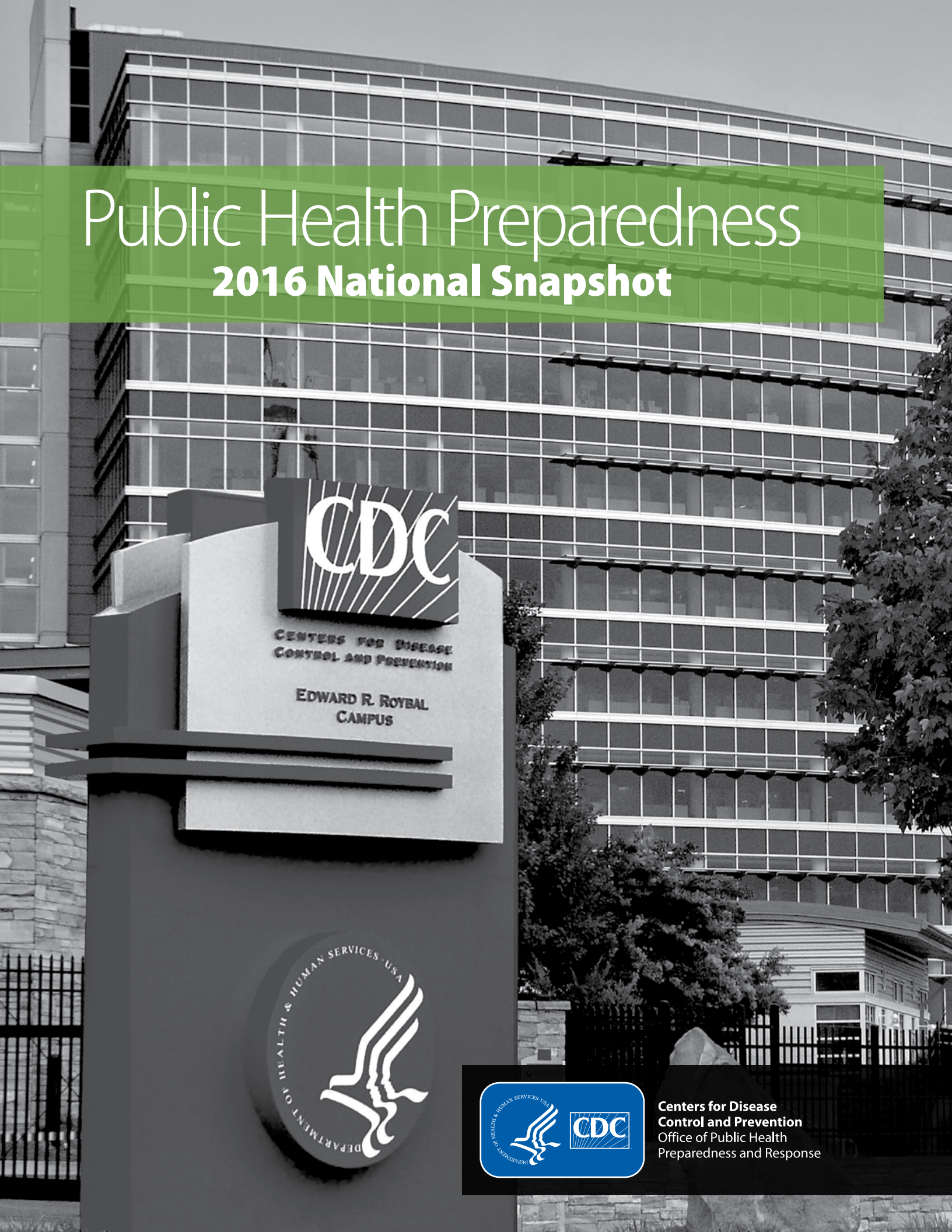
Public Health Preparedness

2016 National Snapshot



Centers for Disease Control and Prevention
Office of Public Health Preparedness and Response

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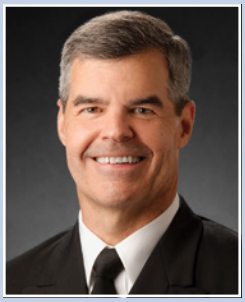


Dear Colleagues,

As we know all too well, the 2014–2015 Ebola outbreak in West Africa dominated much of our work since the summer of 2014. CDC's Incident Management System (IMS) was activated on July 9, 2014, to provide epidemiologic, health communication, laboratory, infection control, and emergency management support to stop Ebola virus transmission. As of September 30, 2015, more than 3,700 CDC staff members provided scientific, technical, and programmatic leadership to support operations, logistics, staffing, communications, management, and other functions in the Ebola response.

We remain focused on the goal of getting to zero Ebola cases, and for countries in West Africa that have reached zero Ebola cases, staying at zero. Despite the great successes we achieved in reducing the number of new cases, at the time of this writing, cases are still occurring. As long as there is Ebola in West Africa, it remains a threat everywhere. We must also commit to preparing for future events that affect global health security. As CDC Director Tom Frieden stated, we must continue the work with countries to assure that systems, trained staff, and equipment are in place to recognize and respond to new disease outbreaks.

In addition to our focus on the Ebola outbreak, we must measure the impact of our programs, maximize our ability to respond, and make the most of public health investments. Defined standards and measures can help us show progress in being ready to respond across the nation as well as show the return on investment in the country's public health infrastructure since 9/11. We are committed to continuously improving our approaches to better preparing and securing our nation against ever-evolving threats. Measuring and demonstrating program impact and improvements are imperative to highlighting the return on investment of our activities.

Finally, we are continuously improving our efficiency and effectiveness with internal and external partners. To protect the public's health, we must work effectively with partners to make the most of limited resources, and to achieve the highest level of readiness possible. We recognize that a comprehensive approach to national health security is necessary to meet the challenges posed by a catastrophic incident. Forging strategic alliances with a broad group of diverse partners is critical as we work to protect America from all health, safety, and security threats.

CDC remains committed to saving lives 24/7 by supporting state and local health departments and using resources to achieve the greatest benefit. This report describes how CDC and our partners work together to improve our nation's health security, and demonstrates Public Health Emergency Preparedness (PHEP) awardees' progress in preparing for major events. As we strive to strengthen the country's resiliency, our partnerships with state and local health departments are essential to preparing the nation to overcome any emergency.

Sincerely yours,

Stephen C. Redd, MD
RADM, USPHS
Director, Office of Public Health Preparedness and Response
Centers for Disease Control and Prevention

Contents

2014–2015 Highlights 1

Background 2

2014–2015 Ebola Response 3

Priority 1: Improving Health Security 10

Priority 2: Protecting People 18

Priority 3: Strengthening Collaboration 24

Fact Sheets 29

Appendices

- **Appendix A: Emergency Management Program Activities** 151
- **Appendix B: Explanation of Fact Sheet Data Points** 160
- **Appendix C: Fact Sheet Endnotes** 172

2014–2015 Highlights
OPHPR Key Facts

$612 Million

Annual PHEP funds awarded to 62 jurisdictions for 2015.

49 Percent

Percentage of OPHPR staff that worked in the Ebola response.

250 Days

Length of care that can be provided to Ebola patients using Ebola-specific personal protective equipment (PPE) purchased by CDC.

29 Countries

Nations supported, including 25 Emergency Operations Center activations for infectious disease outbreaks and 109 exercises.

29,000 Calls

Incoming calls responded to from the public, state health departments, clinicians, and hospitals.

1,992 Trained

Number of federal, state, territorial, and local emergency responders trained on Strategic National Stockpile assets and capabilities.

312 Entities

Registered entities overseen by the Select Agent Program; 256 were inspected during 2014.

128 Field Staff

Number of CDC field staff assigned to 50 different PHEP awardee locations.

Background

CDC plays a pivotal role in ensuring state and local public health systems are prepared to respond to all types of health threats. CDC's Office of Public Health Preparedness and Response (OPHPR) leads the agency's preparedness and response activities by providing strategic direction, support, and coordination for activities across CDC and with local, state, tribal, territorial, national, and international public health partners.

This report highlights how OPHPR strengthens the nation's health security to save lives and protect against public health threats within the context of CDC's 2014–2015 Ebola response and the agency's three overarching priorities:

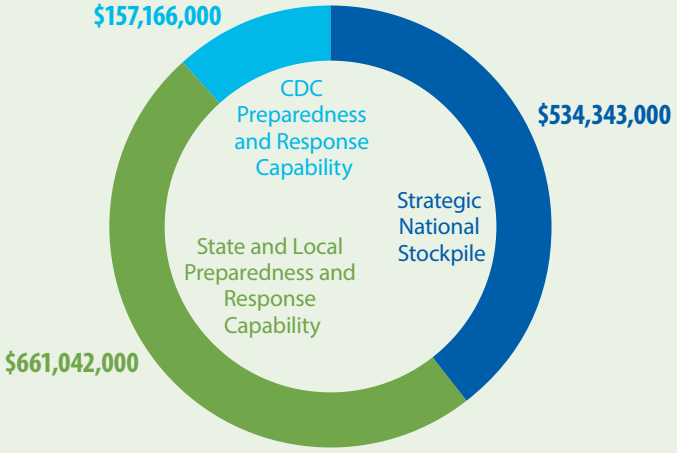
1. Improving health security at home and around the world
2. Protecting people from public health threats
3. Strengthening public health through collaboration

CDC strategically invests in public health preparedness to improve the ability of federal, state, and local public health agencies to prepare for and respond to all types of public health threats. In fiscal year 2015 (FY15), Congress appropriated $1.35 billion to CDC for public health preparedness and response.[1]

Health Security

The state of being prepared for, protected from, and resilient in the face of incidents with health consequences.

Public Health Preparedness and Response Appropriations, FY 2015



CDC Preparedness and Response Capability: critical infrastructure and cross-cutting research including the Emergency Management Program (EMP), Laboratory Response Network (LRN), and regulation of select agents and toxins.

State and Local Preparedness and Response Capability: PHEP cooperative agreement, training, evaluation, and consultation.

Strategic National Stockpile: pharmaceuticals, vaccines, critical medical supplies, and medical equipment to support federal, state and local response to health security threats.

[1] The federal fiscal year begins on October 1 and ends on September 30 of the following year. Fiscal year 2015 began October 1, 2014, and ended on September 30, 2015.

