Office of Applied Research Five-Year Regional Work Plan Region 3

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Contents

Introduction

The Region 3 workplan guides the overall work of a future Region 3 Public Health Preparedness (PHPR) Center. It recommends concentrating the future Center's work on 3 focus areas and building on one cross-cutting, foundational area. This document expands on public health preparedness and response focus areas identified by the Region 3 PHEPR coordinating body (RCB). Johns Hopkins University Center for Health Security conducted an initial gap identification process utilizing COPEWELL domains, which resulted in 10 potential focus areas. After additional discussion and evaluation with the RCB, JHUCHS refined and combined themes that were strongly aligned. This resulted in seven overall focus areas covering a range of related concepts. The RCB was informally polled at the second and third coordinating body meetings as part of priority setting exercises; following polls, the group discussed priorities and identified areas for further refinement. Priority setting exercises identified three focus areas and one foundational area for the workplan.

Framework

The coordinating body selected a framework to guide the overall work of a future Region 3 PHPR Center. Regional partners emphasized the importance of **Social Equity, Vulnerability, and Determinants of Health** as a cross-cutting foundational component of the framework. This concept will underpin all focus areas and each intervention, and ground the work of the future Region 3 PHPR Center. The workplan includes designation of a staff member to take the lead on social equity, vulnerability, and determinants of health for the Center.

The framework includes 3 focus areas, visualized as pillars in Figure 1. These focus areas include: 1) **Communication and Community Engagement**; 2) **Coordination Across Agencies, Community Organizations, and Systems**; and 3) **Workforce Recruitment, Retention, and Competencies Growth**. This workplan describes focus areas in greater detail in

Section 1: Focus Area, Priorities, and Multi-Year Objectives. Outcomes from this work will result in **building agency capabilities** and/or **growing community resilience**, and work will occur across **all hazards**. This framework also serves as a foundation for sustainable communities of practice that will be developed through the work of the future Center to support collaborative approaches to PHPR in Region 3.

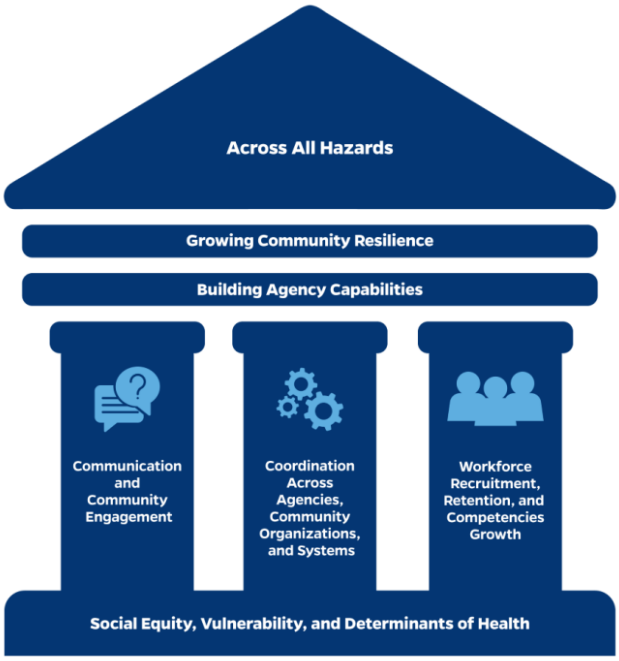

Figure 1. Region 3 Public Health Preparedness and Response Center Framework

Foundational Concept: Social Equity, Vulnerability, and Determinants of Health

This cross-cutting foundational concept reflects the RCB's emphasis on ensuring that interventions serve those who may have access and functional needs, or other social, cultural, or economic barriers to preparedness, response, recovery, and resilience in addition to solving operational and logistical preparedness gaps. Therefore, concepts related to social equity,[1] vulnerability, and determinants of health serve as the foundation for the conceptual framework outlining future work of the Region 3 PHPR Center. These foundational concepts are intended to take on a culture-forward approach, with cultural empathy, humility and congruency as guiding principles throughout. Preparedness gaps that should be considered in the development of interventions for the Center's focus areas include consideration for:

- Access needs
- Unhoused individuals
- Long term care/nursing home residents

[1] Our conceptualization and use of social equity in the foundational concepts is representative of discussions had amongst our Regional Coordinating Body members. Other notable definitions include:
U.S. Centers for Disease Control and Prevention: "Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires focused and ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and healthcare; and eliminate preventable health disparities"
Centers for Medicare and Medicaid Services: "Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

- Justice Involved and Justice Impacted populations (e.g., Incarcerated populations)
- Older adults (including issues related to loneliness)
- Racial and ethnic minority groups
- Indigenous people
- Rural populations
- Individuals with mental health conditions
- People with disabilities (intellectual and physical)
- Youth populations
- Newly transitioning asylum seekers
- Historically marginalized and other traditionally non-included groups (e.g., 2SLGBTQ+, sex workers, etc.), and increasing self-advocacy

Understanding and addressing access and functional needs in the absence of public health emergencies (PHEs) Incorporating concepts related to social equity, vulnerability, and determinants of health into focus area objectives could take many forms. For instance, RCB members mentioned the need for planning *with* instead of *for* focus populations; collaborating with and educating community leaders and communities; and ensuring communication and efforts to combat misinformation amongst socially vulnerable populations as outlined above, which intersect well with potential interventions in the communication and community engagement focus area. The coordinating body also highlighted the need to increase resilience of populations with access and functional needs; provide guidance on how to incorporate equity in emergency preparedness and response activities; and improve data collection that provides information on vulnerable populations. These activities should be integrated into potential interventions focused on coordination across agencies, community organizations, and systems. Although it is more challenging to make direct ties to workforce recruitment, retention, and competencies growth, RCB members highlighted the importance of understanding how populations may be disproportionately affected by different types of PHEs, which may be improved through more diverse and inclusive workforce recruitment. The RCB also noted a need for strengths/asset-based approaches to social equity and vulnerability.

All objectives, interventions, and measures should integrate social equity, vulnerability, and determinants of health. The RCB also emphasized the need to develop and maintain communities of practice in this and other areas, which should be an activity of the new Region 3 PHPR center.

Summary of Proposed Activities

The workplan describes 3 focus areas with 3 priority topics in each area, as identified by the region 3 Coordinating Body. The project team, using guidance from CDC, developed objectives and proposed activities to support each of the 9 priority topics. The extent of these activities, including number of implementing communities and materials produced by the Center, as well as the number of concurrent activities, depends on level of funding for the Center as well as available expertise. However, these activities fall broadly within 4 categories:

1. Implementation of Evidence-Based Strategies and Interventions (EBSIs) in pilot communities
2. Development of trainings and toolkits using EBSIs for select topic areas
3. Development of a regional PHEPR community of practice through the creation of one or more exercises
4. Evaluation of activities

Efforts to conduct these activities may serve to support several objectives at the same time, increasing efficiency of Center activities and allowing ambitious Center objectives to be met in the context of anticipated funding levels.

Section 1: Focus Area, Priorities, and Multi-Year Objectives

Focus Area 1: Improve the Effectiveness of Communication and Expand Community Engagement

The RCB noted a range of preparedness gaps and potential objectives that aligned with communication and community engagement. Although communication and community engagement are two distinct concepts, many interventions and solutions related to these two areas are aligned. As a result, this workplan merges both concepts, with the intent of creating a vibrant focus area that allows for multidisciplinary work. Within communication and community engagement, the RCB identified a range of needs. One area of need was assistance in addressing misinformation and disinformation, including the growing role artificial intelligence (AI) plays in information sharing and health communication messaging (and the dangers associated therein). Public health preparedness officials and partners identified this issue as a new and evolving issue with outsized influence. RCB members also identified the need to build trust to improve message uptake, especially in the context of a decline of trust in public, government, and social institutions, and a perspective of public health as "other." Additionally, the RCB recommended an emphasis on developing partnerships that feature long-term engagement and inclusion by bringing partners to the table as part of decision-making processes, understanding/responding to partner needs, forming meaningful relationships with communities, and providing meaningful benefits to partners. This will have the intended consequence of quicker community mobilization during times of PHEs. Finally, RCB members noted a need to enhance risk communication practices, including more timely two-way communication, targeted and culturally effective communication that is tailored to priority audiences, and consistent communication.

