Five-Year Regional Workplan Report

Prepared by the Region 2 Center for Public Health Preparedness and Response (R2C)

Preparedness & Recovery Institute

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Executive Summary

The purpose of this document is to outline the Five Year Regional Work plan for the HHS Region 2 Center for Public Health Preparedness and Response (R2C). The work plan was developed jointly by the NYC Preparedness & Recovery Institute (PRI), City University of New York Graduate School of Public Health & Health Policy, Rutgers School of Public Health, the Regional Coordinating Body, the Regional Steering Committee, and our cooperative agreement partners at the Centers for Disease Control and Prevention (CDC). For the purposes of this document, we will refer to the annual cycles of the Cooperative Agreement with CDC (Year 1 October 2024-September 2025, Year 2 October 2025-September 2026, etc). For the purposes of this document, the term "jurisdiction" refers to New York State, New York City, New Jersey State, Puerto Rico, the US Virgin Islands.

Based on feedback from local voices, including regional leaders on our Regional Coordinating Body (RCB), R2C's plan focuses on enhancing local and hyperlocal Public Health Emergency Preparedness and Response (PHEPR) capacity across the region - and systematically evaluating those enhancements. These local capacity enhancements will focus on increasing the effectiveness and flexibility of the "traditional" public health workforce, building the capacity of nonprofit/coalitional emergency partners across the region, and creating new forms of hyperlocal surge. Overall, the goal of the workplan is to create a resilient Region 2 where public health systems and communities are prepared for, can respond to, and recover from emergencies using evidence-based strategies and practices.

In the upcoming year, Year 2 (October 2025-September 2026), we plan to prioritize the implementation of Objectives 1.1, 2.1 and 3.1.

Objective 1.1: Establish a Cross-Regional PHEPR Surge Capacity
By September 30, 2026, increase regional surge capacity, defined as the ability to triage and address missions during public health emergencies, by credentialing and rostering at least 60 public health professionals into multiple surge teams based around Mission Ready Packages (MRPs) for Emergency Operations Coordination and Environmental Health Assessment registered in the Emergency Management Assistance Compact (EMAC) which can be deployed throughout R2 and beyond.

Objective 1.2: Build a Regional EMAC Concept of Operations (ConOps) for Public Health Teams
By September 30, 2027, increase regional surge capacity, defined as the ability to supportively deploy teams across jurisdictions, by establishing and implementing a Regional Concept of Operations (ConOps) designed to improve the ability of jurisdictions/localities within the region to deploy, request, and receive public health teams in a public health emergency.

Objective 2.1: Build Strong Coalition of Organizations Active in Disasters (COADs)
By September 2027, enhance the community preparedness capability, defined as the community's ability to share emergency information among its members, of approximately 10 communities through the creation of a Concept of Operations (ConOPs) for COADs (i.e., coalitions of local community organizations) to implement a system- and organizational-level strategy to share emergency preparedness information via door-to-door canvassing among community residents.

This will involve the creation of a Community of Practice among COADs to guide the creation and implementation of this ConOps and a mini-data system to facilitate the collection of process and outcome indicators to implement the ConOps. This objective will start with approximately 5 COADs implementing and exercising the capability by September 2026.

Objective 3.1: Develop High School Surge teams
By September 2026, enhance the capability of high schools to respond to public health emergencies, defined as the ability to have staff and students followed needed mitigation measures, by establishing 5 high school-based surge teams across Region 2 built on the nationally recognized Teen CERT and Junior MRC programs, evaluated by and engaged in at least 2 school- or community-based emergency preparedness exercises annually, including a hyperlocal intervention within each high school to improve uptake of seasonal influenza mitigation measures.

Training will focus on community preparedness for pandemics, epidemiology and surveillance, and nonpharmaceutical interventions for infection control, as determined by each high school chapter. Approximately eighteen months after the initiation of the pilot, efforts will be evaluated through annual school absenteeism or vaccination data during flu season and rates of influenza mitigation efforts at the school level.

These four priorities have emerged through discussions with the Steering Committee and our CDC colleagues as well positioned for implementation and evaluation in Year 2. Some elements of these descriptions may occur after September 2026 based on implementation design.

Through our outreach and collaborative decision making, R2C has broad support and partnership for each of these efforts. We look forward to working collaboratively with CDC throughout this process.

HHS Region Number	Region 2 (New York, New York City, New Jersey, Puerto Rico, and the US Virgin Islands)	
Funded Institution:	The Trustees of Columbia University	
Point of Contact	Mitch Stripling	
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Focus Area 1: Workforce

Objective 1.1: Establishing Cross-Regional PHEPR Surge Teams

Objective 1.1: By September 30, 2027, increase regional surge capacity, defined as the ability to triage and address missions during public health emergencies, by credentialing and rostering at least 60 public health professionals into multiple surge teams based around Mission Ready Packages (MRPs) for Emergency Operations Coordination and Environmental Health Assessment registered in the Emergency Management Assistance Compact (EMAC) which can be deployed throughout R2 and beyond.

Background: Jurisdictions across Region 2 have consistently been faced with public health emergencies that require effective coordination, leadership, and incident management. In many cases, emergency response efforts have necessitated the rapid mobilization and deployment of public health/health department personnel from other parts of the region or beyond. These personnel often have to assume leadership and emergency management roles that are outside of the scope of their traditional job functions.[1,2] Although incident management roles are vital to disaster response, inconsistent experience, limited standardized training, and gaps in familiarity with both Incident Management and broader PHEPR capabilities among traditional public health personnel can lead to disjointed emergency operations and surge efforts.[1] This, in turn, heightens the risk of responder burnout when time and resources during emergencies are already scarce. EMAC as a system is designed to address these issues via support between jurisdictions; however, EMAC has limited public health MRPs and little support designed intentionally for PHEPR related missions. Jurisdictions and localities in Region 2 vary widely in their ability to use EMAC or to field relevant teams quickly. During recent incidents (e.g., Maria, Helene), even a jurisdiction as resource rich as New York took a minimum time of two weeks to fulfill a public health EMAC request - well outside the critical time of need.