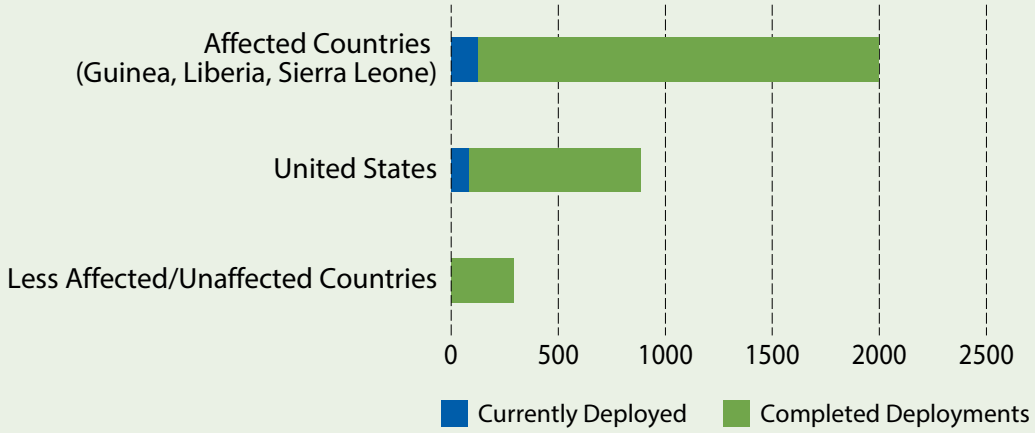
2014–2015 Ebola Response

CDC along with other U.S. government agencies, the World Health Organization (WHO), and international partners, worked tirelessly throughout 2014 and 2015 to respond to the Ebola outbreak in West Africa. CDC and domestic partners also focused efforts on preventing additional Ebola cases in the U.S. More than 3,700 CDC staff, including 488 from OPHPR, have worked in the Ebola response, either domestically or overseas.[2]

Response Goals

4. Extinguish the Ebola epidemic at its source
5. Support immediate and decisive response to any domestic cases
6. Prepare for and respond to disease threats around the world

Number of CDC Staff Responders by Location*



* As of November 5, 2015. Count of responders represent staff responding to cases and engaging in preparedness activities. Source: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/what-cdc-is-doing.html

Roles of CDC Responders

Affected Countries: infection control, training, emergency management support, epidemiology, health promotion, safe burial practices, logistics, laboratory support, exit screening.

United States: assist hospitals treating Ebola virus disease (EVD) patients, advise hospitals on treating EVD patients, screen air travelers from the affected countries, response support at CDC Headquarters.

Less Affected/Unaffected Countries: capacity building, training, emergency management support, epidemiology, health promotion.

[2] CDC Emergency Operations Center Time Tracker System, as of September 30, 2015.

CDC's Response to Ebola: March 2014 – July 2015

Spread to Liberia and Sierra Leone

Spread to Nigeria and Senegal, CDC teams help stop the outbreak

CDC expands Ebola testing among US labs

Traveler with Ebola comes to US (Dallas), 2 nurses infected

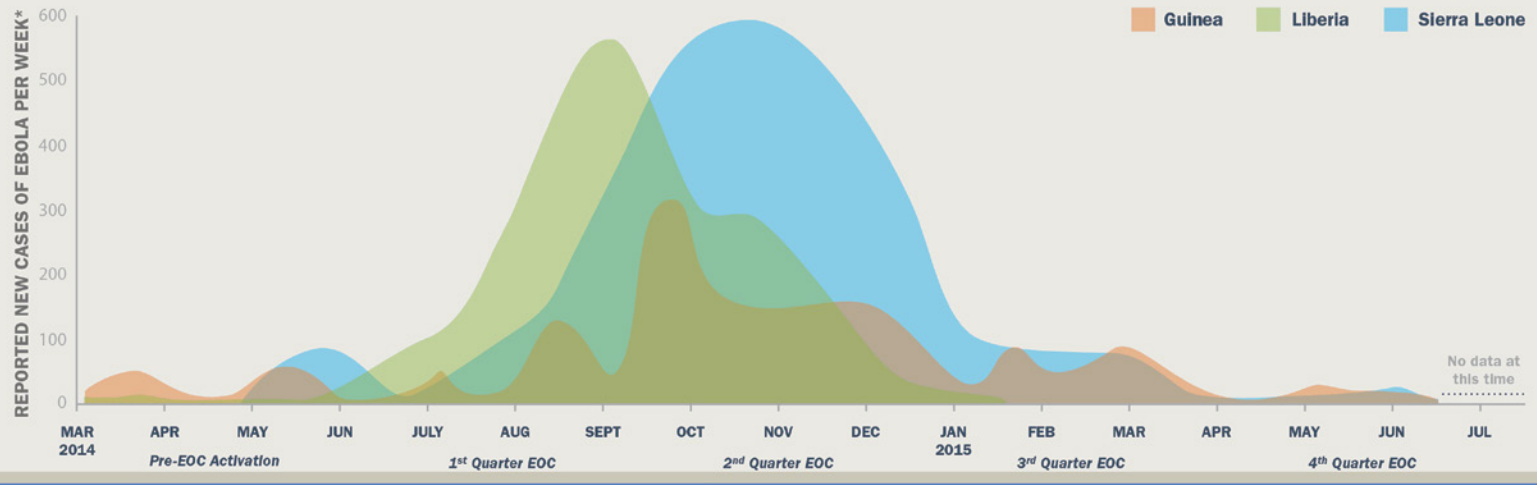
CDC organizes healthcare worker safety course in Anniston, Alabama for West Africa volunteers

Rapid Isolation and Treatment of Ebola (RITE) teams help rapidly control new outbreaks in Liberia

Spread to Mali, CDC teams help stop the outbreak

CDC deploys 1000th staff member

Liberia outbreak declared over



Early reports of Ebola virus disease from Guinea, CDC field team deployed

CDC Emergency Operations Center activated, CDC deployments surge

CDC issues Level 3 Travel Warnings for West Africa

CDC laboratory established in Sierra Leone

Dr. Frieden travels to Guinea, Liberia, and Sierra Leone

Microplanning workshops with county leaders held in Liberia

CDC implements enhanced screening at airports, new tracking program for people coming from countries with Ebola outbreaks

CDC works with states to improve hospital readiness

CDC recommends reduced screening for passengers from Liberia

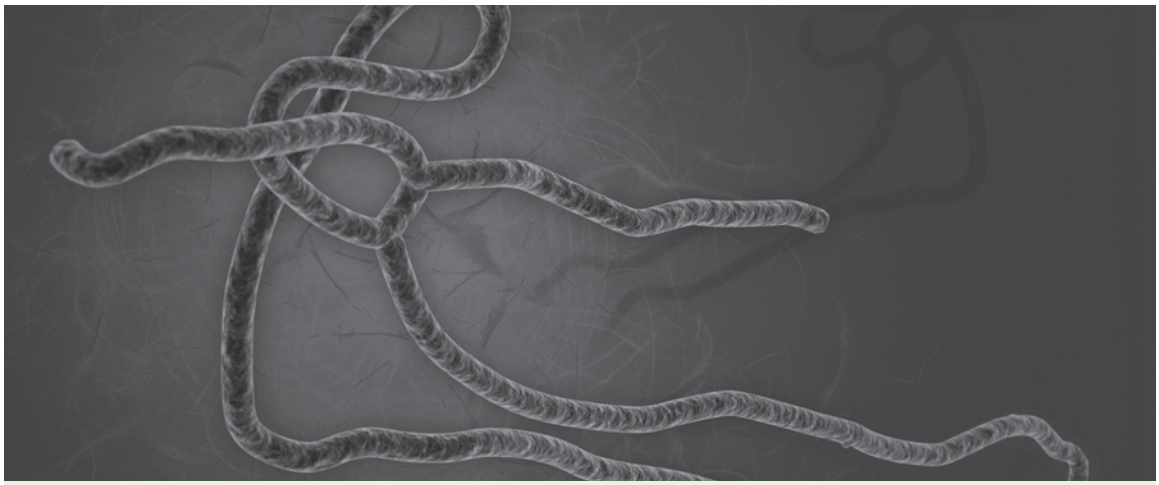
New cases reported in Liberia

* Approximate numbers

365 DAYS

1.7 Million HOURS

CDC staff worked more than 1.7 million hours on the Ebola response during the first year of activation.



CDC Ebola Response Emergency Appropriations, FY 2015–2019

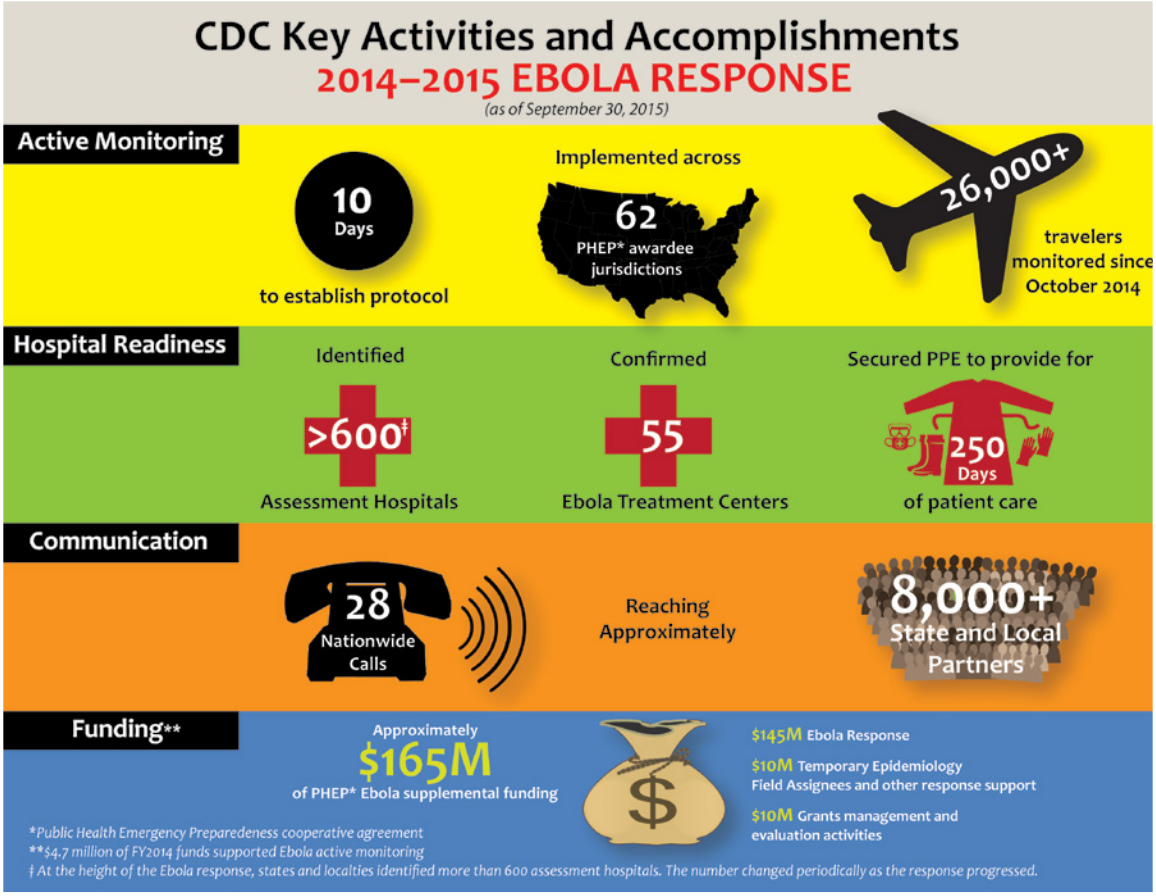
Domestic Preparedness and Response Activities: Building capacity within the United States to prevent the importation and spread of Ebola domestically and performing research to support development of vaccines and treatment.

International Response Activities: Focus on halting the transmission of Ebola virus in the three most affected countries in West Africa and strengthen the ability of countries that are most at risk to prevent further spread of the epidemic.