Regional Priority Topic 1: Improve and expand community and partner engagement	
Objective	By the end of the five-year performance period, the Region 3 Public Health Preparedness and Response (PHPR) Center will improve PHPR preparedness by expanding, guiding, and routinizing community partner engagement (eg NGOs, CBOs, FBOs, EMS, etc) with traditional public health and medical preparedness organizations and activities. Specifically, the Center will facilitate implementation of community engagement EBSIs in pilot communities, develop guidance, training materials, create communication and engagement processes for communities in the Region, and will develop and deliver joint training and/or train-the-trainer programs. Year 1 activities will include identification of at least 2 pilot communities and design or adapt EBSI-based activities for those communities. In years 2 and 3, the Center will work with pilot communities to implement EBSIs. In years 4 and 5, trainings and materials will be created and distributed to facilitate enhanced knowledge, skills, and abilities of public health workers and partners via implementation of EBSIs with a goal of training *at least* 20 participants from across the region each year. Success may be measured through partner engagement metrics such as number of participants and partners reporting improved coordination and collaboration. Additional measures might include the number of trainings conducted, and the participants trained. The goal is to ensure that partners can work efficiently together both in preparation for and in response to emergencies. To build this improved and expanded partner and community engagement in PHPR, we will draw upon EBSI's such as: • COPEWELL. Johns Hopkins Bloomberg School of Public Health. Available at: https://copewellmodel.org/copewell-framework-0. • Williams MV, Chandra A, Spears A, Varda D, Wells KB, Plough AL, Eisenman DP. Evaluating Community Partnerships Addressing Community Resilience in Los Angeles, California. Int J Environ Res Public Health. 2018 Mar 27;15(4):610. doi: 10.3390/ijerph15040610. PMID: 29584681; PMCID: PMC5923652. • Eisenman DP, Glik D, Gonzalez L, Maranon R, Zhou Q, Tseng CH, Asch SM. Improving Latino disaster preparedness using social networks. Am J Prev Med. 2009 Dec;37(6):512-7. doi:

Regional Priority Topic 1: Improve and expand community and partner engagement	
	10.1016/j.amepre.2009.07.022. PMID: 19944917. • Hites LS, Granillo BS, Garrison ER, Cimetta AD, Serafin VJ, Renger RF, Wakelee JF, Burgess JL. Emergency preparedness training of tribal community health representatives. J Immigr Minor Health. 2012 Apr;14(2):323-9. doi: 10.1007/s10903-011-9438-9. PMID: 21240557.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☐ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☐ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☐ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☐ Information Management ☐ Countermeasures and Mitigation ☐ Surge Management ☐ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal[2] ☑ Local ☐ Territorial
Collaboration and Coordination	To conduct and socialize the findings of community engagement EBSIs, it is crucial to collaborate with diverse community partners, including community- and faith-based and spiritual organizations, constituents, and state/local/tribal leaders, and community health workers. These partners can support the implementation, and analysis of EBSI-related activities, as well as recruitment of participants and validation/socialization of findings. Engaging with federal partners may provide an opportunity for regional partners to provide feedback on HHS work in an effort to increase outreach and better meet community needs. Coordinating between representatives of focus populations will be essential for ensuring generalizable exercises and trainings and increasing partner/community engagement in the process.
Population Focus	This objective applies directly to practitioners who conduct work related to public health emergency preparedness and response, and indirectly to community-based organizations (CBOs) and constituents. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities(e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and*

[2] Throughout this workplan, "Tribal" includes Indigenous/Native American communities, including those that are Indigenous to other countries but have lived in Region 3 for many generations.

Regional Priority Topic 1: Improve and expand community and partner engagement	
Considerations	*inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB considered multiple evidence based strategies and interventions (EBSIs) that improve community engagement for populations who experience significant health disparities and inequities. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Use tools like: Assessing the Intensity of Community Engagement for Public Health Emergency Preparedness (CE-PHEP), an instrument for local health departments to set a baseline for planning and tracking; FEMA's Planning Considerations: Putting People First, an emergency management guide for local health departments to prioritize the needs of the community, and; FEMA's Engaging Faith-based and Community Organizations: Planning Considerations for Emergency Managers, a guide for local health departments to engage with faith-based, spiritual and community-based organizations in a meaningful and sustainable way.

Regional Priority Topic 2: Address misinformation and disinformation	
Objective	By the end of the five-year performance period, the Region 3 PHPR Center will increase the capacity of public health authorities to evaluate and address public health misinformation and disinformation. This will be accomplished through activities such as training at least 20 public health officials on EBSIs for health-related misinformation annually, ensuring at least 80% of participants demonstrate improved understanding of effective approaches such as using playbooks to address health misinformation. The effectiveness of the training will be measured through pre- and post-training assessments, with a goal of achieving a minimum 20% increase in knowledge scores. Additionally, follow-up assessments conducted six months post-training will aim for a 50% application rate of the learned approaches in their respective organizations (surveys if allowed under OMB/PRA requirements). To improve the ability of public health officials to evaluate and address mis- and dis-information, the Center will incorporate EBSI's such as: • Nagar A, Grégoire V, Sundelson A, O'Donnell-Pazderka E, Jamison AM, Sell TK. Practical playbook for addressing health misinformation. Baltimore, MD: Johns Hopkins Center for Health Security; 2024. • Ishizumi A, Kolis J, Abad N, Prybylski D, Brookmeyer KA, Voegeli C, Wardle C, Chiou H. Beyond misinformation: developing a public health prevention framework for managing information ecosystems. The Lancet Public Health. 2024 Apr 20. • Whitehead HS, French CE, Caldwell DM, Letley L, Mounier-Jack S. A systematic review of communication interventions for countering vaccine misinformation. Vaccine. 2023 Jan 27;41(5):1018-34.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☐ Utilize and expand relevant technological and analytical capabilities to inform public health and medical

Regional Priority Topic 2: Address misinformation and disinformation	
	preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☐ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☐ Incident Management ☑ Information Management ☑ Countermeasures and Mitigation ☐ Surge Management ☑ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Robust coordination with public health authorities and health communicators will be important for achieving this objective, as will working with partners working with local communities, actors who are already implementing activities to address mis/disinformation, and groups who work with populations that are disproportionately likely to believe in or be impacted by mis/disinformation.
Population Focus	The target population comprises public health authorities at regional, state, tribal, and local levels. The activities they implement to address mis/disinformation will target CBOs, constituents, and populations that are disproportionately like to believe in or be impacted by mis/disinformation. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB considered multiple EBSIs that either discuss how mis/disinformation targets populations who experience significant health disparities and inequities, or discuss how to counter mis/disinformation within these communities and in general populations. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Survey health department communicators' knowledge and confidence pre/post trainings, as well as their overall competencies. Incorporate an information evaluation framework, such as the one proposed in Health Information and Misinformation: A Framework to Guide Research and Practice, to detect misinformation and support health-related decision-making.

Regional Priority Topic 3: Building trust between public health and the public	
Objective	Within the five-year performance period, the Region 3 PHPR Center will improve trust between public health authorities and the public by facilitating implementation of trust-related EBSIs in Region 3 communities. These activities will involve local public health departments, community organizations, and academic institutions. Year 1 activities will include identification of at least 2 pilot communities and design or adaptation of EBSI-based trust building activities for those communities. In years 2 and 3, the Center will work with pilot communities to implement EBSIs. In years 4 and 5, trainings and materials will be created and distributed to facilitate enhanced knowledge, skills, and abilities of public health workers and partners via implementation of EBSIs with a goal of facilitating up to 10 EBSI based trust building activities annually. Timing of some activities may be altered in consideration of other Center activities. Utilizing tools from JHU's CDC-funded project focused on trust in Public Health Emergency Preparedness and Response (PHEPR), a possible goal might be to achieve an increase in the number of collaborative projects initiated between public health authorities and community groups, as documented through project records and partnership agreements. The Center would also seek to partner with public health agencies to incorporate new measures of trust into existing community public health assessments and measure trust over the period of performance. To improve the public's trust in public health, the Center will rely on EBSI's such as: • Potter CM, Fink ER, Nagar A, et al. Checklist to Build Trust, Improve Public Health Communication, and Anticipate Misinformation During Public Health Emergencies. Baltimore, MD: Johns Hopkins Center for Health Security; 2024. Available at: https://centerforhealthsecurity.org/trust-checklist-to-build-trust. • EBSI: Holroyd TA, Oloko OK, Salmon DA, Omer SB, Limaye RJ. Trust and reliability of public health authorities: Communicating recommendations in public health emergencies: The role of public health authorities. Health security. 2020 Feb 1;18(1):21-8. • Platt JE, Taylor LA. Assessing Trust in Health Care: A Compendium of Trust Measures.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☐ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☑ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☐ Incident Management ☑ Information Management ☑ Countermeasures and Mitigation ☐ Surge Management ☐ Biosurveillance
Setting	☐ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Workplan implementers need to build partnerships between local public health authorities, partners, practitioners, academia/subject matter experts, researchers, and other relevant authorities to enhance trust in public health preparedness and response.
Population Focus	The target population comprises any authorities and partners that can enhance public trust in public health preparedness and response, such as local public health officials, CBOs, trusted messengers, etc. Trust-building activities will impact constituents and communities in the long term.

Regional Priority Topic 3: Building trust between public health and the public	
	Sub-population considered (select all that apply): ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB discussed how social vulnerabilities impact trust and how health disparities and inequities change the level of trust marginalized populations have in public health and emergency management. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Use surveys led by local CBOs to assess trust and confidence in public health, featuring known trust measures, scales, and best practices for conceptualizing and operationalizing trust-related measures.

Focus Area 2: Coordination Across Agencies, Community Organizations, and Systems

RCB members stressed the importance of closing gaps in PHPR coordination across agencies, community organizations, and systems. For example, federal coordination with state and local systems, including integration of the Federal ESF#8 capabilities (e.g., Strategic National Stockpile) and access to/deployment of resources across the region, could be improved. They recommended improving coordination between healthcare and public health systems and improving resilience of primary care/preventative health. Here, and throughout Focus Area 2, we define resilience according to COPEWELL's definition that "resilience is the ability to adapt to changing conditions and withstand and rapidly recover from disruption due to emergencies and disasters." The COVID-19 pandemic highlighted the importance of several operational preparedness needs, including the ability to facilitate a multidisciplinary response amongst a range of different public health preparedness partners and deliver key public health emergency response services. Public health agencies must enhance administrative preparedness, improve their ability to move funds effectively during a public health emergency, improve logistics capabilities, and manage medical countermeasures. Data modernization, including improving situational awareness, integrating and increasing interoperability of data systems, and improving data on hard-to-reach populations may also be a component of this focus area.