To fill these gaps, the R2C aims to enhance emergency operations and workforce capacity across Region 2 through two interlinked interventions, this objective (1.1) and the following (1.2). In this objective (**Public Health Team Creation)**, R2C will roster, train, equip and formalize via official planning documents at least four regionally shared public health surge teams supported by a cross-regional, multi-disciplinary roster of at least 60 public health professionals across Region 2 jurisdictions, with all teams established as Mission Ready Packages (MRPs) within the Emergency Management Assistance Compact (EMAC). Based on RCB feedback, these teams will initially focus on Environmental Health and EOC Coordination capability support needs and will be evaluated via functional exercise on their ability to fulfill these capabilities based on existing plans across the region.

This objective only focuses on building the teams themselves as a capacity enhancement. The ***following objective***, 1.2, (Regional EMAC ConOps) will enhance regional jurisdictions' ability to request, receive and deploy these teams.

Both objectives seek to enhance regional capability for inter- and intra-jurisdictional surge support. There have been several instances where Region 2 jurisdictions have benefited from cross-state surge deployment of medical and emergency responder personnel (e.g. during hurricanes Irma and Maria in the

U.S. Virgin Islands and Puerto Rico)[4], commonly through mutual aid agreements such as the Emergency Management Assistance Compact (EMAC). To extend such surge support to incident management-related functions, we aim to integrate into the Region 2 EMAC system by formalizing Mission Ready Packages (MRPs) that clearly define their capabilities, roles, and deployment procedures. Embedding the training and team structures into MRPs will ensure that personnel are pre-credentialed, pre-identified, and rapidly deployable across state and territorial lines in response to public health emergencies. This approach will formalize their participation in mutual aid systems, creating a structured, cross-jurisdictional surge system that enables cohorts of trained personnel to more effectively support EOCs or other public health emergency management functions when demand exceeds local workforce capacity.

This priority topic responds to a regional need to find ways for jurisdictions to support each other through better deployment systems, pre-prepared team structures, and the use of credentialed staff already employed within the public health system. The region is also interested in evidence-based performance criteria, with scenario-based drills organized jointly to apply and evaluate capabilities. Initial planning, training, and exercises will leverage existing course work as relevant and possible (such as CDC's Environmental Health Training in Emergency Response (EHTER)). Equipping prototype teams will ensure the program creates new capacity quickly, in time for the height of the 2026 hurricane season, while the creation of new Jurisdictional ConOps and team ownership commitments will ensure the sustainability of the effort.

Sources

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Implementation Timeframe

- State Date: 10/01/2025
- End Date: 09/31/2027

Activities

Activity 1: By November 2025, convene an Region 2 PH EMAC Advisory Group. (shared with 1.2)

This cross-regional group of 8-10 representatives will validate MRP priority areas, support the compilation of training/exercises materials, endorse EMAC integration efforts, and serve as deliverable reviewers (shared with 1.2). With this group, R2C will create specific conceptual frameworks for needed teams within the Environmental Health and EOC Coordination capabilities.

Activity 2: By February 2026, develop 2 prototype Mission Ready Packages
These will be co-developed with the Advisory Group, aligned with EMAC requirements, with accompanying recommended preparedness playbooks to guide their development, including staffing, training, equipping and exercising.

Activity 3: By May 2026, create and formalize four prototype teams
Through a regional survey, which will be filtered by experience and expertise, R2C will develop candidates, including a requirement that they be released by their home agency for training during certain periods of May through July. Teams will be registered with home jurisdiction's emergency management authority and with NEMA's EMAC program. This requires staff, equipment, a systemic commitment by each jurisdiction in good faith to deploy these teams if requested, and a housing agreement with the jurisdictional health authority to serve as the deploying agency for each team.

Activity 4: By July 2026, train, equip and ready four prototype teams
Guide the majority of pilot team personnel through team-based trainings hosted by the Center with travel provided by the Center. Existing training should be used as available and possible. Equipment for teams should be sourced via jurisdictional partners. Ready/On Call procedures for team notification will be created and institutionalized.

Activity 5: By September 2026, conduct team exercises (linked to jurisdictional exercises in 1.2)
These functional or full-scale exercises, integrated into existing jurisdictional exercises as possible, will test prototype pilot teams' abilities to perform the needed capabilities for the region for both EOC Coordination and Environmental Health MRPs.

Activity 6: By November 2026, create an evaluative report measuring the intervention
This will include creating an evaluation package to measure team activities, including quantitative measures of team activities and qualitative success indicators based on Key Informant Interviews (KIIs). Should measure the creation of the teams and the teams abilities themselves to meet the capabilities measured in exercises, including timeliness.

Example evaluation metrics may include–

- EMCA EOC and EHA MRPs adapted to R2 context and endorsed by XXXX.
- 4 prototype teams trained and increase knowledge by XX% from baseline (pre- post)
- Timeliness of response through exercise– Plan to establish targets, simulate the MRP activation to see if new MRPs can expedite that process. We will need to use existing SOPs for this so we can model out what baseline looks like and how MRPs expedite this process. ICAP has done time-motion assessments that may be suited for this.

Activity 7: By June 2027, systematize the ownership and creation of public health EMAC teams.
Through a series of "Train the Trainer" workshops, R2C will foster development of additional teams,

supporting the creation of separate ConOps for each team to be deployed regionally, with associated playbooks to guide development and maintenance of each team which include all necessary elements of an MRP. Each team will be housed and owned by a specific home agency, with R2C focused on tracking, supporting, training and exercising teams to enhance regional capability.

Activity 8: By September 2027, create a formal evaluation of the Public Health Team intervention. This will involve a regional survey of public health team capacity for deployment, including measures for each created team to be collected by the home jurisdiction.