Global Health Security: Support to CDC's implementation of the Global Health Security Agenda, preventing infectious disease threats from becoming epidemics.

The Ebola response emergency appropriation of $1.77 billion supports efforts to stop the Ebola virus epidemic and prevent further spread to and transmission within the United States.

The funding also supports efforts to prevent, detect, and respond to other outbreaks of Ebola and emerging infectious diseases.



CDC's Strategic National Stockpile (SNS) program worked with personal protective equipment (PPE) manufacturers and hospitals to manage the PPE supply chain and ensure hospitals most likely to encounter Ebola patients had needed equipment. PPE purchased through the SNS program provided a stop-gap measure until state and local partners established the capacity to share PPE as needed or it was available via the commercial market. In addition, CDC's Select Agent Program collaborated with the Laboratory Response Network to ensure safe handling and accountability of clinical specimens from Ebola patients treated in the United States. This included publishing guidance for clinical labs and confirming clinical specimens were destroyed or properly transferred from healthcare centers to facilities registered to possess the Ebola virus.

CDC Collaborates to Prepare Children's Hospitals for Ebola

Ensuring U.S. hospitals were prepared for Ebola-related situations was a major component of CDC's domestic Ebola response. CDC sent Rapid Ebola Preparedness teams across the U.S. to train and prepare hospitals for the possibility of treating a patient sick with Ebola—including a pediatric patient. To date, no children's hospital in the U.S. ever treated a child with Ebola. Suddenly, they had to develop specific protocols and procedures to address the heightened concerns related to infection control. Planning efforts raised questions about topics specific to children, such as parental presence at the bedside, and hospitals discovered new challenges as they implemented these plans with pediatric patients with symptoms that could be from Ebola (i.e., persons under investigation).

Andi Shane, MD, Associate Professor of Pediatric Infectious Disease for Emory University and Medical Director of Hospital Epidemiology for Children's Healthcare of Atlanta.

As questions began to rise, the Ebola response Children's Health Team saw an opportunity for collaboration and shared learning. They established regular Children's Hospital Collaboration Calls. These calls were held every other week during the height of the domestic response. Officials from 40 hospitals in 19 states and the District of Columbia were invited to participate on each call. As awareness of the calls spread, local and state health departments began to participate to better support local children's hospitals.

Discussion topics included guidance for persons under investigation, sustainability of Ebola readiness, and all-hazards preparedness. The calls were well-received and participation grew over the course of the response. Participants reported that CDC's information helped them prepare for both treating a child with Ebola and expanding their general preparedness plans. In the future, the Children's Health Team looks to create a long-lasting network among CDC and children's hospitals throughout the country.

"Thank you again for all of your efforts to ensure that pediatric hospitals are represented in Ebola planning and response. We are so grateful for CDC's commitment to children,"
Andi Shane, MD.

PHEP Funding Provides Foundation for LA County's Ebola Response

As Ebola persons under investigation (PUI) (i.e., patients with symptoms that could be from Ebola) began to surface in Los Angeles County, its Department of Public Health relied upon a strong foundation in public health emergency preparedness to safely and efficiently protect its over 10 million residents. Specifically, the Department of Public Health worked with first responders and healthcare system partners to prepare for and respond to each potential Ebola patient within a hospital setting. However, as the Ebola outbreak progressed, it became clear the county needed a less resource intensive method for assessing low risk PUIs.

Stella Fogleman, Director, Emergency Preparedness and Response Program LA County Department of Public Health

Bringing a potential Ebola patient into an Ebola treatment center requires extensive planning and resources. For example, emergency medical services personnel must be educated on the use of personal protective equipment and know how to safely transport the patient to the treatment center. Healthcare facilities must have isolation units exclusively dedicated to these patients. Staffing requirements are heightened to adhere to safety guidelines in properly putting on, taking off, and using personal protective equipment in caring for a potential Ebola patient.

A physician from one LA County Ebola treatment center raised these planning and resource concerns at a Public Health Emergency Preparedness/Healthcare Preparedness Program (PHEP/HPP) healthcare coalition meeting. He recommended sending a dedicated health assessment and specimen collection team to the patient rather than transporting the patient to the hospital. This would reduce unnecessary burden on the treatment centers while making sure that safety was the number one priority. The Department of Health supported this approach, finding that it would be far less disruptive to healthcare delivery systems.

LA County's Department of Public Health consulted with the California State Department of Public Health and CDC to ensure agreement on the approach. LA County's Emergency Preparedness and Response Program Director, Stella Fogleman said, "The decision to perform the in-home assessment and specimen collection for low risk PUIs posed a challenge because of the lack of precedence or written guidance; but the team was confident that in-home evaluations could be done effectively and safely."

When it was time to actually conduct an in-home evaluation, LA County's Community Health Services program coordinated with the patient and agreed on the plan to assess and collect lab specimens at the home. The Department of Public Health also worked closely with local fire and police departments, emergency medical services, communications, and Ebola treatment center physicians to establish an on-scene incident command staging area at a fire station near the PUI's home. The patient was assessed in the home and the public health laboratory worked with the physicians to ensure proper specimen collection, packaging, and transport. Test results were available within 3 hours and there was no disruption to regular healthcare delivery services. The in-home medical evaluation and specimen collection were successful, resulting in improved processes for future public health responses.

According to Fogleman, PHEP funding and CDC support provides LA County's Department of Public Health, "a foundation for establishing our public health emergency preparedness and allows us to maintain a robust preparedness and response program." The Department of Public Health uses PHEP funding to provide additional resources and staffing support to the Acute Communicable Disease Control program and to expand testing potential for high-risk agents at the lab, while maintaining essential public health laboratory services.

LA County Prepares for Ebola

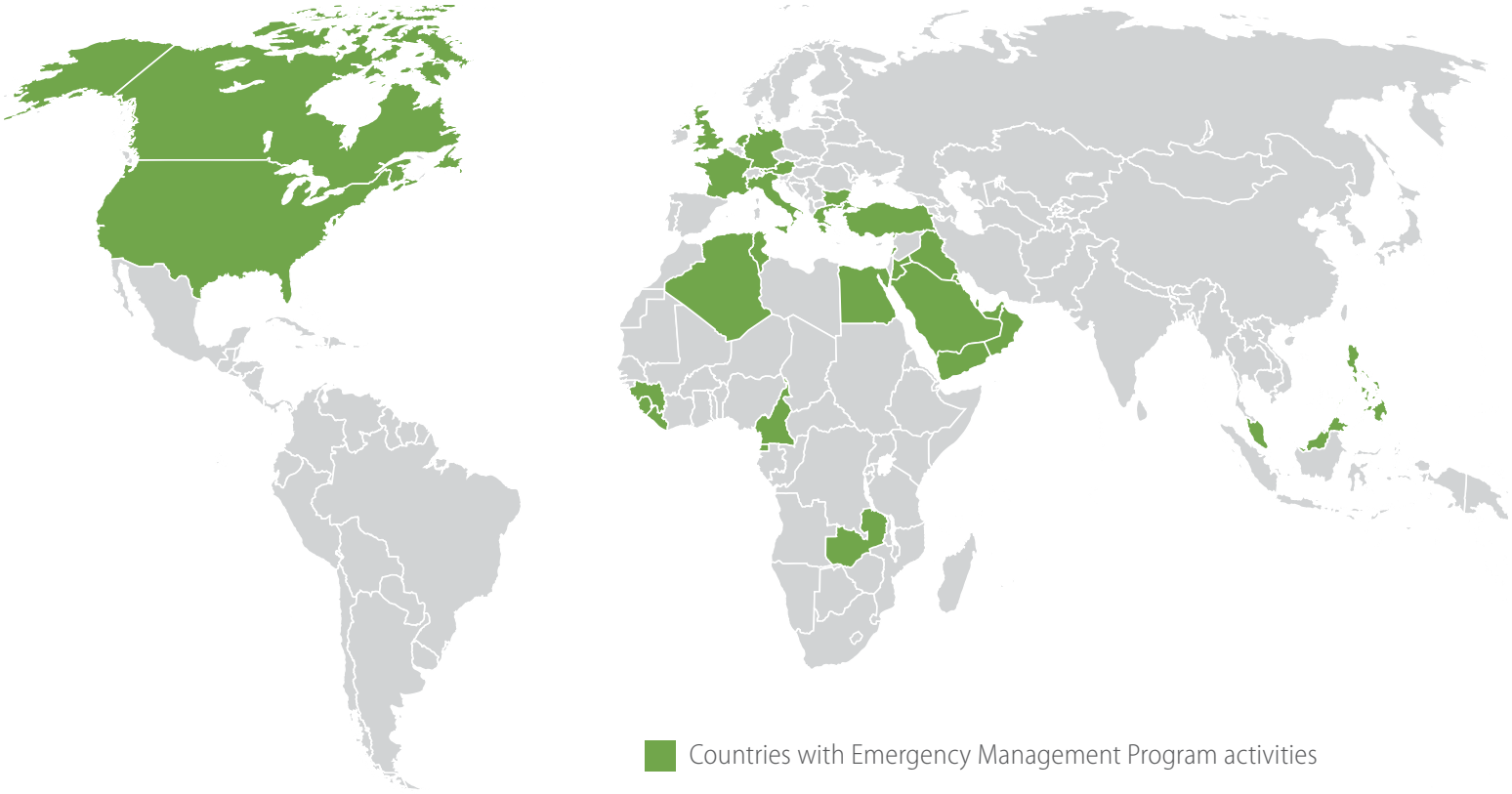
LA County's Environmental Health Division hosted an Ebola preparedness demonstration, training staff on proper PPE and decontamination procedures.

Photo credit: LA County Department of Public Health, Environmental Health Division

Priority 1:
Improving Health Security

Strengthening global health security is a U.S. government and CDC priority. CDC works with other federal agencies, nations, international organizations, and public and private stakeholders to accelerate progress toward a world that is safe and secure from infectious disease threats and to promote global health security as an international security priority. The Emergency Management Program (EMP) and Emergency Operations Center (EOC) provide training and technical assistance to other countries by conducting exercises and responding to real public health emergencies in the United States and abroad.[3]

Global Emergency Management Program Activities, 2014



Across the 62 PHEP awardees in the U.S., including the 4 localities and 8 insular areas, Emergency Management Program activities included:

- **1** activation
- **241** engagements
- **109** exercises

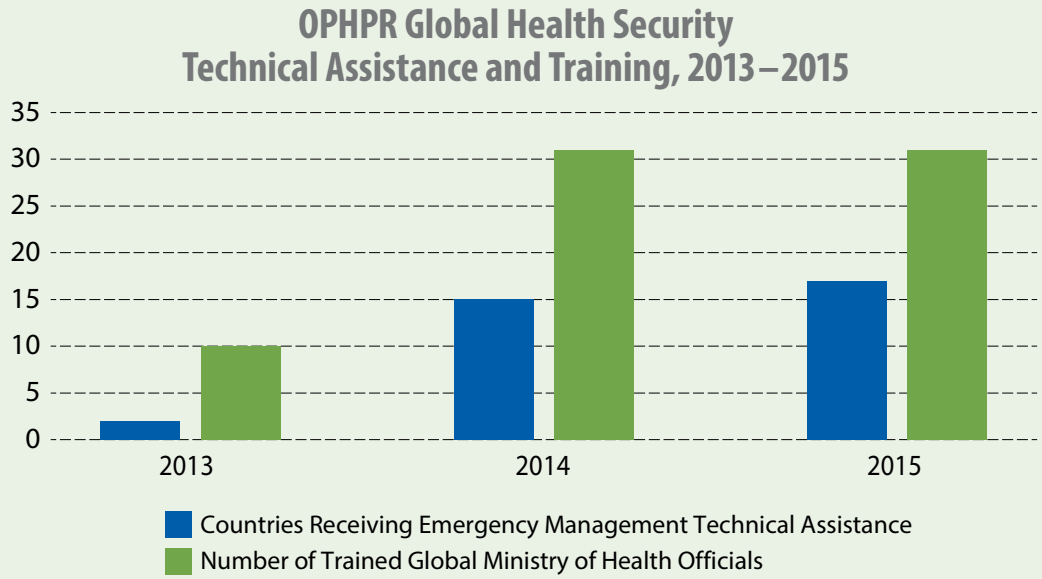
Internationally, Emergency Management Program activities across 29 countries included:

- **25** activations
- **7** engagements

[3] See Appendix A for a list of all domestic and international EMP activities during 2014.