Regional Priority Topic 1: Facilitating a multidisciplinary response - coordinated community resilience-building	
Objective	By the end of the five-year performance period, the Center will improve community resilience in Region 3 by implementing a coordinated community resilience-building approach that engages government and industry sectors outside of public health and medicine to identify and initiate priority areas of collaboration. To do this, the Center will convene community partner preparedness planning sessions with 2 pilot communities in year 1. These sessions will involve public health agencies and healthcare organizations, and will also engage other sectors like environmental health, housing, transportation, and business with the objective of collaboratively planning and implementing at least 1 new EBSI-based preparedness and response initiatives in each community in years 2-3, Additional communities may be added in years 4-5. Progress tracked through meeting minutes, project implementation records, and regular reporting to all partners. To accomplish this objective, the Center will draw upon the COPEWELL model of community resilience and involve EBSIs such as: • Schoch-Spana, M., Gill, K., Hosangadi, D., Slemp, C., Burhans, R., Zeis, J., Carbone, E. G., & Links, J. (2019). The COPEWELL Rubric: A Self-Assessment Toolkit to Strengthen Community Resilience to Disasters. International journal of environmental research and public health, 16(13), 2372. https://doi.org/10.3390/ijerph16132372. • Slemp CC, Sisco S, Jean MC, Ahmed MS, Kanarek NF, Erös-Sarnyai M, Gonzalez IA, Igusa T, Lane K, Tirado FP, Tria M. Applying an innovative model of disaster resilience at the neighborhood level: the COPEWELL New York City experience. Public health reports. 2020 Sep;135(5):565-70. • Radcliff TA, Horney JA, Dobalian A, Macareno BO, Kabir UY, Price C, Strickland CJ. Long-term care planning, preparedness, and response among rural long-term care providers. Disaster Medicine and Public Health Preparedness. 2022 Feb;16(1):12-5.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☐ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☐ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☐ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☐ Information Management ☑ Countermeasures and Mitigation ☑ Surge Management ☑ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Collaboration between multisectoral community partners is an essential component of coordinated community response disaster resilience planning. This objective requires facilitating collaboration between multifaceted actors and enabling easier coordination between them. Stakeholders from key community functioning domains such as education, government, housing, healthcare and public health, mental health, transportation, and other areas should be included. Identify partners from CBOs to represent needs from local underserved populations and include them in coordinating meetings to ensure broad community engagement that is centered on those most impacted. People with pets may present a barrier to evacuation

Regional Priority Topic 1: Facilitating a multidisciplinary response - coordinated community resilience-building	
	and should be considered in coordinated community response disaster resilience planning. Use COPEWELL guides to help facilitate partner meetings and collaborative work
Population Focus	Target populations are community partners, CBOs, public health officials, and emergency management agencies. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB recommended convening diverse CBOs and community partners to promote community resilience to disasters and reviewed/suggested EBSIs that consider health disparities and inequities. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Use tools like: Assessing the Intensity of Community Engagement for Public Health Emergency Preparedness (CE-PHEP), an instrument for local health departments to set a baseline for planning and tracking.

Regional Priority Topic 2: Improve integration between public health and healthcare	
Objective	By the end of the 5-year performance period, establish and sustain a Community of Practice (CoP) involving at least 30 public health and healthcare stakeholders across Region 3. This CoP will focus on improving **integration for public health preparedness and response (PHPR)**. To do this the Center will conduct a multi-disciplinary emergency public health exercise involving public health departments and healthcare partners to increase network building and information sharing during years 2 and 4. Evaluation and improvement of how the CoP and exercises have improved operational preparedess will occur in years 3 and 5. This high-level tabletop exercise for the region will highlight gaps and needs for regional preparedness and response. Success will be measured by quarterly participation rates, the number of collaborative initiatives launched, and the implementation of at least three evidence-based integration strategies within participating organizations. Progress will be evaluated through bi-annual feedback sessions and documented improvements in integrated PHPR activities. To improve integration between public health the healthcare through this community of practice the Center will incorporate some of the following EBSI's and potential methods of assessment:

Regional Priority Topic 2: Improve integration between public health and healthcare	
	• Use existing literature to guide local, state and federal policies to promote greater public health and healthcare integration and assess its impact. ○ Maryland Primary Care Program (MPCP) Maryland Department of Health. Maryland Primary Care Program. Updated June 2021. Accessed December 11, 2023. https://health.maryland.gov/mdpcp/Pages/home.aspx ○ Wynn A, Moore KM. Integration of primary health care and public health during a public health emergency. American journal of public health. 2012 Nov;102(11):e9-12. ○ World Health Organization. Primary health care: closing the gap between public health and primary care through integration. World Health Organization; 2018. ○ Veenema TG, Toner E, Waldhorn RE, et al. The Integration of Primary Care, Public Health, and Community-Based Organizations: A Federal Policy Analysis. Baltimore, MD: Johns Hopkins Center for Health Security; 2024. ○ Veenema TG, Toner E, Waldhorn RE, et al. A Policy Analysis for the Integration of Primary Care, Public Health, and Community-Based Organizations in Public Health Emergencies: Interim Report. Baltimore, MD: Johns Hopkins Center for Health Security; 2023.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☑ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☐ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☑ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☑ Information Management ☑ Countermeasures and Mitigation ☐ Surge Management ☐ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	This objective requires collaboration between multiple public health actors and cross-sectors, such as governmental public health agencies, private non-profits (e.g., healthcare systems), private sector institutions (e.g., pharmacies, hospitals, etc.) and CBOs to improve integration between public health and healthcare. Guiding policies involve coordination with policymakers, advocacy groups, service providers, and existing integrators (e.g., the Maryland Primary Care Program)
Population Focus	Target populations are public health authorities and professionals, clinicians, primary care providers, healthcare institutions, CBOs, and policymakers. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas

Regional Priority Topic 2: Improve integration between public health and healthcare	
	☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB discussed how improving health disparities and inequities are fundamental for integrating public health and healthcare, both in their own work and in emerging evidence with which they are familiar. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Evaluate changes in: the use of 1115 Medicaid waivers; participation in the Medicaid Shared Savings Program; CMS's AHEAD Model; and use of International Classification of Diseases (ICD)-10 Z codes (ICD-11 Q codes) that cover social determinants of health.

Regional Priority Topic 3: Improve public health operational preparedness and regional collaboration and coordination	
Objective	By the end of the 5-year performance period, establish and sustain a Community of Practice (CoP) involving at least 30 regional partners to enhance **Regional collaboration and coordination** for public health preparedness and response (PHPR). To do this the Center will conduct a multi-disciplinary emergency public health exercise involving public health departments, hospital systems, and PHEPR community stakeholders to increase network building and information sharing in years 2 and 4. Evaluation and improvement of CoP building efforts will occur in years 3 and 5. This high-level tabletop exercise for the region will highlight gaps and needs for regional preparedness and response. Success will be measured by participation rates, the number of collaborative initiatives launched following the exercise, and the implementation of at least three region-wide collaborative strategies within participating organizations. Progress will be evaluated through bi-annual feedback sessions and documented improvements in regional collaboration activities. The following EBSI's and potential measures will be useful in shaping these activities: • Kelen, G.D. "Criteria for Declaring Crisis Standards of Care: A Single, Uniform Model." *NEJM catalyst innovations in care delivery.* 13 (2023 • Toerper MF, Kelen GD, Sauer LM, Bayram JD, Catlett C, Levin S. Hospital Surge Capacity: A Web-Based Simulation Tool for Emergency Planners. Disaster Medicine and Public Health Preparedness. 2018;12(4):513-522. • Sell TK, Watson C, Mullen L, Shearer M, Toner E. Pandemic exercises: lessons for a new era in pandemic preparedness. (in preparation) • Potential measures/methods of assessment: Capacity survey in local health department - for communication and information dissemination, surveillance and investigation, plans and protocols, workforce and volunteers, legal infrastructure, incident command, exercises and emergency events, and corrective action activities. • Davis M.V., Mays G.P., Bellamy J., Bevc C.A., Marti C. Improving public health preparedness capacity measurement: Development of the local health department preparedness capacities assessment survey (2013) Disaster Medicine and Public Health Preparedness, 7 (6), pp. 578 – 584

Regional Priority Topic 3: Improve public health operational preparedness and regional collaboration and coordination	
Category	☑ Program ☐ Research and evaluation
Activity	☐ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☑ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☐ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☑ Information Management ☐ Countermeasures and Mitigation ☑ Surge Management ☐ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Success of this objective depends on regular, efficient regional public health preparedness and response entities collaborating on improving their operational preparedness and coordinating activities so they operate in concert with each other.
Population Focus	The target populations are regional public health preparedness and response entities like public health authorities, health departments, hospital systems, and partners. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* This objective builds on an RCB discussion about how operations and logistics often operate in silos, which exacerbates health disparities and inequities. Thereby, operational preparedness was recommended as a priority topic because it improves health equity outcomes and strengthens disaster resilience. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?*

Regional Priority Topic 3: Improve public health operational preparedness and regional collaboration and coordination	
	☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Capacity measurement surveys in local health department to inform communication and information dissemination, surveillance and investigation, plans and protocols, workforce and volunteers, legal infrastructure, incident command, exercises and emergency events, and corrective action activities. Leveraging peer-reviewed resources such as Integrating Government Silos: Local Emergency Management and Public Health Department Collaboration for Emergency Planning and Response to identify potential silos and gaps in collaborative work, and opportunities to integrate activities among partners.