	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
Activity 1	Dec 2025	Project Team	Convene an EMAC Advisory Group (shared with 1.2)	Not Started
Activity 2	Feb 2026	Project Team/AG	Develop 2 prototype Mission Ready Packages	Not Started
Activity 3	May 2026	Team/STLT partners	Create and formalize four prototype teams	Not Started
Activity 4	July 2026	Project Team	Train, equip, and ready four prototype teams (process evaluation completed)	Not Started
Activity 5	Sept 2026	Project Team	Conduct team exercises (linked to jurisdictional exercises in 1.2)	Not Started
Activity 6	Nov 2026	Project Team	Create an evaluative report measuring the intervention	Not Started
Activity 7	June 2027	Project Team/AG/STLT Partners	Systematize the ownership and creation of public health EMAC teams. (MRPs/Playbooks updated/Train-the-trainer documents disseminated; workshop documentation)	Not Started
Activity 8	Nov 2027	Project Team	Evaluation documentation	Not Started

Objective 1.2: Build a Regional EMAC Concept of Operations (ConOps) for Public Health Teams

Objective 1.2: By September 30, 2027, increase regional surge capacity, defined as the ability to supportively deploy teams across jurisdictions, by improving the ability of jurisdictions/localities within the region to deploy, request and receive public health teams during a window of need, defined as beginning work within 96 hours of request, through the creation, exercising and evaluation of a Regional ConOps agreed to by jurisdictions.

In Objective 1.1, the need and purpose for EMAC support between jurisdictions was delineated. **Public Health Surge Teams** were proposed to increase regional surge capacity for meeting public health needs.

However, jurisdictions within R2 struggle to successfully request, deploy and receive these teams, even (perhaps especially) during times of great need. The jurisdictions of New York City/State have often tried to provide surge support to other jurisdictions. After Hurricanes Maria/Irma, it took multiple weeks to deploy teams urgently requested by impacted areas (1). After the recent Hurricane Helene, requested resources were not able to be deployed at all, despite best efforts by multiple jurisdictions within Region 2.

Multiple case studies capturing lessons learned from EMAC emphasize the importance of systemic readiness to handle EMAC requests (2,3,4) including the creation of formal agreements to ready EMAC support (e.g., Concepts of Operations), and the building of systemic capability to handle EMAC requests. These include the ability of a jurisdiction to request an EMAC team, including understanding of the technological systems involved, approval pathway, and mission specification process. In addition, a jurisdiction must know how to efficiently receive an EMAC team once requested, including handling logistics, the creation of day-to-day mission assignments, and the integration of requested teams into local coordinating structures. Many times EMAC teams aren't deployed because requesting jurisdictions, often understaffed and facing disaster conditions, cannot effectively request or receive teams in a timely manner.

On the other side, many jurisdictions have shown difficulty deploying surge teams within the timeline of needs. One aspect of this, the creation of formal teams, is covered in Objective 1.1. But jurisdictions must also know how to connect their created MRPs to jurisdictional requests, gain rapid approval, and conduct the appropriate notification, equipping and travel logistics for these teams within a brief period.

This intervention will focus on the creation of a Concept of Operations for the deployment of public health teams for support within R2, to be created by health and emergency management agencies within the region and to include commitments to the supportive deployments of public health teams, including (but not limited to), teams created in Objective 1.1. This ConOps will include systemic best practices for each jurisdiction, which will be trained and exercised as enhanced capabilities for each jurisdiction's Emergency Operations Center (EOC) and its associated public health Departmental Emergency Operations Center (DEOC) and/or Health/Medical Emergency Support Function (ESF), depending on jurisdictional doctrine.

The ConOps will be institutionalized through ongoing exercises to ensure sustainable capability to deploy public health teams across the region.

Sources

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Implementation Timeframe

- State Date: 10/01/2026
- End Date: 09/31/2028

Activities

Activity 1: By November 2025, convene an advisory group (shared with 1.1)
The Group will advise on appropriate best practices and lessons learned for the initial draft of the regional Concept of Operations.

Activity 2: By March 2026, establish a baseline capability for regional deployment/receipt of EMAC PH teams
Based on existing literature, create a set of criteria for improvement of EMAC deployment and team receipt across jurisdictions. We will explore developing a similar framework for emergency response as the widely used 7-1-7 framework for early disease detection. We will conduct a baseline time-motion assessment to describe and assess process and duration spent on each process with jurisdictional/local emergency management and public health authorities.

Activity 3: By May 2026, draft a regional Concept of Operations for the Deployment of Public Health Teams for Regional Support (ConOps)
This will include relevant best practice guidance tied to the results of the capacity survey, and will include guidance for all phases of the EMAC process, including request, receipt, deployment, team management, team evaluation, handoff and demobilization.

Activity 4: By July 2026, hold 2-3 dissemination workshops
These workshops will explain the commitments required by the ConOps and provide criteria for the successful deployment of public health teams, including the prototype teams. Note that many of these criteria will not be susceptible to individual "training" as such as they require changes to internal jurisdictional procedures over time.

Activity 5: By September 2026, hold a functional exercise (linked with 1.1)
This exercise will test the ability of jurisdictions and selected localities to request, deploy and receive public health teams, including pilot teams, based on the ConOps.

Activity 6: By November 2026, create an evaluative report measuring jurisdictional/locality activities to request, deploy and receive public health teams, including pilot teams.
This will need to measure regional deployment activities, including quantitative measures of jurisdiction/local capabilities to deploy, request, and receive public health teams, including prototype teams.

Activity 7: By July 2027, exercise jurisdictions on the update ConOps
Based on evaluations, update, disseminate, and work with jurisdictions to execute the revised ConOps for the deployment of public health teams via EMAC. Hold a series of functional Public Health Team EMAC exercises with jurisdictional/local EOCs to systematize improvements in regional deployment.

