#,,,,*26255195# US (San Jose)
- +16468287666,,1608983560#,,,,*26255195# US (New York)

Phone:

- View dial-in number for your region
- Passcode: 26255195

# Step 3: Prepare Your Application

## In this step

# Application contents & format

Applications include five main elements. You can find the forms for each in the Grants.gov application package. This section includes guidance on each. Make sure you include each of these:

**Table: Application elements and forms**

| Element | Submission form |
|---|---|
| Project abstract | Use the Project Abstract Summary form |
| Project narrative | Use the Project Narrative Attachment form |
| Budget narrative | Use the Budget Narrative Attachment form |
| Attachments | Insert each in the Other Attachments form |
| Standard forms | Upload using each required form. |

We provide instructions on document formats in the following sections. If you do not provide required documents, your application is incomplete. See initial review to understand how this would affect your application.

**Required format for project abstract, project narrative, and budget narrative**

Font: Calibri

Format: PDF

Size: 12-point font
Footnotes and text in graphics may be 10-point.

Spacing: Single-spaced

Margins: 1-inch
Include page numbers

# Project abstract

Page Limit: 1

File name: Project Abstract Summary

Provide a self-contained summary of your proposed project, including the purpose and outcomes. Do not include any proprietary or confidential information. We use this information when we receive public information requests about funded projects.

# Project narrative

Page Limit: 20

File name: Project Narrative

Your project narrative must use the exact headings, subheadings, and order that we outline in this section.

## Approach

### Strategies and activities

Describe how you will implement the proposed strategies and activities to achieve the period of performance outcomes. Explain whether they are:

- Existing evidence-based strategies
- Other strategies, with a reference to where you describe how you will evaluate them in your evaluation and performance measurement plan.

See program description, strategies and activities.

### Outcomes

Using the PHEP logic model in program description, approach, identify the outcomes you expect to achieve or make progress on by the end of the period of performance.

## Evaluation and performance measurement plan

You must provide an evaluation and performance measurement plan. This plan describes how you will fulfill the requirements in program description, data, evaluation, and performance measurement.

## Work plan

Include a work plan using the requirements in program description, work plan

## Focus populations and health disparities

Describe the specific population or populations you plan to address under this award. Explain how you will include them and meet their needs in your project.

Describe how your work will benefit public health as well as the populations and alleviate health disparities.

Additionally, the collaboration section of your project narrative must contain a description of the process for engagement with local health departments within the jurisdiction, which will include a:

- Description of local health department priorities or strategies for achieving operational readiness
- Description of how local, PHEP-funded activities will contribute to achieving statewide public health preparedness goals

See program description, focus populations.

## Organizational capacity

Describe how you will address the organizational capacity requirements in program description, organizational capacity.

You must provide attachments that support this section including:

- Organizational chart

### Collaborations

Describe how you will collaborate with programs and organizations, either internal or external to CDC. Explain how you will address the Collaboration requirements in program description, collaborations.

# Budget narrative

Page limit: None

File name: Budget Narrative

The budget narrative supports the information you provide in Standard Form 424-A. See standard forms.

The budget narrative must include a five-year budget. Provide actual funding numbers for Budget Period 1 and estimate your budget for Budget Periods 2-5. As you develop your five-year budget, consider If the costs are reasonable and consistent with your project's purpose and activities. CDC will review and must approve costs prior to award.

The budget narrative must explain and justify the costs in your budget. Provide the basis you used to calculate costs. It must follow this format:

- Salaries and wages
- Fringe benefits
- Consultant costs
- Equipment
- Supplies
- Travel
- Other categories
- Contractual costs
- Total direct costs (total of all items)
- Total indirect costs

See funding policies & limitations for policies you must follow.

# Attachments

You will upload attachments in Grants.gov using the Other Attachments Form. When adding the attachments to the form, you can upload PDF, Word, or Excel formats.

## Table of contents

Provide a detailed table of contents for your entire submission that includes all the documents in the application and headings in the "project narrative" section. There is no page limit.

Name of attachment: Table of Contents

## Indirect cost agreement

If you include indirect costs in your budget using an approved rate, include a copy of your current agreement approved by your cognizant agency for indirect costs. If you use the de minimis rate, you do not need to submit this attachment.

Name of attachment: Indirect Cost Agreement

# Organizational chart

Provide an organizational chart that describes your structure. Include any relevant information to help understand how parts of your structure apply to your proposed project.