Focus Area 3: Workforce Recruitment, Retention, and Competencies Growth

The RCB recommended focusing on workforce issues that immediately threaten public health preparedness and response activities in the near and long term. During and following the COVID-19 pandemic, public health preparedness and response has been stymied by a continuing public health and healthcare workforce crisis. Workers face burnout and mental health burdens that threaten their ability to continue in the field and respond to crises. There is a lack of surge staffing capacity when multiple or long-term threats require sustained increased staff response. There are few social service providers to fill gaps that may be exacerbated by public health emergencies. Future work for the Region 3 PHPR Center should include interventions that will improve workforce recruitment, retention, and growth of personnel competencies. There are different levels of education and training opportunities, including low-resource education and even just-in-time education, in addition to longitudinal education resources. Such new training can increase professional development, meet skilling needs, and improve workforce competencies. This focus area could benefit from additional research to better understand drivers of and the most effective interventions to understand worker needs and prevent worker burnout. Additionally, further research is needed to better understand ways to increase long term sustainability of workforces and to increase the inclusion of potential workers with lived experience and non-traditional emergency management experience.

Regional Priority Topic 1: Address workforce crisis and long-term sustainability of workforce	
Objective	By the end of the 5-year performance period, enhance workforce retention and recruitment, long-term growth, and sustainability in State and Local Health Departments in Region 3 by developing, implementing and testing an EBSI-based toolkit focused on best practices with evidence-based capacity-building interventions. By the end of year 1, the Center will identify, collate, and evaluate existing and newly emerging EBSIs focused on retention and recruitment. By the end of year 2, these EBSIs will be formulated into a web-based toolkit. In years 3-4, this toolkit will be implemented and tested with 2-4 pilot communities. Year 5 will focus on measurement and evaluation of change in pilot communities. Success will be measured through % improvement in workforce retention rates and % increase in recruitment rates, evaluated through annual workforce surveys and HR data analysis. To address these workforce issues and better workforce retention and recruitment in state and local public health departments, the Center will employ some of the following EBSI's and measurement strategies: • Develop and test a web-based toolkit with evidence-based capacity-building interventions to address healthcare workforce shortages in the short-term and recruitment and retention best practices for long-term growth and sustainability. ○ Watts Isley J, Little SH, Sha S, Vaughan E, Wingate K, Aleshire ME. To stay or leave: Public health nurse workforce retention in North Carolina. Public Health Nursing. 2022

Regional Priority Topic 1: Address workforce crisis and long-term sustainability of workforce	
	May;39(3):609-17. ○ Runnerstrom MG, Denaro K, Sato B. Bolstering the Public Health Workforce: Recruitment and Retention of Public Health Majors. Pedagogy in Health Promotion. 2023 Jun;9(2):124-30. ○ Miller MR. Identifying strategies to increase the recruitment and retention of minority males in the public health workforce: a two-state comparative case study approach. ○ Pham J. Nursewell App: Four Reasons Why Nurses Should Use it. ACN Foundation. October 3, 2018. Available at: https://www.acn.edu.au/nurseclick/nursewell-app-four-reasons-why-nurses-should-use-it • Measures and methods of assessment: Conduct a workforce survey with STLT and health facility partners to identify what existing recruitment and retention related EBSI's would keep them in the workforce. ○ Sellers K, Leider JP, Lamprecht L, Liss-Levinson R, Castrucci BC. Using public health workforce surveillance data to prioritize retention efforts for younger staff. American journal of preventive medicine. 2020 Oct 1;59(4):562-9.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☐ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☐ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☑ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☐ Information Management ☑ Countermeasures and Mitigation ☑ Surge Management ☑ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Activities for this objective foster collaborations between state and local health departments, health facilities, academic institutions, subject matter experts (including mental health professionals), Work Release Programs/Centers, other agencies whose work connects with workforce development, and potentially CBOs and community groups if recruitment efforts target constituents or seek to identify new talent pipelines. The bulk of the coordination will be between the PHPR Center team and state/local health departments, particularly their human resource management teams.
Population Focus	Target populations are state and local health departments and health facilities. Downstream recruitment strategies may target constituent populations that are underrepresented in the health workforce. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas

Regional Priority Topic 1: Address workforce crisis and long-term sustainability of workforce	
	☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB centered discussion of health disparities, equity, and social vulnerabilities in their prioritization of workforce as a key focus area, especially increasing inclusion of underrepresented populations, managing inequities within the workforce, and EBSIs for building a diverse, resilient workforce. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Conduct a workforce survey with STLT and health facility partners to identify what existing recruitment and retention related EBSIs would keep them in the workforce.

Regional Priority Topic 2: Address burnout and mental health burdens for public health workforce	
Objective	By the end of the 5-year performance period, enhance the ability of public health workers in Region 3 to address and manage mental health burdens by implementing EBSI-based trauma-informed organizational strategies for employers. To achieve this, the Center will develop training on EBSIs focused on trauma-informed care principles for public health employers, develop model supportive policies, and produce a compendium of resources to create a healthier work environment. In years 2-3, these resources will be developed in collaboration with region 3 partners and pilot tested within their organizations. Resources will then be provided to public health agencies throughout Region 3 and evaluated. Success in implementing organizations could be measured by a % reduction in reported workplace stress levels and a % increase in employee satisfaction and mental health support utilization, assessed through annual employee wellness surveys and mental health service usage data. The Following EBSIs and methods of assessment could be used to accomplish these goals: • Implement training in stress management techniques for public health personnel ○ EBSI: The Development of a Model of Psychological First Aid for Non–Mental Health Trained Public Health Personnel: The Johns Hopkins RAPID-PFA. Everly GS, McCabe OL, Semon NL, Thompson CB, Links JM. J Public Health Management Practice, 2014, 20(5), S24–S29. ○ EBSI: Scales SE, Patrick E, Stone KW, Kintziger KW, Jagger MA, Horney JA. Lessons learned from the public health workforce's experiences with the COVID-19 response. Health security. 2022 Oct 1;20(5):387-93. ○ EBSI: Miller SL, Fleury-Steiner R, Camphausen LC, Wells SA, Horney JA. Lessons learned from the COVID-19 pandemic in the United States by domestic violence coalition leaders. Violence against women. 2023 Dec 12:10778012231220369. ○ EBSI: Jenkins JL, Sullivan B, Hsu E. Health Care Worker Wellness Interventions during the COVID-19 Pandemic. Prehospital and Disaster Medicine. 2023;38(S1):s121-s121. doi:10.1017/S1049023X23003230 • Measures and methods of assessment: Survey of depression, anxiety, burnout, career intention, turnover, status, preparedness perceptions, confidence in personal and professional readiness ○ Bryant-Genevier J, Rao CY, Lopes-Cardozo B, et al. Symptoms of depression, anxiety, post-traumatic stress disorder, and suicidal ideation among state, tribal, local, and territorial public health workers during the COVID-19 pandemic – United States, March–April 2021. *MMWR Morb Mortal Wkly Rep*.

Regional Priority Topic 2: Address burnout and mental health burdens for public health workforce	
	2021;70:1680-1685. ○ Scales SE, Patrick E, Stone KW, Kintziger KW, Jagger MA, Horney JA. Lessons learned from the public health workforce's experiences with the COVID-19 response. Health security. 2022 Oct 1;20(5):387-93. ○ Wells SA, Fleury-Steiner RE, Miller SL, Camphausen LC, Horney JA. Impacts of the COVID-19 response on the domestic violence workforce. Journal of interpersonal violence. 2024 Mar;39(5-6):1190-205. ○ Hsu EB, Jenkins JL, Wilson LM, Zhang A, Bass EB. Emergency Medical Service/911 Workforce Mental or Behavioral Health Issues. Topic Development Brief. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No. 75Q80120D00003.) AHRQ Publication No. 22-EHC010. Rockville, MD: Agency for Healthcare Research and Quality; February 2022. DOI: 10.23970 • Additional intervention: Analyze and implement trauma-informed organizational strategies for public health agencies and healthcare employers. ○ EBSI: Greer, J.A. Introducing trauma-informed care principles in the workplace. *Discov Psychol.* 2023;3(31). https://doi.org/10.1007/s44202-023-00094-2 • Additional measures and methods of assessment: Implement tools for recognizing workplace trauma, creating workplaces that support traumatized employees and avoid re-traumatization, and assessing workplace compliance with trauma-informed practices. ○ Bloom SL. The Sanctuary model of trauma-informed organizational change. Natl Abandon Infants Assist Resour Center. 2007;16(1):12–7. https://www.nctsn.org/interventions/sanctuary-model#:~:text=Sanctuary%20is%20a%20trauma%2Dinformed,groups%20through%20exposure%20to%20trauma. ○ Substance abuse and mental health services administration. SAMHSA's concept of trauma and guidance for a trauma-informed approach. 2014. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884.
Category	☑ Program ☐ Research and evaluation
Activity	☑ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☑ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☑ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☑ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☐ Incident Management ☐ Information Management ☑ Countermeasures and Mitigation ☑ Surge Management ☐ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and Coordination	Activities under this objective entail mostly intra-organizational coordination, wherein employers and employees work together to assess mental health burdens and burnout among the public health workforce and work collaboratively to improve work environments and burnout/mental health management using trauma-informed strategies. Some collaboration may occur with employee development subject matter experts, workforce development organizations, mental health advocacy groups, and mental health service providers.
Population Focus	Target populations are public health personnel and the organizations/agencies that employ them. *Sub-population considered (select all that apply):*

Regional Priority Topic 2: Address burnout and mental health burdens for public health workforce	
	☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB discussed how working with or belonging to socially vulnerable and marginalized populations – especially those experiencing health disparities and inequities – can exacerbate burnout and add to the mental health burdens that public health personnel experience. They reviewed EBSIs that explore intersectional burdens driving workforce burnout. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Conducting surveys of depression, anxiety, burnout, career intention, turnover, status, preparedness perceptions, confidence in personal and professional readiness, and implementing tools for recognizing workplace trauma, creating workplaces that support traumatized employees and avoid re-traumatization, and assessing workplace compliance with trauma-informed practices. Implementing Psychological First Aid (PFA), an evidence informed modular approach to mental health recovery following a disaster. Using the guidelines published by the Academy of Consultation and Liaison Psychiatry to assess and attend to the needs of healthcare personnel.