Activity 8: By September 2027, create a formal evaluation of the Public Health EMAC intervention.
This should include the results of a regional survey of EMAC deployment, request and receipt capacity.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	Dec 2025	Project Team	Convene an advisory group (shared with 1.1)	Not Started
2	March 2026	Project Team/AG/STLT	Establish a baseline capability for regional deployment/receipt of EMAC PH teams	Not Started
3	May 2026	Team/AGs	Draft a regional Concept of Operations for the Deployment of Public Health Teams for Regional Support (ConOps)	Not Started
4	July 2026	Project Team	Hold 2-3 dissemination workshops	Not Started
5	Sept 2026	Project Team	Hold a functional exercise (linked with 1.1)	Not Started
6	Nov 2026	Project Team	Create an evaluative report measuring jurisdictional/locality activities to request, deploy and receive public health teams, including pilot teams.	Not Started
7	July 2027	Project Team/AG/STLT Partners	Exercise jurisdictions on the update ConOps	Not Started
8	Nov 2027	Project Team	Create a formal evaluation of the Public Health EMAC intervention.	Not Started

Objective 1.3: StudentSurge Program

Objective 1.3: By September 2028, strengthen regional PHEPR surge capacity, defined as the ability *within* a jurisdiction to support critical public health missions, by implementing StudentSurge via 5 SLTT/Academic partnerships, a program through which students (undergraduate, graduate, and medical) provide surge staffing, for health department and other public health/medical response roles, in both preparedness, response, and recovery efforts through a regional Academic-SLTT Concept of Operations.

Jurisdictions through R2 suffer from a lack of capacity to fulfill public health capabilities during response, recovery and preparedness. Meanwhile, students at multiple levels would like to assist, both from community spirit and a desire for professional development. PH students have also provided needed capacity in PHEs (e.g., contact tracing in COVID-19, shelter staff post-hurricane) [1,2] on an ad hoc basis, but no formalized method exists to enhance and evaluate this capacity more permanently.

StudentSurge would create a systematic and reliable resource for health departments to utilize students as surge capacity to increase public health emergency response system capacity, as well as producing a pipeline of MPH graduates trained for public health emergency preparedness and response roles. The track will involve mentored field experiences toward key preparedness/recovery goals, as well as emergency response and surge integration into defined roles.

R2C would work with a coalition of regional academic institutions, in partnership with local and state health departments, to develop the operational requirements and agreements for this program. Academic-health department partnerships are increasingly being recognized as an emerging and effective strategy to strengthen public health education, practice, and health equity [with many mutual benefits][4], and have been shown to be highly useful during past public health emergencies (e.g. partnership between the Washington DOH and the University of Washington Alliance for Pandemic Preparedness during the COVID-19 pandemic).[3] Building on models such as the City University of New York (CUNY) Urban Health Fellows, the Washington State SEAL program, and the Mt. Sinai Preparedness Residency the present objective will bring together participating institutions and public health agencies to create a specific Concept of Operations which can be implemented by partners across the region. This ConOps will include specific roles for which STLTs agree to utilize students, agreed on capacities students must bring to those roles, and deployment considerations, including potential stipends and allowed time off from education during emergency deployments.

StudentSurge will be piloted and evaluated with willing STLTs via core R2C institutions, then expanded into a regional ConOps integrating all major academic institutions.

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9. Student Epidemic Action Leaders (SEAL) Team | Department of Epidemiology

Implementation Timeframe

- State Date: 10/01/2026
- End Date: 09/31/2028

Activities

Activity 1: Partner Engagement
Convene an initial workgroup of academic institutions, local/state health departments, and emergency preparedness coalitions to co-design program goals.

Activity 2: Concept of Operations Development
Draft program framework (eligibility, training modules, deployment process, and recognition/incentives), including specific surge roles that can be served by undergraduate, graduate and medical students within the public health and medical response enterprise. Assess liability, credentialing, and data-sharing requirements for student deployment. Develop initial Concept of Operations to be agreed on by pairs of academic institutions and public health agencies. This should include needed curriculum based on current models, as applicable. (ICS, epidemiology basics, PPE use, risk communication).

Activity 3: Pilot Site Selection:

Identify 2–3 universities and partner health departments to agree to the ConOps and serve as initial demonstration sites.

Activity 4: Execute Initial Pilot
In each pilot site, choose a small cohort of students, direct them to appropriate training, create an initial roster, and place them into preparedness activities in agreed on roles for partner jurisdictions.

Activity 5: Exercise Integration
Involve trained students in tabletop and functional exercises in partner jurisdictions to test readiness. Evaluate cohort readiness as a systemic capacity enhancement; evaluate public health agency readiness to receive and assign students to mission.

Activity 6: Evaluation
Gather feedback from students and health departments on feasibility, skills gained, and deployment protocols.

Activity 7: Formalize Agreements:
Establish MOUs based on initial ConOps between academic institutions and health departments for long-term collaboration.

Activity 8: Expand Program
Disseminate ConOps and scale to other partnerships across Region 2. Keep a tracking roster of engaged students for surge deployment needs across jurisdictions.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	Feb 2026	Project Team	Advisory group established	Not Started
2	July 2026	Project Team/Workgroup	ConOps Draft	Not Started
3	September 2026	Team/Univ/SLTTs	Pilot Sites Chosen	Not Started
4	August 2027	Project Team	Documentation of cohort projects	Not Started
5	Sept 2027	Project Team	Scenario-based exercise documentation	Not Started
6	Nov 2027	Project Team	Evaluation documents	Not Started
7	May 2028	Project Team/AG/STLT Partners	Signed ConOps/MOUs	Not Started
8	July 2028	Project Team	7 Sites signatories to ConOps	Not Started

Focus Area 2: Coalitions Focused on Addressing Disasters

Objective 2.1: Building Strong COADs

Objective 2.1: By September 2027, enhance the community preparedness capability, defined as the community's ability to share emergency information among its members, of approximately 10 communities through the creation of a concept of operations [CONOPS] for COADs (i.e., coalitions of local community organizations) to implement a system- and organizational-level strategy to share emergency preparedness information via door-to-door canvassing among community residents.