Emergency Management Program's Global Health Security Agenda Activities

In addition to the global EMP activities noted in the map above, CDC strengthens public health emergency management capacity among the international public health community by providing technical assistance and training. These Global Health Security Agenda activities increased significantly from 2013–2014, and stayed about the same from 2014–2015.



Source: CDC, Division of Emergency Operations, 2015

Domestic EMP Activities

The EMP and EOC supported domestic activities in addition to those referenced in the map above (Global Emergency Management Program Activities, 2014), including:

- Planning and participating in **three exercises** within the National Exercise Program Capstone Exercise, which improved CDC's ability to support the United States Government during emergencies.
- Responding to more than **29,000 calls** from the public, state health departments, clinicians, and hospitals.
- Participating in **two emergency contact drills** with (PHEP) awardees.

94 percent of PHEP awardees met the 24/7 Emergency Contact Drill performance target of 45 minutes. The mean time for contact between epidemiologists and laboratorians was 17 minutes.

Health Security through the Strategic National Stockpile

The SNS is a national repository of large quantities of medicines, vaccines, and other medical supplies stored in strategic locations around the nation. These supplies protect the American public if there is a public health emergency (i.e., terrorist attack, influenza outbreak, earthquake) severe enough to deplete local supplies. CDC conducts training and exercises to prepare state and local health departments to respond effectively during an emergency when SNS assets are deployed.

In 2014, CDC:

- **Supported 22 exercises** at CDC facilities and throughout the nation to ensure partners are better prepared to dispense medical countermeasures (MCM) in a public health emergency.
- **Trained 1,992** federal, state, territorial, and local emergency responders on SNS assets and capabilities.
- **Conducted a planning workshop** for addressing pediatric surge in Salt Lake City, Utah, attended by 60 community participants and several federal agency representatives resulting in the creation of a regional (five-state) Pediatric Disaster Coalition.
- **Established a new partnership with Walgreens** to support the national distribution and dispensing of medical countermeasures during a public health disaster.
- **Partnered with FEMA's Center for Domestic Preparedness** to save more than $200,000 in MCM training costs and train 100 state, local, tribal, and territorial responders in Strategic National Stockpile management.

Expect the Unexpected: Public Health Response Planning in Action

On January 17, 2015, a breach in an oil pipeline caused 50,000 gallons of oil to spill into the Yellowstone River. This river is the main drinking water source for the more than 6,000 residents of Dawson County, Montana, which includes the city of Glendive. Fortunately, the Dawson County government, including the Dawson County Health Department (DCHD), was prepared to take action and protect the health of its residents.

Jennifer Fladager, PHEP Coordinator, Dawson County Health Department

Dawson County quickly established an emergency operations center and enlisted community partners, including DCHD, to assist in the response. DCHD relied on planning, training, and exercising—which are funded and supported by CDC's PHEP cooperative agreement—to successfully respond to the oil spill. The water system was quickly shut down, and a point-of-dispensing (POD) was stood up to distribute drinking water to the residents. DCHD's Emergency Medical Countermeasures Plan and related POD training facilitated the efficient water distribution process.

DCHD also activated its emergency notification system to ensure residents received their needed drinking water. Calls were made to schools, daycares, clinics, retirement homes, the county correctional center, and facilities and organizations serving people with disabilities to let them know water would be available. Additional messaging through DCHD press releases and a hotline before and during the operations helped guide residents through the water distribution process.

DCHD provided just-in-time training on point-of-dispensing operations to volunteers and Dawson County employees staffing the POD. Using a toolkit, the POD was set up in 30 minutes in a community center. Water was distributed for a total of five days, with most residents reporting receiving their allocated amount of water within 5–10 minutes of arriving at the point-of-dispensing.

Prior to the emergency, DCHD updated its emergency response plans and the local PHEP coordinator, Jennifer Fladager, received POD training from CDC in July 2013. These preparations, and other PHEP-funded resources, prepared county officials to effectively and efficiently respond to the oil spill. According to Fladager, "When it comes to frontier regions such as Dawson County, PHEP is one of the few resources available in regards to trained individuals and supplies. We don't have big fire departments, and we have a one-person Disaster and Emergency Services department located in Dawson County."

To successfully respond to the oil spill, the water system was quickly shut down, and a point-of-dispensing (POD) was stood up to distribute drinking water to the residents. DCHD's Emergency Medical Countermeasures Plan and related POD training facilitated the efficient water distribution process.

Public Health Response Planning in Action

"PHEP is one of the few resources available in regards to trained individuals and supplies."
Jen Fladager, DCHD PHEP Coordinator.

Photo credit: Maurice Luke

Outside-the-Box Thinking Improves New York City's Ability to Respond

Large, high-population density cities are vulnerable to all types of public health hazards—from disease outbreaks, to severe weather, to acts of terrorism. Intelligence sources believe terrorist groups may attempt to use unconventional weapons, such as chemical weapons, to maximize casualties. Preventing use of a chemical weapon of mass destruction, such as nerve agents, is the primary goal. However, if a chemical weapon attack occurred, CDC's CHEMPACK program provides resources for first responders to save lives.

CDC's CHEMPACK program supports state and city governments across the United States in chemical weapons response capability. CHEMPACK provides sustainable, deployable containers of antidotes that can be immediately accessed to treat people exposed to nerve agents. In New York City (NYC), the Emergency Management Department (NYCEM) and the Fire Department of NY (FDNY) partners with the CDC to oversee and manage the City's CHEMPACK activities and resources.

CHEMPACK containers are typically stored in hospitals or fire stations. Providing CHEMPACK resources to affected people usually takes a few minutes up to two hours. In NYC, however, NYCEM Health and Medical Unit Director Mordy Goldfeder recognized that a new mobile storage unit could result in even faster deployment of CHEMPACK resources. In 2006, the city designed and incorporated a unique mobile unit. In early 2013, Goldfeder requested CDC approval to increase the quantity of CHEMPACK resources within the mobile unit. This request was approved, the additional resources were added in early 2014, and a second mobile unit was added in late 2015.

Mordy Goldfeder, NYCEM Health and Medical Unit Director

NYC's mobile CHEMPACK units have dedicated drivers who can leave their locations within one to three minutes of notification. This enables the FDNY to treat people exposed to nerve agents within three to six minutes. Faster response times will result in more lives saved during a chemical weapon event. Each of NYC's two mobile CHEMPACKS can provide more than 5,440 treatments—twice the amount of the standard containers stored at fire stations. The mobile units are stationed across NYC approximately 12 times a year during major events such as New Year's Eve in Times Square, the Thanksgiving Day parade, and major sporting events.

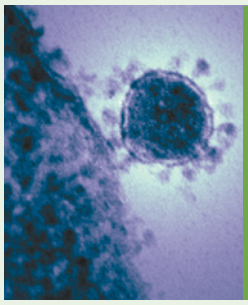
Prior to the shift from stationary CHEMPACK containers to mobile units, Goldfeder said, "I used to stay up at night worrying about chemical weapon events and was so concerned that the antidotes would not reach people fast enough. Since moving to the mobile units, NYC is now as prepared as it can be and I'm not losing as much sleep!"

*More than **1,960 CHEMPACKs** are strategically placed in approximately **1,340 locations** in all states, territories, island jurisdictions, and the District of Columbia.*

The PHEP cooperative agreement is instrumental in ensuring a successful response infrastructure is in place to afford public health laboratories the ability to accommodate sudden increases in testing for both established and novel emerging threats.

Florida Public Health Lab Works Around the Clock to Diagnose MERS

The Middle East Respiratory Syndrome (MERS) causes severe illness and even death. This viral respiratory illness is new to humans and was first reported in Saudi Arabia in 2012. The virus spread globally, and the first case was confirmed in the United States on May 2, 2014. During the two years between initial identification of MERS and the first U.S. case, federal, state, and local health departments worked diligently to ensure the illness could be quickly detected, diagnosed, treated, and contained. Diagnostic capabilities within our public health laboratories were essential to these preparations.



An electron micrograph photo of a single Middle East Respiratory Syndrome Coronavirus (MERS-CoV) virion.

On June 5, 2013, the Food and Drug Administration authorized emergency use of a CDC test for MERS in clinical respiratory, blood, and stool specimens. The Florida Bureau of Public Health Laboratories (BPHL) was among the first state public health labs to receive this test. Over the next nine months the laboratory tested specimens for seven cases that met the MERS case criteria. Using PHEP funds, BPHL's information technology staff also updated the lab's Laboratory Information Management System (LIMS) to ensure accurate reporting to CDC.

A week after the first U.S. MERS case was diagnosed in Indiana, the Florida State Investigations Unit manager and epidemiologist alerted BPHL-Tampa that there was an Orlando hospital patient suspected of having MERS. The patient's blood and respiratory samples arrived at the Tampa lab at 5 p.m. Friday, May 9. Lab staff, in consultation with CDC subject matter experts, worked over the next 30 hours to confirm that the U.S. was likely facing its second case of MERS. This work included obtaining additional clinical samples from the patient to conduct multiple testing methods. CDC lab staff confirmed the MERS diagnosis by 10:45 p.m. on Sunday, May 11.

Advanced preparations by the Tampa public health lab ensured that when called upon, it was ready to respond. On Monday, May 12, after demonstrating success in diagnosing MERS, the lab received about 25 samples from close contacts of the Orlando hospital patient. Also, as news of the diagnosis spread through the community, the Tampa lab experienced an increase in additional samples for testing. All patients symptomatic with respiratory illness that met the case definition were tested to rule out MERS. The BPHL-Tampa lab tested more than 130 samples for MERS in the weeks following the confirmation of MERS in Florida.