Regional Priority Topic 3: Improving public health workforce capacity and willingness to respond (surge staffing capacity)	
Objective	By the end of the 5-year performance period, enhance the capacity and willingness of the public health workforce in Region 3 to respond to emergencies by developing a EBSI-based toolkit and providing comprehensive supportive EBSI-based synchronous and/or asynchronous trainings, skill-building sessions, operational readiness exercises, and just-in-time trainings. In year 1, the Center would collate, organize, and evaluate existing EBSIs focused on workforce capacity for and willingness to respond to public health emergencies. In year 2, the Center would develop trainings and a user-friendly toolkit to translate existing EBSIs into accessible materials that both traditional and non-traditional PHEPR community members could use, with a focus on equity and traditionally non-included populations. In years 3-4 would implement these EBSI-based trainings and toolkits in 2-4 pilot communities. Trainings could include web-based Public Health Infrastructure Training, possibly targeted at a specific aspect of PHEPR or competencies with additional input of steering committee. Year 5 will focus on evaluation of these activities. The Center's aim would be to achieve and increase in emergency response readiness scores in public health agencies and partner organizations as measured by pre- and post-training assessments and participation rates.

Regional Priority Topic 3: Improving public health workforce capacity and willingness to respond (surge staffing capacity)	
	To accomplish this objective, the Center could utilize the following EBSI's and potential measures and methods of assessment: • Harrison KL, Errett NA, Rutkow L, et al. An intervention for enhancing public health crisis response willingness among local health department workers: A qualitative programmatic analysis. American Journal of Disaster Medicine, Vol. 9, No. 2, Spring 2014 • EBSI: Jacobs JA, Duggan K, Erwin P, Smith C, Borawski E, Compton J, D'Ambrosio L, Frank SH, Frazier-Kouassi S, Hannon PA, Leeman J. Capacity building for evidence-based decision making in local health departments: scaling up an effective training approach. Implementation Science. 2014 Dec;9:1-1. • EBSI: Nelson CD, Willis HH, Chan EW, Shelton SR, Parker AM. Federal initiative increases community preparedness for public health emergencies. Health Aff (Millwood). 2010 Dec;29(12):2286-93. doi: 10.1377/hlthaff.2010.0189. PMID: 21134931. • EBSI: Jenkins JL, Bissell R. Development of an Educational Intervention to Train Prehospital Responders in High Consequence Diseases. Prehospital and Disaster Medicine 32 (S1), S167-S168, 2017 • Measures/methods of assessment: Conduct Pre -post survey before and after training to assess knowledge, attitudes and skills. May also conduct pre-post training using exercise scenario training approaches. o Barnett, DJ, Thompson, CB, Errett, NA, et al. Determinants of emergency response willingness in the local public health workforce by jurisdictional and scenario patterns: a cross-sectional survey. BMC Public Health. 2012;12:164. o Hayes JS, Barreto M, Kalin-Mänttäri L, Mexia R, Connolly MA, Voutilainen L. Development of a workforce self-assessment tool for public health emergency preparedness. Eur J Public Health. 2024 Apr 1:ckae030. doi: 10.1093/eurpub/ckae030. Epub ahead of print. PMID: 38561183. o Jenkins JL, Bissell R, Wilson L. Utilization of the Multi-Pathogen Approach in an Online Program for Prehospital Responders in High Consequence Infectious Diseases. Prehospital and Disaster Medicine, 2019. 34(S1), S177-S177
Category	☑ Program ☐ Research and evaluation
Activity	☐ Identify, translate, and disseminate promising research findings or strategies into evidence-informed or evidence-based practices (may include conducting research related to public health preparedness and response systems) ☑ Improve awareness of evidence informed or evidence-based practices and other relevant scientific or public health information through the development, evaluation, and dissemination of trainings and training materials ☑ Utilize and expand relevant technological and analytical capabilities to inform public health and medical preparedness and response efforts (may include participation in drills and exercises and training public health experts) ☑ Provide technical assistance and expertise that relies on evidence-based practices ☐ Coordinate relevant activities to improve public health preparedness and response as informed by needs of the community or communities involved ☑ Collect information on high priority topics that lack sufficient data or evidence ☐ Other
Domain	☑ Community Resilience ☑ Incident Management ☐ Information Management ☑ Countermeasures and Mitigation ☑ Surge Management ☑ Biosurveillance
Setting	☑ Regional ☑ State ☑ Tribal ☑ Local ☐ Territorial
Collaboration and	Activities under this objective mostly require intra-organizational coordination and coordination between

Regional Priority Topic 3: Improving public health workforce capacity and willingness to respond (surge staffing capacity)	
Coordination	workplan implementers, health institutions, and public health personnel.
Population Focus	The target population is public health personnel. *Sub-population considered (select all that apply):* ☑ Vulnerable or at-risk ☑ Underserved ☑ African American ☑ Hispanic/Latino ☑ Asian American ☑ Native American/Indigenous ☑ People with Limited English Proficiency ☑ People living in rural areas ☑ Low-income ☑ Immigrant ☑ People who hold multiple identities (e.g., intersectionality of gender, race, sexual identity, etc.) ☑ Justice Involved and Justice Impacted populations
Health Equity Considerations	*1. Has the coordinating body considered the evidence base documenting drivers of health disparities and inequities to inform development of the objective?* ☑ Yes ☐ No ☐ Not Applicable *2. If yes to Question 1, how? If no, please explain why not.* The RCB discussed how lack of surge capacity disproportionately negatively impacts communities that already experience health disparities and inequities. They recommended integrating health equity as a goal throughout all workforce development interventions and activities. *3. Are considerations for health equity integrated into the decision-making process when developing and framing the objective to improve health outcomes?* ☑ Yes ☐ No ☐ Not Applicable *4. Has the objective considered the burden of social determinants of health on populations with access and functional needs, low socioeconomic status, and communities experiencing racism?* ☑ Yes ☐ No ☐ Not Applicable *5. Are there known unintended positive or negative impacts on health equity?* ☑ Yes ☐ No ☐ Not Applicable
Measures/ methods of assessment	Conduct surveys before and after trainings, potentially using exercise scenario training methodologies, to assess changes in workforce's knowledge, attitudes, and skills.

Section 2: Partners, Roles, and Resources Needed to Accomplish Objectives

Focus Area 1: Communication and Community Engagement

Regional Priority Topic 1: Improve and expand community and partner engagement	
Partners	CBOs, faith-based and spiritual organizations, constituents, State, Tribal, Local, Territorial (STLT) leaders, and community health workers
Roles and responsibilities	CBOs and faith-based and spiritual organizations are well positioned to understand the needs of target communities where the community engagement activities will will be implemented. They can guide and assist in planning and implementing community engagement EBSIs, recruiting participants, developing training materials and communication processes, and providing feedback to evaluate partner engagement success. .CBOs are often under resourced, so participating in these activities may pose undue burdens on their time. Constituents can help co-design, implement, and evaluate the results of partner engagement activities by providing feedback on relevant metrics (e.g., number of participants and partners reporting improved coordination and collaboration, number of trainings conducted, etc.). They provide inputs to improve uptake of EBSIs and increase participation. The timing of activities may be limited by constituent's time-availability. STLT leaders represent state, local, and tribal-level decision-making on health, emergency preparedness, and related issues, and can guide the design and implementation of EBSIs and related activities, as well as validation and strategic prioritization of its outcomes. Traditional medicine and community elders, specifically, are highly respected STLT leaders that are connected to communities and well attuned to their needs. Guidance from such STLT leaders on customizing processes to reflect constituent interests, factoring in population-specific considerations, and recruiting participants would be valuable. Leaders are often under resourced, so participating in this activity may pose undue burdens on their time. Community health workers are well positioned to build meaningful relationships with members of the community, provide ongoing communication, and gather feedback on emerging needs (e.g., by holding booths at community events, conducting surveys and focus groups, etc.)
Resources needed to implement objectives	Administrative: Coordinators to manage scheduling, implementation, and monitoring of activities, liaise between, Center staff, and community partners, and perform financial and logistical administrative duties. Financial: Funding to support staff salaries, provide incentives for partners/ participants, purchase technology. Technical support: Staff, subject matter expert input, data analysts.[3]
Resources available through partners	Spaces for convening participants; documents and data relevant to the EBSIs; administrative/logistical support for organizing community events that would support implementation of the EBSIs; technical support for connecting with constituents and local leaders; local networks; and in-kind inputs from staff, experts, and local leaders.
Potential barriers/issues that may be encountered	Partners may exhibit a lack of engagement because they are stretched thin with other responsibilities, not interested in the outcomes of the EBSIs, are excluded from early phases of EBSIs planning and implementation or are reticent to work with academic institutions/CDC/public health because of negative prior experiences. Partners may also be reluctant to engage if they feel that their suggestions are not being heard and/or are brushed off. Such previous negative experiences are likely to exacerbate these concerns. Gaps in federal and state coordination in deploying resources and difficulties accessing funding across the region may contribute to siloed work.
Potential	Lack of engagement can be overcome by understanding partners' availability, level of interest, and