Background: As the nation's public health emergency preparedness and response (PHEPR) assurances shift to state and local governments, the role of local voluntary organizations is increasingly vital to securing the public's readiness for health emergencies. Voluntary organizations are often the first to arrive and assist communities after an emergency event. Identifying an effective, acceptable, systematic approach to strengthening their capability in community preparedness is key to community-level responses that augment local jurisdictional practices and save lives.

Community organizations active in disasters (COADs) are coalitions of nongovernmental organizations involved in emergency preparedness and recovery at the local level. They are crucial because of their flexibility, capacity to rapidly provide services unavailable from the government, and credible local outreach to underserved populations. When appropriately supported, COADs have the capacity to coordinate emergency response efforts, provide essential health and other services, and contribute to overall public safety during emergencies. [1]

Strategy description: This strategy is designed to enhance the community preparedness capability of COADs and comprises three parts – a core strategy (CONOPS) and two supporting mechanisms, a community of practice [COP] and a mini-data system.

The CONOPS strategy with supporting mechanisms (COP and mini-data system) will aim to strengthen the community preparedness capability of select COADs via functions (2) strengthen community partnerships to support public health preparedness; (3) coordinate with partners and share information through community social networks; and (4) coordinate training and provide guidance to support community involvement in preparedness efforts.

The **CONOPS core strategy** will describe detailed procedures and practices at organizational (individual COAD member organizations) and systems (COAD network) levels to carry out a door-to-door canvassing operation in the relevant geographic catchment areas. The operation will aim to share emergency information with household constituencies and to identify potentially vulnerable household members (e.g., elderly, intellectually disabled). PRI will outline a draft CONOPS, based on existing resources and best practices (e.g., Be a Buddy program, PECO (Post-emergency canvassing operation)), and will collaboratively work with the COAD members to align the document to local COAD context and needs. The emergency-specific threat and messages (e.g., heat adaptation knowledge and behaviors) will be agreed upon by the COAD members. The final CONOPS will describe:

- The goals, division of responsibilities, sequence of actions, and resource requests (e.g., who can request, who can fulfill requests) for conducting a door-to-door canvassing operation, and
- An overview of direction and control activities, alert and warning processes, and rostering/logistics procedures.

A **COP** of COAD organizations will be established as a supporting mechanism for the CONOPS strategy. The COP will facilitate exchanging knowledge, experiences, and insights among COP COAD members to adapt the CONOPS procedures to their local context and needs. It will be convened on a minimum quarterly basis, with more frequent meetings when needed, particularly during project start-up.

The COP will foster capability strengthening among the COAD members by using cross-training, peer support, and peer mentorship per RCB guidance. This will enable more experienced COADs and COAD members to support those that are newer or less resourced. The COP meetings will be structured through a short series of education sessions on knowledge sharing and skills building in COAD operational functions (e.g., coordination and distribution of resources within COAD networks) and CONOPS areas like identifying and training volunteers, mapping and allocating geographic areas for canvassing, delivering health messages and communications, and setting up data collection systems, etc. PRI will develop the education sessions based on existing materials, including the National VOAD Points of Consensus & Guidelines which details recommended structures and operations for COADs and Disaster Agency Response Technology which includes training modules on promoting coordinated efforts during emergencies.[2 3 4 5] (Note: VOADs (Voluntary Organizations Active in Disasters) operate at state and national levels, comprising networks of nongovernmental organizations and COADs. As appropriate, VOADs may be included in the initial participating cohort of this objective)

A **mini-data system** will be used as a second supportive mechanism to successfully implement the CONOPS strategy. PRI will propose several options to COP members (e.g., Power BI dashboard, REDCAP project, excel file, re+connect) to collectively determine the most feasible and appropriate system for the CONOPS. PRI will facilitate guidance on the implementation of these data collection systems, including during exercises as well as any potential future emergency events.

Evaluation plan: We propose to evaluate the CONOPS core strategy for function 3:coordinate with partners and share information through community social networks. Data collection will include a survey to evaluate function 3.

Sources

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Implementation Timeframe

- State Date: 10/01/2025
- End Date: 09/31/2027

Activities

Activity 1: Establish a cohort of approximately 5 COADs across Region 2 to receive the strategy (CONOPS plus supporting mechanisms of COP and mini-data system).
PRI will identify potential participating COADs and voluntary organizations through various recruitment strategies (e.g., social media, organizational referrals from key sources like New York VOAD, New Jersey VOAD). All COADs that are identified from the jurisdictional partners will be invited to participate in an electronic survey. The survey will include select modules, including but not limited to: current organizational structures, participation in any existing COAD or informal organizational network, and prior experience in PHEPR. Selection criteria will be developed that will allow for both mature and emerging organizations to be invited to the initial COAD cohort. Responses to the survey will serve as baseline data collection on current operating procedures, efforts, and partnerships. Survey items will be repeated at later evaluation benchmarks to identify organizational changes. Survey findings will be used to help interpret evaluation results, as well as to inform modifications to the CONOPS and COP materials in the following project year (see activity 6). The COAD cohort members will be established by Jan 2026.

Activity 2: Establish and promote the COAD COP.
PRI will launch the COAD COP by March 2026. A terms of reference for the COP will be developed and agreed upon by all COAD members, including a purpose, member role and responsibilities, and meeting schedule. Education sessions will be designed and delivered on such topics as PHEPR overview; COAD purpose, criteria, and operations; as well as facilitated discussion sessions to review and collectively finalize the CONOPS content. PRI will also establish mechanisms for peer sharing and peer mentorship including COP sessions activities/exercises and an online knowledge and resource management platform.

Activity 3: Develop a CONOPS on door-to-door canvassing
PRI will draft a CONOPS, as described in the above narrative, and will facilitate the review and revision process among COP members in order to have a final version 1.0 by around July 2026. The CONOPS will be revised after the year 1 evaluation to incorporate lessons learned and necessary modifications to improve the strategy's performance by COP member organizations.