Name of attachment: Organizational Chart

# Letters of support

## Health official letter

Provide a letter signed by the jurisdiction's health official on official agency letterhead confirming that the PHEP director, the environmental health lead, the epidemiology lead, and the public health laboratory director or designated representatives have provided input into PHEP-funded plans, strategies, and investment priorities for epidemiology, surveillance, and laboratory work plans.

If you cannot get their input, submit separate attachments with your funding application describing:

- The steps you took to get their feedback
- Why you were not successful

Name this attachment "Health Official Letter" and upload it as a PDF under "Other Attachment Forms" at Grants.gov

## Local health department concurrence letter

Each decentralized state must provide a written, signed letter to provide evidence that the state has consulted with at least a majority, if not all, of local health departments within the jurisdiction to reach consensus, approval, or concurrence on the relative distribution of amounts, approaches, and priorities described in the application. This letter should be signed by the local health departments or representative entities within the jurisdiction.

If you cannot get 100% concurrence, despite good-faith efforts to do so, submit a document with your application describing:

- The reasons for lack of concurrence
- The steps taken to address them

Name this attachment "Local Health Department Concurrence Letter" and upload it as a PDF under "Other Attachment Forms" at Grants.gov

## Duplication of efforts

You must provide this attachment only if you have submitted a similar request for a grant, cooperative agreement, or contract to another funding source in the same fiscal year and it may result in any of the following types of overlap.

### Programmatic

- They are substantially the same project
- A specific objective and the project design for accomplishing it are the same or closely related

### Budgetary

- You request duplicate or equivalent budget items that already are provided by another source or requested in the other submission

### Commitment

- Given all current and potential funding sources, an individual's time commitment exceeds 100 percent, which is not allowed

We will discuss the overlap with you and resolve the issue before award.

Name of attachment: "Report on Overlap"

# Standard forms

You will need to complete some standard forms. Upload the standard forms listed in the following table at Grants.gov. You can find them in the NOFO application package or review them and their instructions at Grants.gov Forms.

**Table: Standard forms**

| Forms | Submission requirement |
|---|---|
| Application for Federal Assistance (SF-424) | With application |
| Budget Information for Non-Construction Programs (SF-424A) | With application |
| Disclosure of Lobbying Activities (SF-LLL) | If applicable, with the application or before award |

# Step 4:
# Learn About Review & Award

## In this step

# Application review

## Initial review

We review each application to make sure it meets responsiveness requirements. We will not consider an application that:

- Is from an organization that does not meet eligibility criteria. See requirements in eligibility
- Is submitted after the deadline
- Proposes research activities (see 45 CFR 75.2 for the definition of research)

If you do not follow page limit or formatting requirements, we may remove pages from your application.

## Merit review

Project officers from CDC's Division of State and Local Readiness (DSLR) and CDC subject matter experts will jointly conduct technical reviews of all eligible applications in accordance with the following criteria.

### Criteria

1. Approach
2. Organizational capacity
3. Evaluation and performance measurement

### Approach

Ensure that responses are consistent with the program description requirement sections shown in the following table.

**Table: Approach assessment**

| Evaluate the extent to which the applicant provides: | Consistent with: |
|---|---|
| Strategies and activities consistent with the PHEP logic model. | Approach, logic model |
| Outcomes consistent with the period of performance outcomes in the PHEP logic model. | Approach, logic model |
| Strategies and activities that are achievable and appropriate to achieve outcomes. | Strategies & activities |
| Strategies and activities that are evidence-based, to the degree possible. | Strategies & activities |
| At least one focus population for the activity and consistent with the applicant's background and purpose. | Focus populations |
| Considerations to address health disparities in designing and implementing strategies and activities. | Focus populations, health disparities |
| A work plan that is aligned with the strategies, activities, outcomes, and performance measures in the approach and is consistent with the content and format proposed by CDC. | Work plan |
| A proposed use of funds that aligns with the work plan and is an efficient and effective way to implement the strategies and activities and attain the period of performance outcomes. | Work plan |
| A description of the process used to engage local health departments to reach consensus/approval/concurrence for the strategic approach or direction of the preparedness program. | Local health department concurrence letter |
| Narrative descriptions for work plan activities, technical assistance needs, budget and five-year forecasts that have a reasonable relationship, correlation, and continuity, where applicable, with data from past performance. | Project narrative, work plan |
| Adequate planned activities to prioritize, build, and sustain public health capabilities. | Work plan |
| Adequate planned activities that reflect progress to coordinate public health and health care preparedness program activities and leverage program funding streams. | Work plan |

## Organizational capacity

Ensure that responses are consistent with the program description section organizational capacity generally, including any subsection or required attachment shown in the following table.