[3] This type of technical support applies to all focus areas, priority topics, and objectives

Regional Priority Topic 1: Improve and expand community and partner engagement	
strategies to overcome barriers/ issues	capacity to participate in activities during the planning phase. Being transparent about the purpose of the EBSIs, providing adequate compensation for technical support, and involving partners during the planning and implementation phases can help improve engagement. Opportunities for partners to share feedback must also be established. Collaborative efforts that encourage interaction across disciplines can help partners overcome seemingly narrow grants and other funding barriers. Open avenues for funding that affect public health during emergency and non-emergency times can also help partners overcome siloed efforts (e.g., Justice40, EPA initiatives, etc.).
Technical assistance	The following types of technical assistance are needed: knowledge of community interests, participant recruitment, and social dynamics from community partners; diverse subject matter expertise from leaders and experts to guide the implementation of EBSIs and other activities; a robust staff that includes data analysis skills; and collaborative planning between all partners to translate community engagement EBSIs to sustainable solutions and future activities

Regional Priority Topic 2: Address misinformation and disinformation	
Partners	Public health authorities, health communicators, CBOs, groups who work with populations that are disproportionately likely to believe in or be impacted by mis/disinformation, and actors who are already implementing activities to address mis/disinformation.
Roles and responsibilities	Public health authorities and health communicators can identify training needs, coordinate training logistics, provide lessons learned from their experiences with mis/disinformation and incorporate EBSIs for health-related misinformation, and implement actions gleaned through these activities. They should partner with CBOs, groups who work with populations that are disproportionately likely to believe in or be impacted by mis/disinformation, and actors who are already implementing activities to address mis/disinformation, as these groups have established relationships with constituents. All partners have limited time and resources at their disposal, which may constrain their participation. Partners can help measure the effectiveness of the trainings by providing feedback through pre- and post-training assessments.
Resources needed to implement objectives	Administrative: Coordination effort for managing logistics, scheduling, and implementation, as well as liaising between partners. Financial: Funding to support activity implementation and provide incentives for partners to be a part of this work during all phases of disasters. Technical support: Implementation staff, trainers.
Resources available through partners	Spaces for convening trainings; logistical support; technical inputs; sponsorship; knowledge of community norms, practices, and beliefs; and existing networks of trusted messengers.
Potential barriers/issues that may be encountered	Cognitive biases and preexisting sociocultural beliefs/norms limit the extent to which people are receptive to efforts that counter mis/disinformation. Partners may exhibit a lack of engagement because they are stretched thin with other responsibilities or are unwilling to engage communities on polarizing rumors and beliefs, among other reasons.
Potential strategies to overcome barriers/ issues	Communicators can address mis/disinformation strategically (e.g., through moral reframing, leveraging cognitive biases) and minimize trainees' resistance to efforts that counter mis/disinformation. Partners can focus their efforts on building trust and filling information voids to avoid aggravating audiences, and could be provided with incentives and supportive resources to participate in activities under this objective.
Technical assistance	The following types of technical assistance are needed: knowledge of community interests; understanding of rumors that are common in specific populations and areas; designing trainings and materials to address mis/disinformation.

Regional Priority Topic 3: Building trust between public health and the public	
Partners	Local public health authorities, practitioners, academia/subject matter experts, CBOs, faith-based

Regional Priority Topic 3: Building trust between public health and the public	
	and spiritual organizations, trusted messengers, the media at-large.
Roles and responsibilities	Local public health authorities and practitioners can help implement EBSI-based trust-building activities and strategies to become a more trustworthy presence in their communities. Academics and subject matter experts can provide guidance on how to engage communities, strengthen public trust, and work with secondary messengers in an evidence-informed manner. CBOs, faith-based and spiritual organizations, and trusted messengers, who have existing and trusted relationships with specific populations, will provide technical expertise and be active partners in or implementers of trust-building activities. Media partners can help position public health officials as trusted experts in health-related matters by giving them a platform/screen-time in non-emergency times (so that they are not only in front of the cameras when something bad is occurring).
Resources needed to implement objectives	Administrative: Coordination effort for logistics, implementation, and liaising between partners. Financial: Funding to support activity implementation and provide incentives for partners to be a part of this work during all phases of disasters. Technical support: Implementation staff, trainers.
Resources available through partners	Spaces for convening people for trust-building activities; social capital and existing relationships with specific populations; logistical support; and technical inputs.
Potential barriers/issues that may be encountered	Many vulnerable and marginalized populations have fraught histories with public health and medical institutions, which may limit the effectiveness of trust-building activities. Health departments are also chronically understaffed and have limited time and resources to dedicate to trust-building activities, which require long-term commitment, consistent community engagement, and sharing decision-making with constituents and community members.
Potential strategies to overcome barriers/ issues	Public health authorities will need to cultivate meaningful, intentional, consistent, and long-term connections with local communities and historically oppressed population. This includes direct, in-person engagement in local communities (ie, meeting community partners where they are). Cultural respect, humility, and empathy are integral to building trust through these activities and strategies. They will also need more resources to implement trust-building activities and personnel with strong health communication skills. Public health authorities also need to provide opportunities for the public to share feedback on existing processes and to participate in trainings and exercises.
Technical assistance	The following types of technical assistance are needed: population-specific community engagement strategies and diverse subject matter expertise from community leaders.

Focus Area 2: Coordination Across Agencies, Community Organizations, and Systems

Regional Priority Topic 1: Facilitating a multidisciplinary response - coordinated community resilience-building	
Partners	Public health authorities, healthcare institutions, emergency management agencies, the private sector, CBOs, healthcare coalitions, Emergency Medical Services (EMS) clinicians and non-traditional public health responders, and Veterinary Medical Assistance Teams (VMAT).
Roles and responsibilities	All partners need to identify their preparedness and response goals, establish shared priorities with other stakeholders to enable collective planning around disaster resilience and implementation of EBSI-based preparedness and response initiatives, and work with multisectoral organizations (and each other) to devise collaborative efforts. Public health authorities are responsible for clearly communicating rollout efforts, including what is required from state actors and local entities, in a coordinated community response, to ensure that partners are not limited in their work during an emergency. Partners are responsible for coordinating behavioral mental health assets for community members experiencing disasters (care often takes place among a

Regional Priority Topic 1: Facilitating a multidisciplinary response - coordinated community resilience-building	
	network of small providers rather than larger hospital systems).
Resources needed to implement objectives	Administrative: Effort for liaising between partners, managing collaborations and partners, facilitating collective planning, coordinating logistics, and more capacity to do inventory management (e.g., stockpile PPE). Financial: Financial incentives to promote collective planning and additional funding to compensate partners for implementing collaborative initiatives. Technical support: Group facilitation, partnership development, and consortium-building skills.
Resources available through partners	Existing public health preparedness and response initiatives, service provision networks, network of partners and collaborators (e.g., leveraging transportation, commercial kitchen, housing shelter, etc. resources available through the faith community), operational procedures/expertise, and technical expertise. Using these resources to create a repository of ideas that is searchable and accessible to all partners.
Potential barriers/issues that may be encountered	During public health emergencies, the locus of control often shifts away from public health agencies, which complicates collective understanding of who is responsible for specific disaster response actions. Organizations that are used to implementing operations their own way may struggle to share decision-making power, work outside of their stated scope, alter strategies, and adopt new ways of working multisectorally. There is often also a lack of access to private sector resources that, if leveraged, could support partners (particularly the government) when a disaster occurs.
Potential strategies to overcome barriers/ issues	Collaborators should first identify roles and responsibilities during public health emergencies and ensure that all partners are apprised of operational procedures. During the beginning stages of collective planning, all partners should identify shared priorities, develop shared norms to guide their collaborations, and communicate transparently and realistically about what does or does not work for them. This includes identifying private sector partners who are able and willing to provide support when it is needed at the community and/or state level. This requires an increase in information sharing across sectors. The Metropolitan Washington Council of Governments' regional collaboration, for example, expands private-public partnerships to increase collaboration amongst Emergency Support Functions (ESFs), and could be used to inspire similar opportunities in Region 3 resilience planning. . Listening and working through solutions that actively address the concerns raised by partners is essential to successful collaboration.
Technical assistance	The following types of technical assistance are needed: public health and emergency management operations expertise; knowledge of information management, coordination, and communication systems used by all partners; knowledge of collective planning and collaborative approaches that have worked well for partners in the past.

Regional Priority Topic 2: Improve integration between public health and healthcare	
Partners	Public health authorities, healthcare institutions (including primary care providers), non-traditional healthcare settings (including jails and prisons), healthcare coalitions, EMS clinicians and non-traditional public health responders, federal partners, CMS, insurers, CBOs, policymakers, advocacy groups, service providers.
Roles and responsibilities	Partners' roles and responsibility depend on the type of integration activities they choose to pursue. First, all partners must identify which systems and operations would benefit from integration (e.g., biosurveillance (to include primary care provider records), electronic health records, sharing health data, closed loop referrals during emergencies, service provision) and establish official partnerships, agreements, and MoUs with each other. CBOs and advocacy groups must represent and elevate constituent interests within the CoP and during the high-level tabletop exercise.. Policymakers could work to remove barriers to and enables integration. All partners should work with policymakers to ensure that integration needs guide federal, state, and local policy development.
Resources needed	Administrative: Coordinators for liaising between partners.