Activity 4: Establish and implement mini-data system
PRI will identify and present to COP members approximately three options for collection of strategy data (e.g., number of visits to households to achieve household contact; household questionnaire; completed delivery of messages/information). COP sessions will be used to deliberate the most useful approach for field data collection and management for the COAD organisations. The final data system will be selected around May 2026 and incorporated into the CONOPS. PRI will provide COP members with guidance on data system design and implementation during field exercises (around August 2026 and 2027).

Activity 5: Conduct at least 2 scenario-based simulation exercises (functional or field drills) to assess COAD performance according to the CONOPS. Key evaluation metrics may include:

- Proportion of volunteers mobilized and activated per pre-defined roster
- Time from exercise start to volunteers initiating canvassing
- Proportion of household in catchment area approached within 24 and 48 hours
- Proportion of households in catchment area successful canvassed (i.e., completed canvassing messaging/activities with at least one member of household) within 24 and 48 hours

Activity 6: Expand the cohort to another ~5 COADs across Region 2 to implement and evaluate the strategy (CONOPS plus supporting mechanisms of COP and mini-data system).
Between October 2026 – September 2027, lessons learned from the initial cohort and evaluation will be identified and reviewed collaboratively within the COAD cohort. The CONOPS and supporting tools (e.g., COP education sessions, mini-data system forms) will be modified and subsequently implemented by the original COAD cohort plus additional COAD members.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	Jan 2026	Project Team/STLT Partners	Cohort established, baseline survey completed	Not Started
2	March 2026	Project Team/STLT Partners	CoP established	Not Started
3	July 2026	Project Team/STLT Partners	CONOPS version 1.0 developed	Not Started
4	May 2026	Project Team/STLT Partners	Mini-data system selected by COP members	Not Started
5	Aug 2026 and 2027	Project Team/STLT Partners	Conduct evaluation exercises	Not Started
6	Nov 2026	Project Team/STLT Partners	Select second round cohort	Not Started

Objective 2.2: Integrate COAD Network into EOCs

Objective 2.2: By September 2028, improve hyperlocal preparedness and response by formally integrating at least 5 COADs/VOADs (1 per jurisdiction) into local government emergency management structures in Region 2, demonstrated by signed agreements, participation in Emergency Operations Center (EOC) functions, and inclusion in hazard mitigation planning.

Background: Emergency Operations Centers (EOCs) serve as the management system for emergencies, which ensures the consistency in disaster response effort by multiple stakeholders at once. Even though the official FEMA guide mentions tribal representatives as potential actors to be included in an EOC, it does not however stipulate any specific provisions on including COADs and VOADs in its architecture.[1]

The objective thus aims to shift how the community-level knowledge and capabilities of COADs and VOADs are recognized and utilized within formal government emergency response systems in general and within EOCs in particular. It creates formal structures for integration and collaboration for COADs/VOADs (e.g. formal process of integration into municipal Public Health Incident Command Systems) to productively utilize their insights and generated data on community needs, available resources, and local emergency planning. Building on the understanding that inter-organizational partnerships contribute to an improved disaster relief performance[2,3], it also ensures that the work of community-based organizations directly informs and enhances governmental emergency planning. Ultimately by integrating COAD/VOADs, the objective will deepen the capacity of local health departments to effectively respond to emergencies and enhance emergency operations coordination with Offices of Emergency Management and health departments.

The intervention responds to the call for greater inclusion of community organizations into decision-making processes. Many communities as well as related community organizations and coalitions already possess extensive knowledge of their own needs and assets. External facilitation and stronger coordination structures can help activate this local expertise more effectively. The call for a dedicated coordinating and financing body aligns with the intervention's aim to formalize relationships between COADs/VOADs and local government. By embedding COAD/VOAD practices into emergency management structures and promoting real-time information exchange, the intervention responds to the community's request for clearer communication channels and more meaningful involvement in emergency governance.

In this sense, the objective conforms to the FEMA's Whole Community Approach for Emergency Management by integrating community knowledge and experiences into the emergency preparedness and recovery processes[4]

Sources

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3. Wolf-Fordham, S. (2020). Integrating Government Silos: Local Emergency Management and Public Health Department Collaboration for Emergency Planning and Response. *The American Review of Public Administration*, *50*(6-7), 560-567. https://doi.org/10.1177/0275074020943706
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Implementation Timeframe

- State Date: 10/01/2026
- End Date: 09/31/2028

Activities

Activity 1: By March 2026, develop a jurisdiction-wide inventory ("COAD Network") that maps all active COADs/VOADs, identifies geographic and functional gaps, and makes findings available to local emergency management agencies. (aligned with 2.1)

Activity 2: By December 2026, facilitate 2-3 formal agreements (e.g., MOUs) between local emergency management departments and the COAD/VOAD Network, designating them as official representatives under a relevant Emergency Support Function (ESF).

Activity 3: By September 2027, embed 2-3 funded COAD/VOAD representatives into local Emergency Operations Centers to provide situational awareness, community status updates, and inventories of community assets and resources during planning and response.

Activity 4: By September 2027, support COAD/VOAD partners in carrying out 2-3 joint preparedness or response missions (e.g., shelter operations, food/water distribution, volunteer mobilization) in collaboration with local government agencies.

Activity 5: By September 2027, include COAD representatives as voting members in 2-3 local hazard mitigation planning committees, ensuring that community-based organizations are represented in mitigation strategies.