**Table: Organizational capacity assessment**

| Evaluate the extent to which the applicant describes: | Consistent with: |
|---|---|
| Relevant experience and capacity to implement the activities and achieve the outcomes. Experience includes management, administrative, and technical. | Organizational capacity |
| Experience or capacity to implement the evaluation plan. | Organizational capacity |
| Provides an organizational chart that supports the structure. | Organizational chart |
| Collaborations that support your capacity or add value to the project. | Collaborations |

## Evaluation and performance measurement

Ensure that responses are consistent with the Program Description's Data, Evaluation, and Performance Measurement section generally, including any of the following subsections.

**Table: Evaluation and performance assessment**

| Evaluate the extent to which the applicant describes: | Consistent with: |
|---|---|
| The ability to collect the data needed for evaluation and performance measurement. | Methods |
| Clear monitoring and evaluation procedures and how they will incorporate evaluation and performance measurement into planning, implementation, and reporting of activities. | Methods |
| How they will report and use performance measurement and evaluation findings to demonstrate outcomes and for continuous program quality improvement. | Methods |
| Appropriate participation in the evaluation and performance measurement planning process by key partners. | Methods |
| How they will share evaluation findings with communities and populations of interest in a way that meets their needs. | Methods |
| Their available data sources and feasibility of collecting appropriate evaluation and performance data. | Data management |
| A data management plan that includes data, access, standards, long-term and archiving plans, collection methods, data limitations. This includes how they will update the plan throughout an award. | Data management |
| The type of evaluations, such as process, outcome, or both, and the key evaluation questions, data sources, and measures. Includes how evaluation and performance measurement will contribute to developing an evidence base for programs that lack a strong effectiveness evidence base. | Methods |

# Risk review

Before making an award, we review the risk that you will not prudently manage federal funds. As part of that review, we need to make sure you have handled any past federal awards well and demonstrated sound business practices. We use SAM.gov Responsibility / Qualification to check this history for all awards likely to be over $250,000.

You can comment on your organization's information in SAM.gov. We will consider your comments before making a decision about your level of risk.

We may ask for additional information prior to award based on the results of the risk review.

If we find a significant risk, we may choose not to fund your application or to place specific conditions on the award.

For more details, see 45 CFR 75.205.

# Selection process

We will provide awards to all eligible applicants who submit a complete and responsive application.

Our ability to make awards depends on available appropriations.

# Award notices

The Notice of Award (NoA) is the official award document. The NoA tells you about the amount of the award, important dates, and the terms and conditions you need to follow. Until you receive the NoA, you do not have permission to start work.

Once you draw down funds, you have accepted all terms and conditions of the award including administrative and federal requirements.

If you want to know more about NoA contents, go to Understanding Your Notice of Award at CDC's website.

# Step 5: Submit Your Application

## In this step

# Application submission & deadlines

See find the application package to make sure you have everything you need.

You must obtain a UEI number associated with your organization's physical location. Some organizations may have multiple UEI numbers. Use the UEI number associated with the location of the organization receiving the federal funds.

Make sure you are current with SAM.gov and UEI requirements before applying for the award. See get registered.

You will have to maintain your registration throughout the life of any award.

## Deadlines

### Application

Due by 11:59 p.m. ET on April 24, 2024.

Grants.gov creates a date and time record when it receives the application. If you submit the same application more than once, we will accept the last on-time submission.

The grants management officer may extend an application due date based on emergency situations such as documented natural disasters or a verifiable widespread disruption of electric or mail service.

## Submission methods

### Grants.gov

You must submit your application through Grants.gov. See get registered.

For instructions on how to submit in Grants.gov, see the Quick Start Guide for Applicants. Make sure your application passes the Grants.gov validation checks. Do not encrypt, zip, or password-protect any files.

See Contacts & Support if you need help.

# Other submissions

## Intergovernmental review

This NOFO is not subject to executive order 12372, Intergovernmental Review of Federal Programs. No action is needed.

## Mandatory disclosure

You must submit any information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. See Mandatory Disclosures, 45 CFR 75.113.

Send written disclosures to Damond Barnes at xhp5@cdc.gov and to the Office of Inspector General at grantdisclosures@oig.hhs.gov.