The MERS event required well trained staff, testing agents, and adequate testing equipment. The PHEP cooperative agreement is instrumental in ensuring a successful response infrastructure is in place to afford public health laboratories the ability to accommodate sudden increases in testing for both established and novel emerging threats.

Priority 2:
Protecting People

CDC protects people from public health threats by:

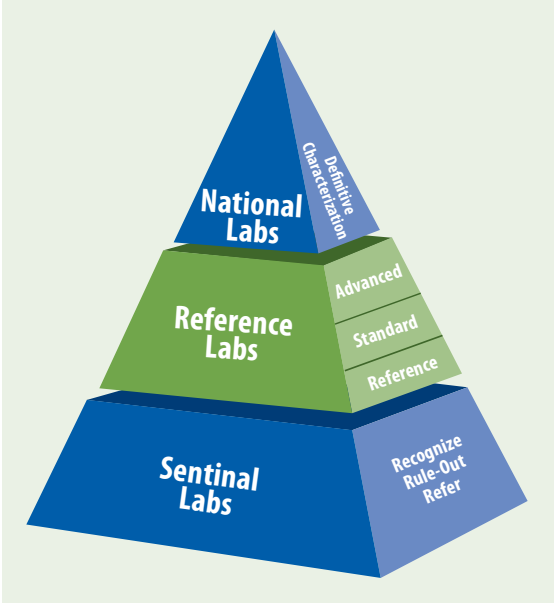
- Regulating and monitoring the ownership, use, and transfer of dangerous biological agents and toxins
- Quickly identifying and responding to disease agents and outbreaks through the Laboratory Response Network
- Providing critical personnel to states and localities to support public health preparedness planning and response

The Select Agent Program oversees and inspects laboratories that house dangerous materials, such as anthrax, that cause disease in humans and pose a severe threat to public health and safety. The Select Agent Program continuously facilitates improved and strengthened biosafety and security practices and procedures among entities registered to possess select agents and toxins. During 2014, the Select Agent Program:

- Regulated **65** select agents and toxins
- Managed **312** registered entities and **9,448** individuals approved to access select agents and toxins
- Inspected **82 percent** of the registered entities[4]

The Laboratory Response Network (LRN) is a national security asset that, with its partners, develops, maintains, and strengthens an integrated domestic and international network of laboratories. These labs respond quickly to biological, chemical, and radiological threats and other high priority public health emergency needs through training, rapid testing, timely notification, and secure messaging of laboratory results.

LRN-Biological (LRN-B) was reconfigured during 2014 to achieve efficiency and sustainability amid funding constraints. Reconfiguration established three levels of reference laboratories—Reference, Standard, and Advanced—based on their testing capabilities.

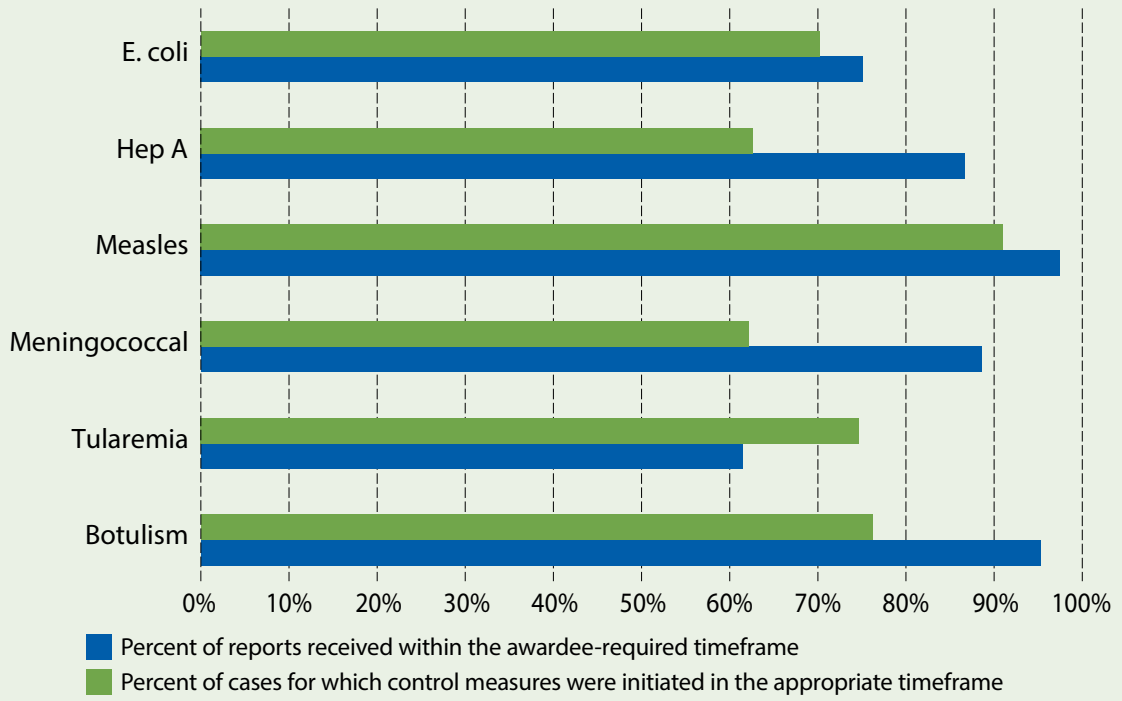


Laboratories must meet Standard level requirements to receive PHEP funding. This applies to the 50 state public health laboratories and the public health labs operated by Los Angeles County, New York City, and Washington, D.C. (53 total). Other non-public health laboratories can also elect to meet the Standard level requirements. Laboratories that do not meet Standard level requirements will remain in the LRN as Reference labs, but will not receive PHEP funding. Labs contributing significantly more than the Standard testing level are referred to as Advanced reference labs.

Emergency use authorization for assays for MERS and Ebola have been deployed to **LRN-member laboratories** to increase the preparedness of the U.S. to respond to these emerging infectious diseases.

[4] Entities may be on either a 12-month or 18-month inspection cycle.

Timely reporting and intervention are essential for effective response to infectious disease outbreaks. Quick investigations and meaningful interventions /control measure initiation protect the health of individuals and communities by limiting the spread of disease and eliminating or reducing sources of infection. The chart below shows the percentage of selected disease cases for which PHEP awardees met the required reporting and intervention timeframes during FY 2014.



Source: CDC, Division of State and Local Readiness, 2014

Public health emergency responses begin at the local level, with state and federal governments providing support as needed. CDC enhances local and state level response capabilities and mitigates workforce gaps through a robust field staff program. During 2014, 128 CDC field staff were assigned to 50 different PHEP awardee locations.[5] Field staff fill critical roles in epidemiology, medical countermeasure management, and technical assistance. In addition to their daily job functions, CDC field staff can be called upon to assist during public health emergencies.

[5] Field staff include Career Epidemiology Field Officers, Epidemic Intelligence Service Officers, Public Health Associate Program fellows and graduates, Public Health Prevention Service fellows, and Public Health Associates. See Appendix B for more information.

Ready Wrigley Teaches Kids about Preparedness and Response

Photo credit: Stacey Brawner

Jack and Leila Brawner, ages 8 and 5, learning about preparedness from Ready Wrigley.

Ready Wrigley engages children in learning about preparedness.

"Ready Wrigley helped my family finally have a communication plan for emergencies. We talked about it before, but the book gave us a fast and easy way to write everything down."
Jack Brawner, age 8.

"Ready Wrigley books are so much fun!"
Leila Brawner, age 5.

Ready Wrigley, the preparedness pup, is building capacity in children's preparedness by inspiring youth readiness and promoting individual resilience. Endorsed by the American Academy of Pediatrics (AAP) and Save the Children, Ready Wrigley is making her way into the homes and classrooms of children across the United States. Launched in 2013, the activity book series follows Wrigley and her family as they prepare for the unexpected.

CDC designed Ready Wrigley to incorporate creative learning tools, such as coloring pages, word searches, knowledge checks, and guidance, for children of all skill levels and ages. The books are accessible to children, families, schools, camps, and community organizations online at www.cdc.gov/readywrigley. Four editions of Ready Wrigley are currently available: preparing for hurricanes, tornadoes, earthquakes, and winter weather.

Ready Wrigley can be used during elementary school science lessons on weather and earth science, or by pairing the preparedness activities in the books with school emergency drills. Incorporating Ready Wrigley into the curriculum teaches children how to prepare for unexpected weather events. An added benefit is that these lessons are often then shared with parents and guardians at home. Coupling science education in schools with actionable learning through Ready Wrigley is just one way to bring the preparedness message home.

CDC is expanding Ready Wrigley's preparedness issues and reach. New topics will include helping individuals with special healthcare needs and preparing for other emergencies like wildfires and flooding. CDC recently launched a child-friendly Ready Wrigley mobile app in the Apple App Store.

Also available in Spanish!

In addition, partnering with Save the Children and AAP helps CDC reach a significantly broader audience and provides subject-matter expertise for future activity book development.

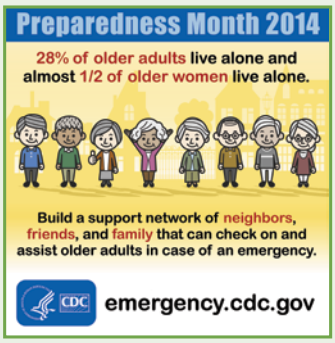
Partnerships multiply the effectiveness of interventions such as Ready Wrigley and CDC counts on exactly this type of community support to further its mission.

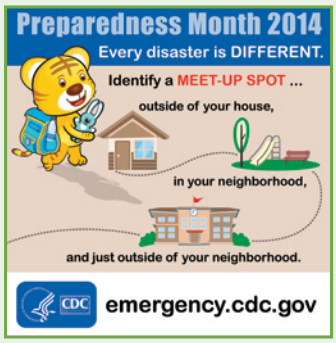
Save the Children endorsed CDC's Ready Wrigley campaign, noting the importance of preparing youth for natural disasters. "Children should be taught about emergency preparedness from a young age," says Dr. Paul Myers, Save the Children's Director of Emergency Preparedness. "By instilling the importance of personal responsibility and safety through disaster education and planning, parents or guardians will help their children develop habits that could very well save their lives."

National Preparedness Month and PrepareAthon Activities

Each September, CDC partners with local, state, and federal agencies to promote National Preparedness Month through blog posts, social media messages, and graphics. In 2014, CDC focused its National Preparedness Month activities on preparing vulnerable populations. Each week, messages and products focused on children, people with disabilities, older adults, pet owners, and business owners. CDC saw a dramatic growth in followers on social media channels and blog readership, and hosted one of the largest non-Ebola Twitter chats in CDC history. More than 50 public, private, and non-profit partners helped spread the word about the importance of preparedness for vulnerable populations in emergencies.

America's PrepareAthon is a nationwide, community-based campaign for action to increase emergency preparedness and resilience through hazard-specific drills, group discussions and national-level exercises. The PrepareAthon coincides each fall with National Preparedness Month and is also held each year in April. The month-long activities in September and April culminate in a national day of action, focused on energizing the public to be more prepared for emergencies. The PrepareAthon focuses on specific natural hazards, such as earthquakes, hurricanes, wildfires, winter weather, tornadoes, and flooding. For more information, visit www.ready.gov/prepare.