Activity 6: By September 2028, develop and disseminate a COAD Integration Toolkit (roles within ICS, liaison protocols, reimbursement pathways, sample MOUs). Pilot the toolkit in at least 3 jurisdictions to guide sustainable and replicable integration.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	March 2026	Project Team/STLT Partners	COAD Network established	Not Started
2	Dec 2026	Project Team/STLT Partners	Formal agreement established	Not Started
3	Sept 2027	Project Team/STLT Partners	COAD/VOAD rep embedded in EOC	Not Started
4	Sept 2027	Project Team/STLT Partners	Collaborate in missions	Not Started
5	Sept 2027	Project Team/STLT Partners	Participate in hazard mitigation planning	Not Started
6	Sept 2028	Project Team/STLT Partners	Toolkit created	Not Started

Objective 2.3: COAD/PHEPR Data Integration Tool

Objective 2.3: By September 2028, improve hyperlocal preparedness and response by piloting a shared, mobile-friendly, multilingual data system in at least 3 jurisdictions that integrates regional COADs/VOADs bi-directionally with local emergency management departments, enabling real-time updates on needs, assets, and resources.

Background: Creating a shared understanding of assets, hazards, risks, and vulnerabilities provide community-based organizations with an opportunity to initiate the process of organizational resilience, eliminate the duplication of efforts, and pave the way for the integration of sustainable data sharing practices across organizations [1] [2] [3] [4] In turn, integrating data analytics into emergency and preparedness response efforts provides opportunities for effective response strategies through real-time data sharing and its usage [5]

To this end, the objective enhances how COADs and VOADs document, monitor, and communicate their existing resource base and emergency-related information. It ensures a technological sophistication of real-time monitoring of locally gathered data, its granular analysis, and effective external communication. The interventions under the objective systematize and visualize the data in ways that are easily interpretable by local governments and regional emergency management stakeholders. It helps to ensure that hyperlocal-level data insights are integrated into broader governmental preparedness and response strategies and that there is a clearly defined data governance policy that clarifies ownership, access permissions, privacy safeguards, and long-term data stewardship. Ultimately, it helps enhance digital equity at the hyperlocal level by centering community ownership of data to ensure communities define what data is collected, how it is used, and who gets access.

The intervention also responds to regional feedback highlighting the value of community-based tools, like photovoice and mapping, as empowering mechanisms that help residents surface vulnerabilities and take actionable steps toward disaster mitigation. Community representatives emphasized that many local practices already exist, even if they are not formally documented, and that tools should be flexible enough to support and articulate these lived practices rather than replace them. By introducing GIS, participatory asset mapping, and network analysis in ways that are grounded in local contexts, the intervention strengthens the ability of COADs and VOADs to visualize, monitor, and communicate their knowledge without requiring rigid and formal plans. Instead, it builds capability for communities to enhance what they already do well, while ensuring that this knowledge can be more easily shared with external stakeholders and integrated into broader regional planning by respective emergency management agencies.

Sources

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Implementation Timeframe

- State Date: 10/01/2026
- End Date: 09/31/2028

Activities

Activity 1: By June 2026, conduct a participatory network assessment in 3 pre-selected locations using network analysis and GIS to map inter-organizational relationships, communication pathways, key actors, and gaps in coordination.

Activity 2: By December 2026, complete asset maps for the same 3 COADs/VOADs, cataloguing physical infrastructure, service providers, and personnel, and assessing effectiveness of existing resource allocation.

Activity 3: By June 2027, conduct risk, hazard, and vulnerability assessments in the 3 pilot sites to identify priority community threats, gaps in preparedness, and vulnerable populations.

Activity 4: By September 2027, design and pilot a shared, mobile-friendly, offline-capable, multilingual dashboard in 3 jurisdictions.

- Engage at least 30 COAD/VOAD/government users in testing.
- Recruit and train at least 15 high school or university student volunteers to support data collection and entry.
- Test the platform during at least one functional exercise in each pilot jurisdiction.

Activity 5: By December 2028 , conduct an inventory of existing systems and practices across all 3 pilot jurisdictions. Produce a gap analysis and integration plan that highlights opportunities to build on existing platforms and avoid redundancy and identify opportunities for quality improvement.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	June 2026	Project Team/STLT Partners	Network assessment completed	Not Started
2	Dec 2026	Project Team/STLT Partners	Participatory asset mapping completed	Not Started
3	June 2027	Project Team/STLT Partners	Risk, hazard, and vulnerability assessment completed	Not Started
4	Sept 2027	Project Team/STLT Partners	Data dashboard developed	Not Started
5	Dec 2028	Project Team/STLT Partners	Inventory conducted	Not Started

Focus Area 3: Community

Objective 3.1: High School Surge teams

Objective 3.1: By September 2026, enhance the capability of high schools to respond to public health emergencies, defined as the ability to have staff and students followed needed mitigation measures, by establishing 5 high school-based surge teams across Region 2 built on the nationally recognized Teen CERT and Junior MRC programs, evaluated by at least 2 school- or community-based emergency preparedness exercises annually, including a hyperlocal intervention within each high school to improve uptake of seasonal influenza mitigation measures.

Background: Public health emergencies require rapid, coordinated response efforts that extend beyond traditional public health and emergency management personnel. Schools are uniquely positioned to serve as active nodes in community readiness and resilience, with established leadership structures, communication systems, and trusted relationships with students and families. High school students, in particular, represent an untapped resource for surge capacity, capable of supporting emergency logistics, communications, and public outreach when appropriately trained and integrated into local response frameworks (Miller et al., 2014) (Ryan, 2021).

Despite this potential, youth engagement in public health emergency preparedness and response (PHEPR) is often informal, episodic, and disconnected from broader emergency management systems. Research has shown that when students receive targeted training, simulation-based exercises, and structured opportunities for participation, both procedural knowledge and readiness significantly improve (Sattler et al., 2014). Moreover, introducing students to PHEPR roles early fosters leadership skills, enhances civic engagement, and creates structured entry points into long-term public health and emergency management career pathways.

There are at least two existing programs to train high school students to be part of community response in a disaster. In particular, the Teen CERT program includes a 20 hour training for high school age students who wish to support their community or school in an emergency. Teens trained in CERT can support their schools and peers year round by participating in drills and exercises, supporting professionals within the school, and providing preparedness outreach. Evaluation has been limited but has shown promise in specific situations (1,2) The Junior MRC program contains much of the same underlying training as Teen CERT but with an additional public health component and connection to local Medical Reserve Corps (MRC) programs. In a dissertation, youth engagement in this program has been seen as beneficial both to the youth involved and the surrounding communities. In many high schools (e.g., Brookline) these clubs are co-located. Both Teen CERT and Junior MRC have established national and international competitions in conjunction with HOSA-Future Health Professionals - a national association that promotes student engagement in the health sciences.