Regional Priority Topic 2: Improve integration between public health and healthcare	
to implement objectives	Financial: Financial incentives to promote integration, additional funding to compensate partners for implementing EBSIs and other collaborative initiatives, and budget line items to support policy changes. Technical support: System dynamics/network analysis, partnership development, and policy analysis research support.
Resources available through partners	Existing EBSIs, initiatives and activities that partners have experience implementing, policymakers' expertise with developing policies, integrated data systems, regional health information exchange platforms like CRISP, history of working with insurers and electronic health record managers (e.g., Epic), and existing exemplary practices (e.g., community health worker programs, use of 1115 Medicaid waivers).
Potential barriers/issues that may be encountered	Payment reform, data interoperability, workforce reform, and other transformative actions needed for effective integration can require broad-sweeping changes in federal policies and corporate interests, which is difficult for Region 3 to achieve on its own. Changing policies depends on influence, social capital, political will, and other factors that are difficult to work on in a cost effective and time-bound manner. Integration activities may require some partners to work outside of their mandate or current scope, which can be difficult because CBOs and public health authorities are often underfunded and stretched thin by other commitments.
Potential strategies to overcome barriers/ issues	Partners can identify integration strategies that are easier to achieve in the short term, with limited funding, and pose minimal burden on collaborators. They can depend on policy analysts and experts who have a strong understanding of the current policy landscape and can guide collaborators on how to influence policymaking strategically. Integration requires dedicated long-term funding, so requests for integrated activities could come with dedicated budget line items, federal funding, or restructuring how organizations manage their financial resources.
Technical assistance	The following types of technical assistance are needed: Policy analysis, partnership development, consortium-building, data interoperability, organization-specific payment and data systems, service provision network analysis, and working with policymakers to inform policy development.

Regional Priority Topic 3: Improve public health operational preparedness and regional collaboration and coordination	
Partners	STLT leaders, public health authorities, health departments, hospital systems, specialty centers (e.g., trauma, neonatal, burn, etc.), healthcare coalitions, federal partners, and emergency management agencies.
Roles and responsibilities	All partners should be transparent and cooperative in identifying gaps and needs of their internal operational readiness, preparedness, and response processes with the CoP and during the tabletop exercise. They should contribute their expertise to develop shared goals around operational preparedness, harmonize preparedness and response systems where possible, and formalize coordination systems using partnership agreements, MoUs, contracts, and/or coalitions and consortia.
Resources needed to implement objectives	Administrative: Coordinators for liaising between partners, providing logistical support for activities, managing contracts/agreements, and project management support for implementing tabletop exercises. Financial: Budget line items to ensure long-term operational outcomes, funding to acquire resources needed for tabletop exercises. Technical support: Public health emergency preparedness and response operations, experience with designing and implementing tabletop exercises. FEMA's Ebola Virus Disease Regional Network Coordination Table Top Exercise, for example, could be leveraged as a possible scenario for consideration for public health preparedness multi-jurisdictional exercises.
Resources available through partners	Existing networks and partnerships with regional partners, current operational policies, access to transportation, and spaces for convening meetings.
Potential	Partners have established their own operational procedures depending on what works for them,

Regional Priority Topic 3: Improve public health operational preparedness and regional collaboration and coordination	
barriers/issues that may be encountered	so they may not be open to adapting their operations or adapting to other partners' systems and needs. Many public health partners are stretched thin and under resourced, especially during disasters and emergencies, so they may not have enough personnel, time, and financial resources to dedicate towards regional collaboration and coordination. Additionally, during tabletop exercise, participants may feel pressured to share what they ought to do and not what they actually do during emergencies. Partners may also face barriers, such as time and access to transportation, to participating in such exercises.
Potential strategies to overcome barriers/ issues	Partners need to identify where their operations overlap, which existing processes may benefit from collaboration and coordination with others, and unite around shared priorities around operational preparedness. They could identify how operations are expected to change during emergencies, so that public health authorities are ready to pivot their resources when a disaster strikes. Social desirability bias during tabletop exercises can be reduced by creating injects strategically (e.g., asking detailed questions about each step of decision-making, collaboration, and coordination with other agencies). A clear objective should be articulated (e.g., finding and addressing gaps and problems) prior to the tabletop exercise. The PHEPR Center could help establish and facilitate communities of practice across the region that enable recurring face to face meetings between partners to encourage the development of actionable solutions and strategies, and information/resource sharing In doing so, the PHEPR Center should work to convene new partners that are diverse in thought, experience and representation. Costs/barriers (time, transportation, etc.) to participating in tabletop exercises and other face to face meetings should be communicated explicitly. The PHEPR Center and its partners may consider leveraging existing partnerships, such as the partnership between Native American LifeLines and Uber to get clients to events, to increase accessibility.
Technical assistance	The following types of technical assistance are needed: understanding operational policies of relevant partners and their networks of influence.

Focus Area 3: Workforce Recruitment, Retention, and Competencies Growth

Regional Priority Topic 1: Address workforce crisis and long-term sustainability of workforce	
Partners	State and local health departments, healthcare facilities, healthcare coalitions, academic institutions, subject matter experts (including mental health professionals), Work Release Programs/Centers, workforce development organizations, and population-specific CBOs.
Roles and responsibilities	State and local health departments, healthcare coalitions, and health facilities are responsible for bringing their organizational knowledge, human resources departments, personnel, and management teams together to explore ways to implement EBSIs to improve recruitment and retention. Academic institutions and subject matter experts should provide technical assistance with workforce development and human resources management, especially best practices in recruitment, retention, and economic empowerment. Work Release Programs/Centers should provide guidance on how to incorporate Justice Involved and Justice Impacted populations into the PHEPR workforce, particularly when emergencies occur and there is a shortage of human resources. Population-specific CBOs should guide health departments and facilities in implementing EBSI-related activities in pilot communities, and on ways to improve recruitment and retention of populations that are underrepresented in the workforce.
Resources needed to implement objectives	Administrative: Champions in health departments and health facilities to encourage organizational policy reform and liaise with human resources and senior management, as well as project management support for implementing EBSI-related activities. Financial: Flexible funding to hire staff quickly, provide incentives for retaining workers during a shortage or when surge support is needed, offer professionalization and upskilling opportunities, and providing incentives to recruit personnel, especially from underrepresented and socially

Regional Priority Topic 1: Address workforce crisis and long-term sustainability of workforce	
	vulnerable groups. Technical support: Guidance on changing institutional policies, subject matter expertise to understand factors driving workforce shortages regionally, and subject matter expertise on recruitment and retention best practices.
Resources available through partners	Current workforce, existing human resources policies, human resources personnel.
Potential barriers/issues that may be encountered	Improving workforce recruitment and retention may need structural reform to occur, like improving labor laws, requiring institutions to prioritize the wellbeing of employees, changing how and how much personnel are paid for their work, reforming medical education, and providing long-term pathways and pipelines for underrepresented and focus populations to enter the workforce.
Potential strategies to overcome barriers/ issues	Partners can pursue state-level policy reform for more structural-level barriers to workforce recruitment and retention. They can work with public health and medical education programs – as well as other capacity-building and professional initiatives – to improve inclusion of underrepresented and socially vulnerable groups in the workforce.
Technical assistance	The following types of technical assistance are needed: understanding employers' human resources policies, subject matter expertise on workforce development.

Regional Priority Topic 2: Address burnout and mental health burdens for public health workforce	
Partners	Public health agencies, health departments, healthcare institutions, healthcare coalitions, subject matter experts, unions, mental health advocacy groups and CBOs, and mental health service providers.
Roles and responsibilities	Public health agencies, health departments, and healthcare institutions are responsible for improving working conditions for their personnel. They must identify human resources managers, senior management, supervisors, and other personnel that will participate in EBSI-related trainings and activities under this objective. Subject matter experts, unions, advocacy groups, healthcare coalitions, and mental health service providers should support workplaces with improving their work environment, providing guidance on ways to reduce burnout, and implementing interventions (e.g., psychological first aid). Mental health service providers may have the added responsibility of providing personnel with referral services they need to improve stress management and minimize mental health burdens. Prior to an emergency, partners should establish a clear leader or coordinating body that is responsible for leading behavioral health services for the public health workforce/responders when a disaster strikes. This includes coordinating behavioral mental health assets (which often takes place within small provider networks rather than large hospital systems).
Resources needed to implement objectives	Administrative: Coordinators for liaising with human resources and senior management, as well as project management support for implementing activities. Financial: Remuneration for clinicians/mental health service providers and trainers, incentives to workplaces or personnel for participating in trainings and activities. Technical support: Support for implementing trainings and activities under this objective, subject matter expertise on trauma-informed programming.
Resources available through partners	Current workforce, existing human resources policies, human resources personnel, mental health services, referral services, psychological first aid programming.
Potential barriers/issues that may be encountered	Workforce burnout and mental health burdens can be affected by more than just workplace conditions. For example, experiences with structural oppression (e.g., racism, sexism, ableism), socioeconomic status, regional susceptibility to frequent hazards (e.g., coastal storms, winter storms, terror threats), and political instability could contribute to the mental health burdens that employees experience. This could limit the effectiveness of workplace-focused interventions.
Potential strategies to	The PHPR Center can work with partners to prioritize achievable, time-bound interventions that workplaces can implement to focus first on improving burnout and mental health burdens among

Regional Priority Topic 2: Address burnout and mental health burdens for public health workforce	
overcome barriers/ issues	the public health workforce, and then explore activities that build workforce's resilience to structural threats and challenges.
Technical assistance	The following types of technical assistance are needed: understanding employers' human resources policies, subject matter expertise on psychological first aid and trauma-informed policies and interventions.