# Application checklist

Make sure that you have everything you need to apply:

**Table: Application checklist**

| Component | How to upload | Page limit |
|---|---|---|
| ☐ Project abstract | Use the Project Abstract Summary Form. | 1 page |
| ☐ Project narrative | Use the Project Narrative Attachment form. | 20 pages |
| ☐ Budget narrative | Use the Budget Narrative Attachment form. | None |
| Attachments (6 total) | Insert each in a single Other Attachments form. | |
| ☐ 1. Table of contents | | None |
| ☐ 2. Indirect cost agreement | | None |
| ☐ 3. Organizational chart | | None |
| ☐ 4. Health official letter | | None |
| ☐ 5. Local health department concurrence letter | | None |
| ☐ 6. Duplication of efforts | | None |
| Standard forms (3 total) | Upload using each required form. | |
| ☐ Application for Federal Assistance (SF-424) | | No |
| ☐ Budget Information for Non-Construction Programs (SF-424A) | | No |
| ☐ Disclosure of Lobbying Activities (SF-LLL) | | No |

# Step 6: Learn What Happens After Award

In this step

# Post-award requirements & administration

We adopt by reference all materials included in the links within this NOFO.

## Administrative & national policy requirements

There are important rules you need to read and know if you get an award. You must follow:

- All terms and conditions in the NoA. The NoA includes the requirements of this NOFO.
- The rules listed 45 CFR part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
- The HHS Grants Policy Statement (GPS). This document has policies relevant to your award. If there are any exceptions to the GPS, they will be listed in your Notice of Award.
- All federal statutes and regulations relevant to federal financial assistance, including the cited authority in this award, the funding authority used for this award, and those provisions in the HHS Administrative and National Policy Requirements.
- All applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the HHS Office for Civil Rights website.
- The following CDC's Additional Requirements (AR) apply to this NOFO's awards: 7, 9, 11, 12, 13, 14, 16, 20, 21, 24, 25, 26, 27, 29, 30, 34, 37, 38.

# Reporting

If you are successful, you will have to submit financial and performance reports. These include the following.

**Table: Reporting requirements**

| Report | Description | When |
|---|---|---|
| Evaluation and performance measurement plan | • Builds on the plan in the application.<br>• Incorporates evaluation and performance measurement into planning, implementation, and reporting of activities.<br>• Describes how data are collected and used (Data Management Plan). | • December 31, 2024 |
| Quarterly update | • Indicates progress on:<br>  ◦ Response readiness framework activities and administrative and federal requirements.<br>• Provides quarterly budget update<br>• Update evaluation and performance management plan, if needed<br>• Update performance measures for completed activities. | Quarterly starting:<br>• January 31 for time period October 1 to December 31<br>• April 30 for time period January 1 to March 31<br>• July 31 for time period April 1 to June 30<br>• October 31 for time period July 1 to September 30 |
| Performance report | • Serves as yearly administrative update to receive annual funding.<br>  ◦ Cumulative review of Q1 – Q3 updates<br>  ◦ SF-424<br>  ◦ SF-424A | • March 31, 2025<br>• March 31, 2026<br>• March 31, 2027<br>• March 31, 2028<br>• April 2, 2029 |
| Federal financial report | • Includes funds authorized and disbursed during the budget period.<br>• Indicates exact balance of unobligated funds and other financial information. | • September 28, 2025<br>• September 28, 2026<br>• September 28, 2027<br>• September 28, 2028 |

| Report | Description | When |
|---|---|---|
| Final performance report | • Includes information summarizing period of performance activities and outcomes (Closeout) | • October 28, 2029 |
| Final financial report | • Includes aggregated financial information in Federal Financial Report. (Closeout) | • October 28, 2029 |

To learn more about these reporting requirements, see Reporting on the CDC website.

# CDC award monitoring

We will use application submission information to identify strengths and weaknesses and to establish priorities for site visits and technical assistance.

Monitoring activities include:

- Routine and ongoing communication between CDC and recipients
- Site visits
- Recipient reporting, including work plans, performance reporting, and financial reporting

We expect to include the following in post-award monitoring:

- Tracking recipient progress in achieving the outcomes
- Ensuring the adequacy of your systems to hold information and generate data reports
- Creating an environment that fosters integrity in performance and results

We may also include the following activities:

- Ensuring that work plans are feasible based on the budget
- Ensuring that work plans are consistent with award intent
- Ensuring that you are performing at a level to achieve outcomes on time.
- Working with you to adjust your work plan based on outcome achievement, evaluation results, and changing budgets.
- Monitoring programmatic and financial performance measures to ensure satisfactory performance levels.
- Other activities that assist CDC staff to identify, notify, and manage risk, including high-risk recipients.