This intervention seeks to establish High School Surge Teams, which are student-led emergency preparedness groups embedded within school systems and supported by local public health and emergency management agencies. These teams will each participate in the Teen CERT training and, via Junior MRC, a supplemental training package on pandemic preparedness and influenza. Each team will participate in age-appropriate, scenario-based PHEPR training through integration into curricula, extracurricular programs, via partnerships with youth leadership organizations such as HOSA. Guided by trained facilitators, students will develop and promote school-specific emergency response plans aligned with municipal and public health protocols. For the purposes of evaluation, all high school surge teams will focus on planning for and promoting non pharmaceutical interventions for influenza.

The program will include the recruitment and training of diverse student participants; delivery of facilitator orientation and guidance; development of school-specific surge team operating procedures; and implementation of flu awareness and mitigation efforts at the school level.. Partnerships with local agencies will provide mentorship, technical assistance, and logistical support, while regional conferences will allow student teams to exchange knowledge, showcase capabilities, and strengthen a growing youth PHEPR network. Training will focus on community preparedness for pandemics, epidemiology and surveillance, and nonpharmaceutical interventions for infection control, as determined by each high school chapter. Approximately eighteen months after the initiation of the pilot, efforts will be evaluated through annual school absenteeism during flu season and rates of influenza mitigation efforts at the school level.

By formalizing student involvement in emergency preparedness and linking them directly to local response structures, high school surge teams will enhance school-level readiness and mitigate ongoing pandemic threats. This dual benefit supports both immediate preparedness outcomes and the long-term goal of cultivating the next generation of public health emergency leaders.

Sources

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Implementation Timeframe

- State Date: 10/01/2025
- End Date: 09/31/2026

Activities

Activity 1: By November 2025, convene a stakeholder advisory group
This will include representatives of HOSA, regional educators, and individuals with experience in CERT, plus other advisors to determine the ways in which to engage schools and faculty leads and advise on curriculum, as well as students from the target population.

Activity 2: By January 2026, create curriculum competencies
Enhance Teen CERT and Junior MRC curricula based on recent evaluations and with the addition of established and supplemental material related to flu preparedness to be delivered within high school settings. Competencies will be specific, measurable, and demonstrable skills, knowledge, and attitudes that students will be expected to achieve to successfully implement pandemic mitigation within a school environment, and will be reviewed and approved by the stakeholder advisory group.

Activity 3: By March 2026, charter 5 teams
Identify 5 high schools (at least one in each jurisdiction) that will support the creation of a high school surge team including at least one faculty lead and two student champions currently enrolled as sophomores or juniors who will serve as team leads, and contract with these teams for a minimum 18

months of activities.

Activity 4: By March 2026, orient team leads
Develop a faculty and student leader guide and orientation program for student and faculty leads of high school surge teams, equipping them to oversee and lead high school surge teams. The guide will be based on the established competencies. Leadership guide focuses on expectations for each chapter to achieve and minimum efforts expected of each chapter.

Activity 5: By May 2026, deploy a resource toolkit for high school participants
Create a toolkit based on the Teen CERT and Junior MRC program, supplemented with additional curriculum focused on nonpharmaceutical interventions for pandemic preparedness especially flu preparedness, building on CDC's recommendations for school-based flu prevention. The toolkit will be created with input from the stakeholder advisory committee. Toolkit focuses on the expected activities of each individual chapter. . (Teen CERT | Ready.gov; Community Emergency Response Team (CERT) Basic | FEMA.gov)

Activity 6: By September 2026, conduct a baseline survey
Survey each target high school faculty, staff and students to understand preparedness knowledge, perceived organizational readiness for pandemic, and existing school plans to address seasonal or pandemic flu.

Activity 7: By November 2026, implement flu awareness intervention.
Support each high school to follow the given materials (leadership guide and toolkit) to implement flu awareness and preparation materials throughout the school. R2C will support each high school surge team leader to enroll at least five other students into the team. Team members will each complete the curriculum and utilize the toolkit to co-design school level efforts. Each team will follow a standard protocol to promote mitigation at least two times school wide. Track participation, knowledge acquisition (≥80% of students demonstrate competency) among surge team participants.

Activity 8: By March 2027, evaluate efforts
Compare flu absenteeism and mitigation uptake at the high school level to prior years to evaluate the effect of surge team efforts. .

Activity 9: By June 2027, conduct a national model evaluation
Working with HOSA, update their Teen Cert and/or Junior MRC national competitions to include capabilities taught and utilized by this program. Support the competition of pilot teams, and evaluate their capability versus other HOSA teams not part of these interventions.

Activity 10: By June 2028, scale efforts to ten further high schools
Update and disseminate all materials. Work with HOSA and SLTT partners to spur the creation of teams at further schools around the region.

Activity	Target date	Responsible Position or Party	Progress or Process Measure(s)	Status
1	Nov 2025	Project team	Convene a stakeholder advisory group	Not started
2	Jan 2026	Project team	Create curriculum competencies	Not started
3	March 2026	Project team	Charter 5 teams	Not started
4	May 2026	Project team/ school team	Orient team leads	Not started
5	June 2026	Project team	Deploy a resource toolkit for high school participants	Not started
6	Sept 2026	Project team/ school teams/ STLT partners	Conduct a baseline survey	Not started
7	Nov 2026	Project team/ school teams/ STLT partners	Implement flu awareness intervention.	Not started
8	March 2027	Project team/ school team	Evaluate efforts	Not started
9	June 2027	Project team/ school team	Conduct a national model evaluation	Not started
10	June 2028	Project team/ school team	Scale efforts to 10 further high schools	Not started