1,712,132
TWITTER FOLLOWERS

77,529
CDC EMERGENCY FANS

14,738
PHPR LINKEDIN GROUP MEMBERS

42,896
GovD FOLLOWERS

Priority 3:
Strengthening Collaboration

CDC collaborates with state and local health departments, other federal agencies, the healthcare delivery system (i.e., hospitals, doctors, and other healthcare providers and facilities), and private industry to prepare for and respond to health threats. CDC also works with other countries to help prevent global public health threats from reaching the United States.

Key examples of how CDC collaborates with other federal agencies, private organizations, academic institutions, and national associations include:

- Assistant Secretary for Preparedness and Response: joint administration of the PHEP and Hospital Preparedness Program cooperative agreements
- Federal Emergency Management Agency, Center for Domestic Preparedness: SNS training and medical countermeasure deployment exercises
- American Red Cross: Ready CDC Personal Preparedness Intervention
- National Association City and County Health Officials: enhancing local public health preparedness and response capabilities
- American Academy of Pediatrics: blog contributions and Twitter chat participation
- National Academy of Medicine: conduct SNS review and contribute to Ebola research priorities
- FBI's Criminal Justice Information Services Division: prevent access to select agents by individuals who might intend to misuse them, such as a bioterrorist

PHEP awardees received $612 million in annual funds for 2015, the same amount as for 2014.

The PHEP cooperative agreement is a critical collaboration between CDC and state and local public health departments. PHEP awardees protect their communities by implementing a framework of 15 public health preparedness capabilities based on national standards for all-hazards planning.[6]

PHEP awardees can choose how to allocate their funding across the 15 public health preparedness capabilities within their state, locality, or insular area. Nationally, the five capabilities awardees most frequently funded during 2014 were:

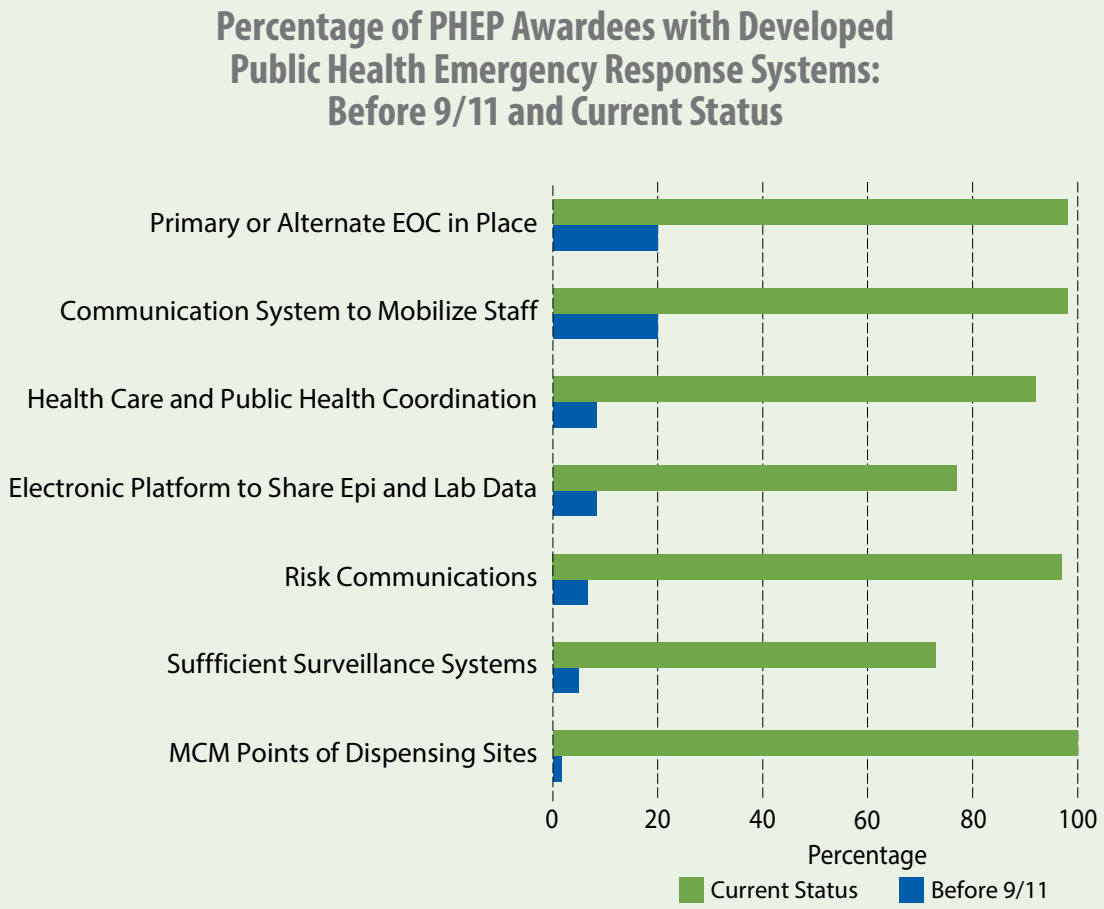
7. Public Health Surveillance and Epidemiological Investigation
8. Public Health Laboratory Testing
9. Community Preparedness
10. Information Sharing
11. Emergency Operations Coordination

[6] Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011. Accessed on June 13, 2014, at URL http://www.cdc.gov/phpr/capabilities/dslr_capabilities_july.pdf. All capabilities are listed in Appendix B.

Awardees use annual PHEP funds to build and improve their public health preparedness capabilities. Over the past three years, PHEP awardees reported an above average level of preparedness and maintained or increased capacity in the following seven high-priority public health preparedness capabilities:[7]

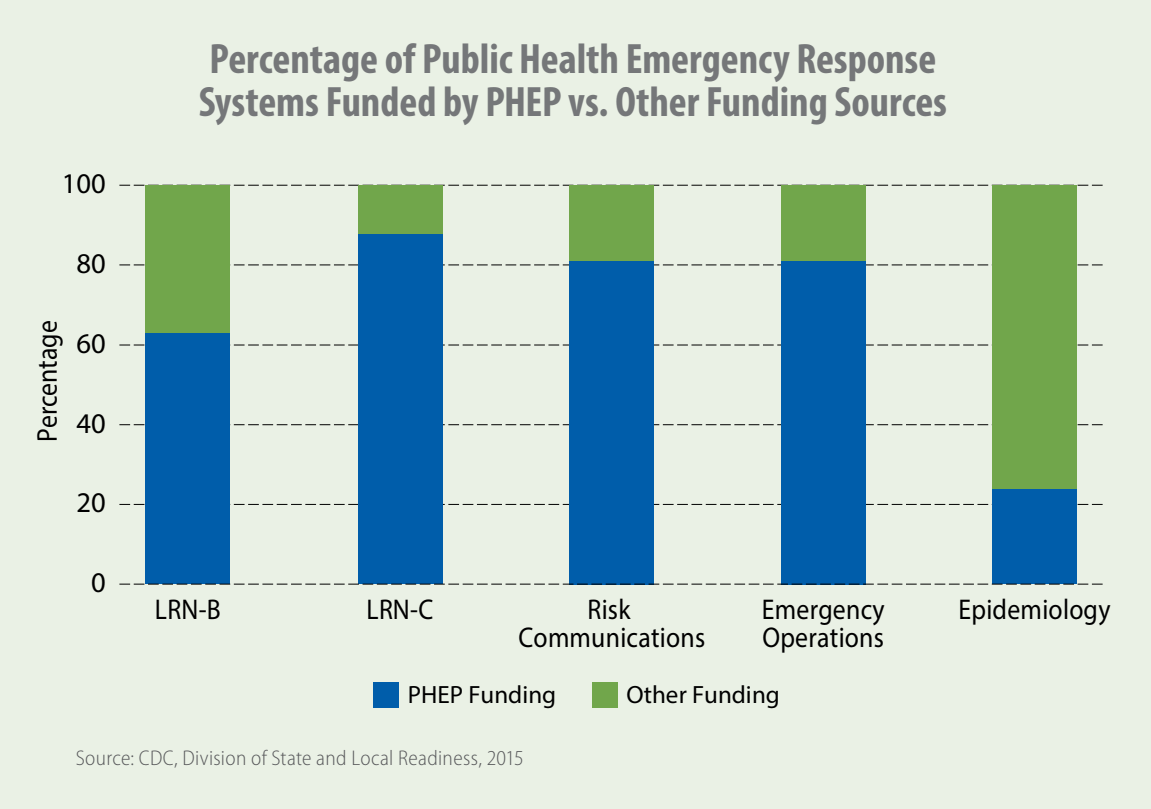
- Community Preparedness
- Emergency Operations Coordination
- Emergency Public Information and Warning
- Information Sharing
- Public Health Laboratory Testing
- Public Health Surveillance and Epidemiological Investigation
- Responder Safety and Health

Since September 11, 2001, awardees have used PHEP funding to build and improve response systems and infrastructure. Many of the resources states now use to respond to public health emergencies would not exist without PHEP funding.



Source: CDC, Division of State and Local Readiness, 2015

[7] CDC prioritizes the 15 public health preparedness capabilities into two tiers. There are eight high-priority capabilities, also referred to as Tier 1, that provide a strong basic foundation for public health preparedness. PHEP awardees are encouraged to develop the Tier 1 capabilities prior to significantly investing in Tier 2 public health preparedness capabilities.


Percentage of Public Health Emergency Response Systems Funded by PHEP vs. Other Funding Sources
100
80
60
40
20
0
Percentage
LRN-B
LRN-C
Risk Communications
Emergency Operations
Epidemiology
PHEP Funding
Other Funding
Source: CDC, Division of State and Local Readiness, 2015

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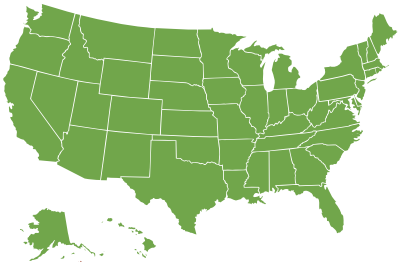
Fact Sheets:

National, 50 States, 4 Localities, and 8 Insular Areas (territories and freely associated states)

National

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. Nationally, 36.0% of households included children and 18.5% included older adults. In addition, 9.8% of adults reported having diabetes, 20.2% a condition that limits activities, and 8.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance and Epidemiological Investigation
3. Community Preparedness
4. Information Sharing
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	104	102	99
Proportion of LRN-B proficiency tests passed[3]	288 / 312	82 / 94	240 / 249
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	71	72	70
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	94% (target: 90%)	91% (target: 90%)	96% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	92% (target: 90%)	90% (target: 90%)	93% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	10	10	10
Number of Level 2 LRN-C labs[5]	37	36	36
Number of Level 3 LRN-C labs[5]	10	11	10
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	7/9	8/9	8/9
Average number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Percentage of Level 1 and Level 2 labs that passed the LRN-C exercise to collect, package, and ship samples[3]	100%	100%	100%