We can take corrective action if your performance is poor. We can also take corrective action if you have failed to materially comply with the terms and

conditions of award. We may withhold, suspend, or terminate the award. The regulatory procedures are specified at 45 CFR 75.371

# CDC's role

Partnership between us and the recipient is essential to the success of the PHEP cooperative agreement. Therefore, close collaboration and a willingness to work together to ensure these goals are met is extremely important.

Our staff and subject matter experts across CDC will review applications to ensure activities are in scope and are not duplicative with those funded by other grants and cooperative agreements.

To ensure PHEP recipients achieve the purpose of this award, we will conduct the following activities:

- Provide ongoing guidance, programmatic support, training, and technical assistance related to:
  - Public health emergency preparedness
  - Activities outlined in this funding opportunity
- Provide and maintain Ready CAMP
- Offer and facilitate PHEP community of practice
- Facilitate opportunities to collaborate with peers

# Nondiscrimination & assurance

If you receive an award, you must follow all applicable nondiscrimination laws. You agree to this when you register in SAM.gov. You must also submit an Assurance of Compliance (HHS-690). To learn more, see the Laws and Regulations Enforced by the HHS Office for Civil Rights.

# Contacts & Support

## In this step

# Agency contacts

## Program

James Diggs
vqh3@cdc.gov
770-488-1989

## Grants management

Damond Barnes
xhp5@cdc.gov
770-488-2611

# Grants.gov

Grants.gov provides 24/7 support. You can call 1-800-518-4726 or email support@grants.gov. Hold on to your ticket number.

# SAM.gov

If you need help, you can call 866-606-8220 or live chat with the Federal Service Desk.

# Secure Access Management Services

Call the Secure Access Management Services (SAMS) Help Desk at 877-681-2901 (Select Option #5) or email samshelp@cdc.gov. The Help Desk is open:

- 8 a.m. to 6 p.m. ET
- Monday through Friday (except for federal holidays)

# Reference websites

U.S. Department of Health and Human Services (HHS)

Grants Dictionary of Terms

CDC Grants: How to Apply

CDC Grants: Already Have a CDC Grant?

Grants.gov Accessibility Information

Code of Federal Regulations (CFR)

United States Code (U.S.C.)

# Appendix

### PHEP Budget Period 1 (Fiscal Year 2024) Funding

Planning numbers to be updated based on availability of funds

**Table: PHEP funding for Budget Period 1 (fiscal year 2024)**

| Recipient | FY 2024 Base Plus Population Funding | FY 2024 Cities Readiness Initiative Funding | FY 2024 Level 1 Chemical Laboratory Funding | FY 2024 Total Funding Available |
|---|---|---|---|---|
| Alabama | $8,643,707 | $422,387 | $0 | $9,066,094 |
| Alaska | $5,000,000 | $210,000 | $0 | $5,210,000 |
| American Samoa | $413,850 | $0 | $0 | $413,850 |
| Arizona | $11,185,007 | $1,822,072 | $0 | $13,007,079 |
| Arkansas | $6,387,402 | $302,001 | $0 | $6,689,403 |
| California | $35,476,444 | $8,053,928 | $1,351,920 | $44,882,292 |
| Chicago | $8,195,326 | $2,276,178 | $0 | $10,471,504 |
| Colorado | $9,495,252 | $1,117,591 | $0 | $10,612,843 |
| Connecticut | $7,033,119 | $790,842 | $0 | $7,823,961 |
| Delaware | $5,000,000 | $426,073 | $0 | $5,426,073 |
| Florida | $27,741,019 | $4,522,895 | $1,072,165 | $33,336,079 |
| Georgia | $15,137,461 | $2,293,562 | $0 | $17,431,023 |
| Guam | $544,542 | $0 | $0 | $544,542 |
| Hawaii | $5,000,000 | $386,337 | $0 | $5,386,337 |
| Idaho | $5,156,621 | $285,678 | $0 | $5,442,299 |
| Illinois | $13,994,773 | $2,764,266 | $0 | $16,759,039 |
| Indiana | $10,599,804 | $1,202,109 | $0 | $11,801,913 |
| Iowa | $6,559,662 | $313,910 | $0 | $6,873,572 |
| Kansas | $6,266,741 | $587,289 | $0 | $6,854,030 |