Regional Priority Topic 3: Improving public health workforce capacity and willingness to respond (surge staffing capacity)	
Partners	Health departments, healthcare institutions, healthcare coalitions, and training/capacity-building organizations.
Roles and responsibilities	Health departments and healthcare institutions are responsible for creating conditions that support surge staffing during emergencies. They should improve the public health workforce's capacity to respond to disasters by training them on necessary skills, strengthening competencies, and creating an enabling environment for mobilizing public health personnel during times of crisis. Healthcare coalitions can help coordinate implementation among partners. Partners should seek to expand surge staffing capacity by using local human resources rather than using external human resources (Psychological First Aid can be used as a tool to assist surge staffing capacity in the community).
Resources needed to implement objectives	Administrative: Project management support for implementing activities. Financial: Remuneration for trainers, incentives for surge staff and emergency responders, incentives for personnel who are willing to respond during times of crisis, and funding for public health personnel to proactively build their capacities and competencies. Technical support: Trainers, support for implementing capacity-building interventions.
Resources available through partners	Spaces for convening, personnel, trainers, surge staffing policies, and potentially emergency funding that is available during public health emergencies.
Potential barriers/issues that may be encountered	High turnover among public health and healthcare personnel (e.g., health department employees, nurses) may impact whether the benefits of training personnel persist within institutions. Workforce shortages and demands of workers' time means that employees are already stretched thin, so they may be unavailable to participate in trainings. Compensation levels are also barrier for most response roles and contribute to a loss of talent to the private sector.
Potential strategies to overcome barriers/ issues	Personnel could receive remuneration or other incentives to promote their participation in trainings and to boost their willingness to work during emergencies. Employers could modify retention policies to ensure that personnel who participate in trainings choose to remain in their workplace instead of opting for other professional opportunities.
Technical assistance	The following types of technical assistance are needed: developing skill building trainings, improving surge staffing policies.

Section 3. General Questions

1. Within the HHS region, which organizations or groups, if any, currently support activities in the focus area of interest?

This workplan for Region 3 was developed in collaboration with a Regional Coordinating Body (RCB), comprising diverse partners (e.g., organizations, groups, and leaders) who support activities in the focus areas of interest, in addition to other focus areas relevant to public health emergency preparedness and response in Region 3.

Composition: The RCB includes 31 members, as well as 4 designees who represent specific members when they are unable to attend a meeting. RCB members represent 6 Region 3 states and districts, namely Delaware (4 members), Maryland (8), Pennsylvania (3), Virginia (5), Washington DC (2), and West Virginia (7). Two members represent Region 3 at large. Members represent multiple domains of expertise, such as communication, corrections/ incarceration, economy, education, emergency management, environmental health, equity, food and water, healthcare, housing and homeless populations, implementation science, indigenous health, 2SLGBTQ+ people, nurturing and care, public health, substance use, transportation, vulnerable populations, and wellbeing. The RCB is comprised of health department officials, city officials, coalitions, community-based organizations, faith-based and spiritual organizations, emergency management representatives, healthcare institutions, medical professionals, public health representatives, and subject matter experts.

Recruitment strategy: JHUCHS used COPEWELL domains to ensure that recruitment approaches were grounded in a coordinated community response and resilience framework. The team set recruitment goals to ensure the RCB was representative of Region 3 and included expertise from important PHEPR domains, threats, and hazards that the RCB will need to consider. JHUCHS developed an extensive list of potential RCB candidates using recruitment goals, steering committee inputs, and internal subject matter expertise. An initial round of invites went out to a subset of potential invitees to solicit interest. Depending on their response, JHUCHS used a snowball sampling approach to send subsequent invitations to specific individuals to fill specific gaps. This approach leveraged the relationships of those RCB members who had committed to participate early in the invitation process to identify specific colleagues who may have backgrounds or expertise in different topics or areas within Region 3. JHUCHS regularly evaluated RCB composition as each new member was added to ensure alignment with pre-identified diversity needs and recruitment goals.

2. Who participated in the development of the objectives? Please refer to the Statement of Work: Task 2 for potential list of members and complete the table below.

RCB Member Type	Affiliation	Location	Area(s) of Expertise
Public health representative	Pennsylvania Department of Health	Pennsylvania	Public health, communication
Public health rep (Designee)	Pennsylvania Department of Health	Pennsylvania	Public health
Researcher	Center for Drug and Health Studies, University of Delaware	Delaware	Substance use, vulnerable populations
City official	City of Philadelphia	Pennsylvania	Pediatrics, equity, vulnerable populations, public health
City official	Baltimore City Fire Department	Maryland	Communication, emergency response
Indigenous Health service	Native American LifeLines	Maryland	Indigenous health, public health

RCB Member Type	Affiliation	Location	Area(s) of Expertise
provider			
Public health representative	Maryland Department of Health	Maryland	Public health
Emergency management agency representative	Maryland Department of Emergency Management	Maryland	Emergency management
Medical professional	Johns Hopkins Bloomberg School of Public Health	Maryland	Mental health, wellbeing
Emergency management agency representative	Delaware Department of Health and Social Services	Delaware	Emergency management, public health
Local public health representative	Cabell-Huntington West Virginia Health Department	West Virginia	Public health, substance use, healthcare
Healthcare coalition representative	West Virginia Healthcare Coalition North Reg 6/7	West Virginia	Healthcare
Public health representative	Virginia Department of Emergency Management	Virginia	Emergency management, public health
Public health representative	West Virginia Department of Health and Human Resources	West Virginia	Public health
Community organization representative	Partnership of African American Churches	West Virginia	Vulnerable populations, equity, wellbeing
Long term care/ nursing home director	Virginia Center for Assisted Living	Virginia	Healthcare, nurturing and care
Primary care representative	DC Primary Care Association	Washington, DC	Healthcare, vulnerable populations
Transportation official	Virginia Department of Health	Virginia	Transportation, emergency management
Local housing and community development expert	REACH Initiative and West Virginia Reentry Councils	West Virginia	Housing, homelessness, corrections, incarceration, substance use
Indigenous health expert	Johns Hopkins Center for Indigenous Health	Maryland	Indigenous health
Public health representative	State of Delaware	Delaware	Vulnerable populations, public health
Emergency management agency representative	Virginia Department of Emergency Management	Virginia	Emergency management
Corrections/incarceration expert	Falcon Correctional and Community Services, Inc.	Maryland	Corrections, incarceration, wellbeing, vulnerable populations
Health economist	Greenbrier County Commission; National Association of Counties	West Virginia	Emergency management, economy, substance use
Public health rep (Designee)	West Virginia School of Osteopathic Medicine	West Virginia	Emergency management, economy, substance use
Public health rep (Designee)	West Virginia School of Osteopathic Medicine	West Virginia	Emergency management, economy, substance use
Hospital system representative	University of Maryland Medical System	Maryland	Healthcare, emergency management, public health
Public health representative	DC Health and Medical Coalition	Washington, DC	Vulnerable populations, public health, healthcare
Public health rep (Designee)	Office of Health Equity at the District of Columbia Department of Health	Washington, DC	Vulnerable populations, public health, healthcare
Food security expert	Kennett Area Community Service	Pennsylvania	Food and water, housing, homelessness

RCB Member Type	Affiliation	Location	Area(s) of Expertise
Public health representative	CDC; assigned to Office of the Deputy Secretary for Public Health Services, Maryland Department of Health	Maryland	Public health
Public health representative	Office of Epidemiology, Virginia Department of Health	Virginia	Public health
Public health representative	CDC; Assigned to Delaware	Delaware	Public health
Emergency management agency representative	FEMA	Region 3	Emergency management, public health
Region 3 federal representative	DHHS	Region 3	Emergency management, public health

3. How will progress towards achieving the objectives be monitored and evaluated?

Based on the defined objectives, workplan implementers should identify and establish key performance indicators (KPIs) to measure progress toward and success of those objectives. JHUCHS recommends following Kirkpatrick's evaluation framework to assess reaction, satisfaction, knowledge, behavior change, outcomes change, etc.[i]

KPIs should be identified at the start of a collaboration and iteratively reviewed throughout the implementation process. KPIs can include metrics related to organizational objectives. For example, if the objective is to improve community and partner engagement in Region 3, the following are some KPIs that implementers can use:

- Percent satisfaction of community group leaders and partners with engagement
- Increased knowledge of community members and partners about PHPR gaps and EBSIs (via pre- and post-surveys)
- Number of community groups engaged per year
- Number of participants in community meetings with facilitated discussion

Workplan implementers should conduct regular process monitoring to ensure that activities are implemented as expected. They should also conduct regular performance reviews to assess progress towards organizational objectives, including measures and methods of assessment for objectives such as ones included for each focus area's objectives in

Section 1: Focus Area, Priorities, and Multi-Year Objectives. Data collected in performance management systems can be analyzed to identify trends, strengths, areas for improvement, opportunities for improving implementation, and opportunities for innovation. The PHPR Center should prioritize continuous improvement based on performance data and feedback. This may involve adjusting strategies and resources and addressing challenges proactively.

Implementers should work closely with CDC project officers and others to develop an evaluation plan that balances the need for timely and rigorous evaluation data with the constraints of data collection policies, including the Paperwork Reduction Act (PRA). Implementers should generate reports to communicate findings to key partners and CDC.

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[i] Kirkpatrick JD, Kirkpatrick WK. Kirkpatrick's four levels of training evaluation. Association for Talent Development; 2016 Oct 1.