National

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Average number of minutes for state public health staff with incident management lead roles to report for immediate duty[3]	27 (target: 60)	39	29
Average number of minutes for locality and insular area public health staff with incident management lead roles to report for immediate duty[3]	50	40	34
Percentage of states, localities, and insular areas that prepared an after-action report and improvement plan following a real or simulated response[3]	98%	98%	100%

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Percentage of awardees with expedited procedures for receiving emergency funds[6]	97%
Percentage of awardees that reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	92%
Percentage of awardees that reduced the cycle time for hiring and/or reassignment of staff[6]	81%

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$584,696,784
CDC preparedness field staff[8, 9, 10]	128
CDC Emergency Management Program activities[11]	351
Public health personnel who received CDC Strategic National Stockpile training[12]	1,231

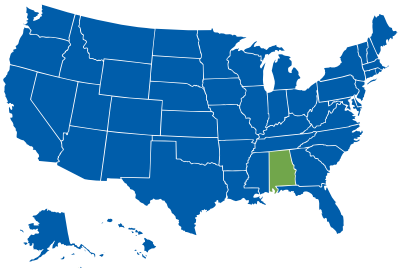
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

TAR Scores (100-point scale)	2011–2012	2012–2013	2013–2014
Median State TAR score[3]	98	99	99
Median CRI Metropolitan Statistical Area (MSA) TAR Score[3]	93	95	97
Median Directly Funded Locality TAR Score[3]	100	98	99
Median Island TAR Score[3]	67	71	74

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Alabama

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Alabama, 34.0% of households included children and 19.6% included older adults. In addition, 13.8% of adults reported having diabetes, 27.5% a condition that limits activities, and 11.1% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Surveillance & Epidemiologic Investigation 2. Community Preparedness 3. Public Health Laboratory Testing 4. Information Sharing 5. Medical Countermeasure Dispensing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Alabama

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	8 (target: 60)	3	5
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	No	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$8,609,718
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	38

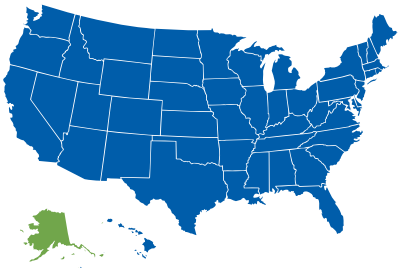
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Birmingham-Hoover, AL (100-point scale)[3]	97	99	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Alaska

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Alaska, 40.6% of households included children and 12.7% included older adults. In addition, 7.1% of adults reported having diabetes, 20.1% a condition that limits activities, and 6.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Laboratory Testing 2. Public Health Surveillance & Epidemiologic Investigation 3. Community Preparedness 4. Mass Care 5. Medical Surge

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	N/A
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	100% (target: 90%)	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Alaska

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	35 (target: 60)	10	15
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$3,987,619
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	15

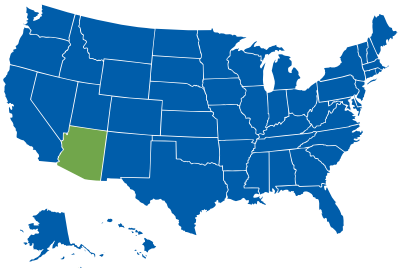
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	87	96	91
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Anchorage, AK (100-point scale)[3]	79	88	93

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Arizona

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Arizona, 38.1% of households included children and 20.0% included older adults. In addition, 10.7% of adults reported having diabetes, 19.6% a condition that limits activities, and 8.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Medical Countermeasure Dispensing
2. Medical Surge
3. Emergency Public Information and Warning
4. Public Health Laboratory Testing
5. Public Health Surveillance & Epidemiologic Investigation

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Arizona

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	19 (target: 60)	7	25
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$11,209,189
CDC preparedness field staff[8, 9, 10]	6
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	29

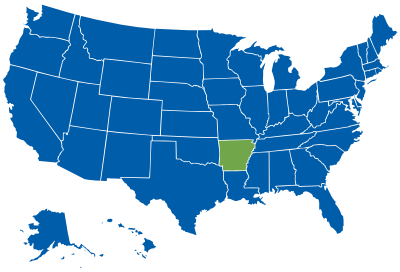
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	92	93	97
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Phoenix-Mesa-Scottsdale, AZ (100-point scale)[3]	95	99	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Arkansas

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Arkansas, 36.3% of households included children and 20.4% included older adults. In addition, 11.5% of adults reported having diabetes, 26.2% a condition that limits activities, and 11.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Community Preparedness
2. Information Sharing
3. Public Health Laboratory Testing
4. Public Health Surveillance & Epidemiologic Investigation
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	92% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	7 / 9	7 / 9	7 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Arkansas

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	14 (target: 60)	5	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,438,717
CDC preparedness field staff[8, 9, 10]	2*
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	2

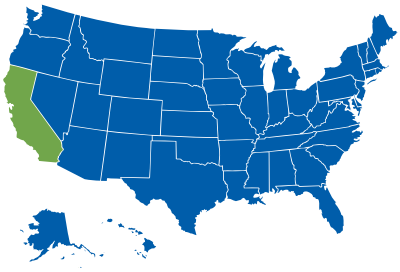
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Little Rock-North Little Rock, AR (100-point scale)[3]	92	92	97
Memphis, TN-MS-AR (100-point scale)[3]	94	96	99

*One EIS Officer is funded by the U.S. Army.
Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

California

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In California, 41.9% of households included children and 16.5% included older adults. In addition, 10.2% of adults reported having diabetes, 18.6% a condition that limits activities, and 7.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Emergency Operations Coordination
3. Public Health Surveillance & Epidemiologic Investigation
4. Medical Materiel Management & Distribution
5. Medical Countermeasure Dispensing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	14	14	14
Proportion of LRN-B proficiency tests passed[3]	39 / 44	12 / 13	38 / 40
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	6	6	5
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	90% (target: 90%)	97% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	90% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

California

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	8 (target: 60)	7	5
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$39,704,132
CDC preparedness field staff[8, 9, 10]	8*
CDC Emergency Management Program activities[11]	9
Public health personnel who received CDC Strategic National Stockpile training[12]	1

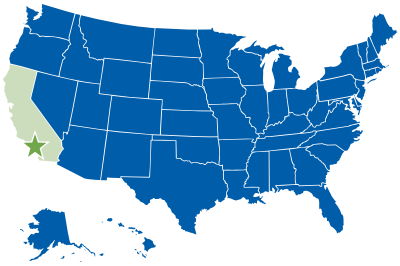
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	98	98
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Fresno, CA (100-point scale)[3]	87	79	93
Los Angeles-Long Beach-Santa Ana, CA (100-point scale)[3]	100	98	96
Riverside-San Bernardino-Ontario, CA (100-point scale)[3]	94	95	96
Sacramento-Arden-Arcade-Roseville, CA (100-point scale)[3]	98	97	98
San Diego-Carlsbad-San Marcos, CA (100-point scale)[3]	92	98	100
San Francisco-Oakland-Freemont, CA (100-point scale)[3]	96	98	97
San Jose-Sunnyvale-Santa Clara, CA (100-point scale)[3]	95	94	97

*One EIS Officer is funded by the Department of Veterans Affairs.
Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Los Angeles County

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Los Angeles County, 32.4% of households included children and 11.7% included older adults. In addition, 10.6% of adults reported having diabetes, 17.7% a condition that limits activities, and 6.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Community Preparedness
3. Medical Countermeasure Dispensing
4. Emergency Operations Coordination
5. Public Health Laboratory Testing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	2 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	94% (target: 90%)	96% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	92% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Los Angeles County

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	90	25	14
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	No
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$19,078,070
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	1

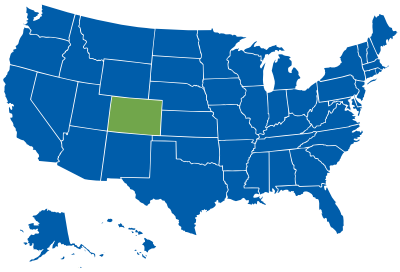
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Directly Funded Locality TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	100	96	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C

Colorado

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Colorado, 39.0% of households included children and 16.2% included older adults. In addition, 6.5% of adults reported having diabetes, 18.8% a condition that limits activities, and 6.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Community Preparedness
3. Medical Materiel Management & Distribution
4. Community Recovery
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	3	3	3
Proportion of LRN-B proficiency tests passed[3]	4 / 5	1 / 1	5 / 6
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	98% (target: 90%)	96% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	91% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Colorado

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	25 (target: 60)	60	20
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$9,259,900
CDC preparedness field staff[8, 9, 10]	2*
CDC Emergency Management Program activities[11]	9
Public health personnel who received CDC Strategic National Stockpile training[12]	115

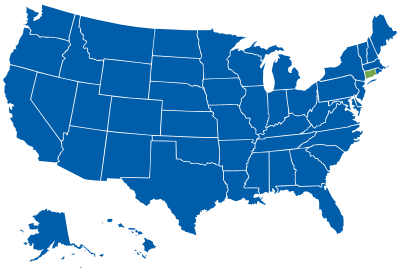
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	94	93	97
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Denver-Aurora, CO (100-point scale)[3]	68	81	83

*One EIS Officer is funded by a federal facility.
Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Connecticut

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Connecticut, 35.8% of households included children and 19.7% included older adults. In addition, 8.3% of adults reported having diabetes, 17.5% a condition that limits activities, and 8.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Information Sharing
4. Emergency Operations Coordination
5. Medical Countermeasure Dispensing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	95% (target: 90%)	96% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Connecticut

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	52 (target: 60)	53	31
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$7,519,140
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	1

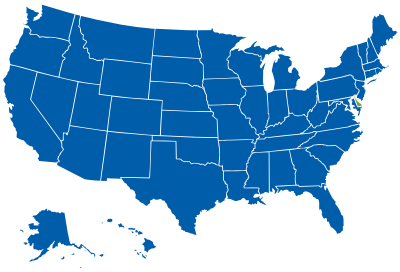
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	97	97	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Hartford-West Hartford-East Hartford, CT (100-point scale)[3]	87	92	90
New Haven-Milford, CT (100-point scale)[3]	89	91	91

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Delaware

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Delaware, 36.2% of households included children and 20.3% included older adults. In addition, 11.1% of adults reported having diabetes, 18.7% a condition that limits activities, and 8.1% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Medical Materiel Management & Distribution
3. Community Preparedness
4. Emergency Operations Coordination
5. Public Health Surveillance & Epidemiologic Investigation

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Delaware

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	45 (target: 60)	34	37
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,309,494
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	28

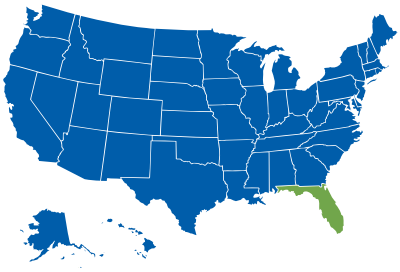
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	94	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Dover, DE (100-point scale)[3]	89	96	100
Philadelphia-Camden-Cecil-Wilmington, PA-NJ-MD-DE (100-point scale)[3]	97	98	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Florida