| Recipient | FY 2024 Base Plus Population Funding | FY 2024 Cities Readiness Initiative Funding | FY 2024 Level 1 Chemical Laboratory Funding | FY 2024 Total Funding Available |
|---|---|---|---|---|
| Kentucky | $8,018,658 | $557,433 | $0 | $8,576,091 |
| Los Angeles County | $16,647,676 | $4,820,141 | $0 | $21,467,817 |
| Louisiana | $8,106,309 | $813,139 | $0 | $8,919,448 |
| Maine | $5,000,000 | $210,000 | $0 | $5,210,000 |
| Marshall Islands | $419,776 | $0 | $0 | $419,776 |
| Maryland | $9,856,425 | $2,085,798 | $0 | $11,942,223 |
| Massachusetts | $10,765,454 | $1,919,847 | $1,242,166 | $13,927,467 |
| Michigan | $14,160,088 | $1,667,951 | $1,223,125 | $17,051,164 |
| Micronesia | $478,510 | $0 | $0 | $478,510 |
| Minnesota | $9,358,736 | $1,366,011 | $1,256,812 | $11,981,559 |
| Mississippi | $6,269,975 | $323,510 | $0 | $6,593,485 |
| Missouri | $9,871,215 | $1,297,160 | $0 | $11,168,375 |
| Montana | $5,000,000 | $210,000 | $0 | $5,210,000 |
| Northern Marianas Islands | $408,982 | $0 | $0 | $408,982 |
| Nebraska | $5,188,753 | $318,338 | $0 | $5,507,091 |
| Nevada | $6,534,365 | $849,096 | $0 | $7,383,461 |
| New Hampshire | $5,000,000 | $378,731 | $0 | $5,378,731 |
| New Jersey | $13,300,998 | $3,336,509 | $0 | $16,637,507 |
| New Mexico | $5,350,492 | $347,603 | $1,260,832 | $6,958,927 |
| New York | $15,467,524 | $2,439,280 | $1,985,744 | $19,892,548 |
| New York City | $15,033,716 | $5,489,605 | $0 | $20,523,321 |
| North Carolina | $14,899,555 | $863,996 | $0 | $15,763,551 |
| North Dakota | $5,000,000 | $210,000 | $0 | $5,210,000 |

| Recipient | FY 2024 Base Plus Population Funding | FY 2024 Cities Readiness Initiative Funding | FY 2024 Level 1 Chemical Laboratory Funding | FY 2024 Total Funding Available |
|---|---|---|---|---|
| Ohio | $16,084,474 | $2,250,075 | $0 | $18,334,549 |
| Oklahoma | $7,470,881 | $537,690 | $0 | $8,008,571 |
| Oregon | $7,715,943 | $755,407 | $0 | $8,471,350 |
| Palau | $370,357 | $0 | $0 | $370,357 |
| Pennsylvania | $17,427,658 | $2,520,139 | $0 | $19,947,797 |
| Puerto Rico | $6,653,125 | $0 | $0 | $6,653,125 |
| Rhode Island | $5,000,000 | $415,557 | $0 | $5,415,557 |
| South Carolina | $8,875,423 | $467,835 | $1,162,649 | $10,505,907 |
| South Dakota | $5,000,000 | $210,000 | $0 | $5,210,000 |
| Tennessee | $10,842,603 | $1,138,889 | $0 | $11,981,492 |
| Texas | $36,399,331 | $6,515,933 | $0 | $42,915,264 |
| Utah | $6,760,175 | $473,678 | $0 | $7,233,853 |
| Vermont | $5,000,000 | $210,000 | $0 | $5,210,000 |
| Virgin Islands (U.S.) | $466,932 | $0 | $0 | $466,932 |
| Virginia | $12,658,049 | $2,320,334 | $1,107,387 | $16,085,770 |
| Washington | $11,659,466 | $1,704,775 | $0 | $13,364,241 |
| Washington, D.C. | $5,747,189 | $803,357 | $0 | $6,550,546 |
| West Virginia | $5,000,000 | $231,898 | $0 | $5,231,898 |
| Wisconsin | $9,553,768 | $713,645 | $1,662,020 | $11,929,433 |
| Wyoming | $5,000,000 | $210,000 | $0 | $5,210,000 |
| TOTAL FY 2024 PHEP Funding | $561,653,311 | $78,760,478 | $13,324,820 | $653,738,609 |