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Florida, 34.4% of households included children and 23.5% included older adults. In addition, 11.2% of adults reported having diabetes, 21.2% a condition that limits activities, and 8.8% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Community Preparedness
3. Public Health Laboratory Testing
4. Medical Countermeasure Dispensing
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	4	4	4
Proportion of LRN-B proficiency tests passed[3]	11 / 12	4 / 4	12 / 12
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	3	3
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Level 1 lab: passed; Level 3 lab: passed	Level 1 lab: passed; Level 3 lab: passed	Passed

Florida

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	43 (target: 60)	11	12
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$27,466,901
CDC preparedness field staff[8, 9, 10]	6
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	51

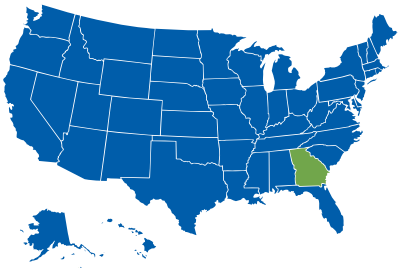
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	95	97	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Miami-Fort Lauderdale-Pompano Beach, FL (100-point scale)[3]	97	93	97
Orlando-Kissimmee, FL (100-point scale)[3]	93	89	94
Tampa-St. Petersburg-Clearwater, FL (100-point scale)[3]	92	96	95

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Georgia

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Georgia, 39.7% of households included children and 16.0% included older adults. In addition, 10.8% of adults reported having diabetes, 18.7% a condition that limits activities, and 8.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Emergency Operations Coordination
2. Medical Countermeasure Dispensing
3. Community Preparedness
4. Public Health Laboratory Testing
5. Public Health Surveillance & Epidemiologic Investigation

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	2
Proportion of LRN-B proficiency tests passed[3]	5 / 6	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	3	3	3
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	92% (target: 90%)	81% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	92% (target: 90%)	88% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Georgia

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	23 (target: 60)	30	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$15,155,658
CDC preparedness field staff[8, 9, 10]	3*
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	99

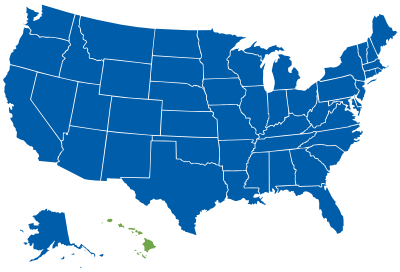
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	96	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Atlanta-Sandy Springs-Marietta, GA (100-point scale)[3]	97	94	98

*One EIS Officer is funded by the U.S. Army.
Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Hawaii

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Hawaii, 38.5% of households included children and 20.1% included older adults. In addition, 8.4% of adults reported having diabetes, 15.2% a condition that limits activities, and 6.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Information Sharing
3. Public Health Surveillance & Epidemiologic Investigation
4. Emergency Operations Coordination
5. Emergency Public Information and Warning

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	93% (target: 90%)	95% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	95% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Hawaii

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	51 (target: 60)	651	55
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,763,065
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	10

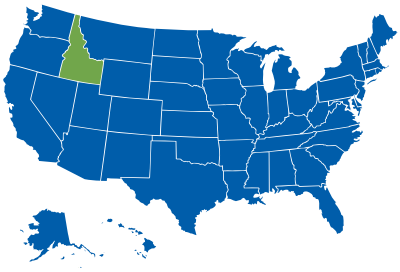
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	89	92	95
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Honolulu, HI (100-point scale)[3]	82	91	95

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Idaho

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Idaho, 41.3% of households included children and 18.6% included older adults. In addition, 8.4% of adults reported having diabetes, 20.5% a condition that limits activities, and 6.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Community Preparedness
4. Information Sharing
5. Emergency Public Information and Warning

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	2 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	74% (target: 90%)	73% (target: 90%)	93% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Idaho

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	53 (target: 60)	33	—
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,904,757
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	2

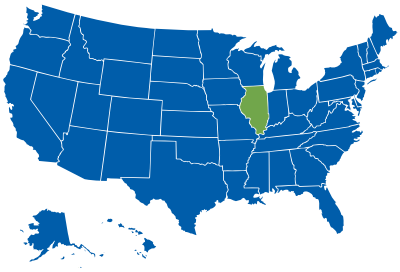
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	97	99	99
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Boise City-Nampa, ID (100-point scale)[3]	88	95	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Illinois

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Illinois, 39.8% of households included children and 17.9% included older adults. In addition, 9.9% of adults reported having diabetes, 17.0% a condition that limits activities, and 7.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Information Sharing
4. Emergency Public Information and Warning
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	3	3	3
Proportion of LRN-B proficiency tests passed[3]	7 / 9	1 / 1	7 / 8
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	2
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	96% (target: 90%)	92% (target: 90%)	96% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	88% (target: 90%)	87% (target: 90%)	94% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	3	3	3
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Level 3 labs: all passed	Level 3 labs: all passed	Level 3 labs: all passed

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	6 (target: 60)	—	7
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$16,171,811
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	34

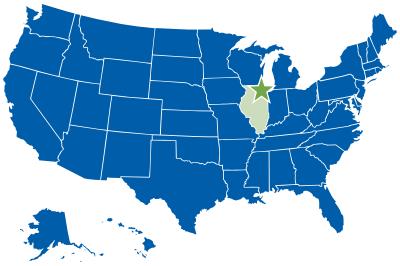
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	98
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Chicago-Naperville-Joliet, IL-IN-WI (100-point scale)[3]	95	95	89
Peoria, IL (100-point scale)[3]	93	93	91
St. Louis, MO-IL (100-point scale)[3]	95	97	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Chicago

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Chicago, 34.9% of households included children and 11.2% included older adults. In addition, 8.0% of adults reported having diabetes, 16.7% a condition that limits activities, and 7.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Medical Materiel Management & Distribution 2. Community Preparedness 3. Public Health Surveillance & Epidemiologic Investigation 4. Information Sharing 5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	Lab located in Chicago is operated by the state of Illinois. See Illinois fact sheet.		
Proportion of LRN-B proficiency tests passed[3]	—	—	—
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	—	—	—
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	—	—	—
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	—	—	—

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	Lab located in Chicago is operated by the state of Illinois. See Illinois fact sheet.		
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	—	—	—
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	—	—	—
Result of LRN-C exercise to collect, package, and ship samples[3]	—	—	—

Chicago

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	60	69	N/A
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$9,577,708
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

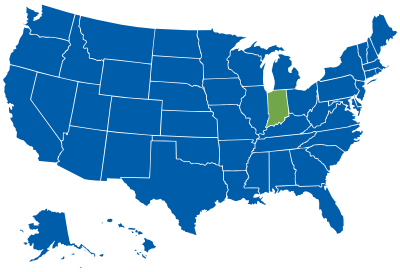
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Directly Funded Locality TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	100	100	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C

Indiana

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Indiana, 37.1% of households included children and 18.6% included older adults. In addition, 11.0% of adults reported having diabetes, 20.4% a condition that limits activities, and 8.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Information Sharing
4. Medical Materiel Management & Distribution
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	0 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Indiana

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	38 (target: 60)	52	30
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$10,943,177
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	5

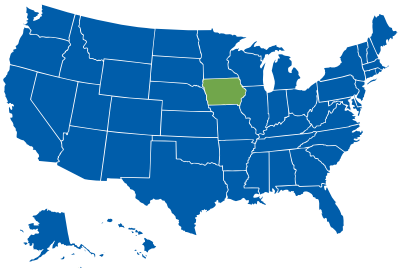
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Chicago-Naperville-Joliet, IL-IN-WI (100-point scale)[3]	95	95	89
Cincinnati-Middletown, OH-KY-IN (100-point scale)[3]	90	92	96
Indianapolis-Carmel, IN (100-point scale)[3]	93	93	86
Louisville, KY-IN (100-point scale)[3]	87	89	94

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Iowa

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Iowa, 35.7% of households included children and 20.6% included older adults. In addition, 9.3% of adults reported having diabetes, 19.1% a condition that limits activities, and 7.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Information Sharing
4. Non-Pharmaceutical Interventions
5. Community Recovery

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	2 / 2
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	2
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	89% (target: 90%)	88% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1*	1*	1*
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	7 / 9	7 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

*Iowa has two labs with different capabilities that together represent the state's full capabilities.

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	53 (target: 60)	17	59
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,587,966
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

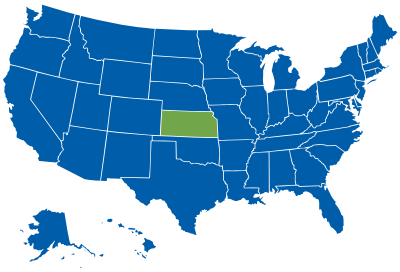
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	98	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Des Moines-West Des Moines, IA (100-point scale)[3]	89	90	87
Omaha-Council Bluffs, NE-IA (100-point scale)[3]	88	95	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Kansas

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Kansas, 37.0% of households included children and 18.9% included older adults. In addition, 9.6% of adults reported having diabetes, 19.1% a condition that limits activities, and 7.8% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Medical Surge
3. Volunteer Management
4. Emergency Public Information and Warning
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Kansas

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	59 (target: 60)	60	57
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,558,282
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	11

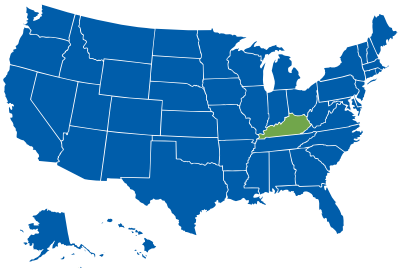
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Kansas City, MO-KS (100-point scale)[3]	97	97	98
Wichita, KS (100-point scale)[3]	89	94	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Kentucky

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Kentucky, 35.7% of households included children and 19.1% included older adults. In addition, 10.6% of adults reported having diabetes, 25.8% a condition that limits activities, and 10.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Medical Materiel Management & Distribution
4. Information Sharing
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	2 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	90% (target: 90%)	81% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	78% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Kentucky

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	16 (target: 60)	12	19
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$8,206,827
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	5

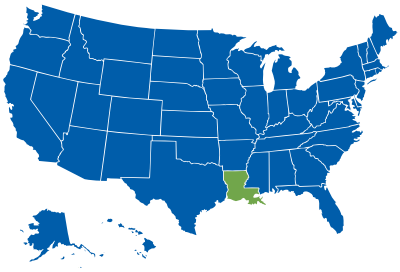
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Cincinnati-Middletown, OH-KY-IN (100-point scale)[3]	90	92	96
Louisville, KY-IN (100-point scale)[3]	87	89	94

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Louisiana

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Louisiana, 36.1% of households included children and 17.8% included older adults. In addition, 11.6% of adults reported having diabetes, 22.8% a condition that limits activities, and 9.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Medical Countermeasure Dispensing
2. Medical Materiel Management & Distribution
3. Information Sharing
4. Public Health Surveillance & Epidemiologic Investigation
5. Public Health Laboratory Testing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	2
Proportion of LRN-B proficiency tests passed[3]	2 / 3	0 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	0% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	0% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0 / 9	0 / 9	0 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Louisiana

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	30 (target: 60)	50	10
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$8,557,781
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	32

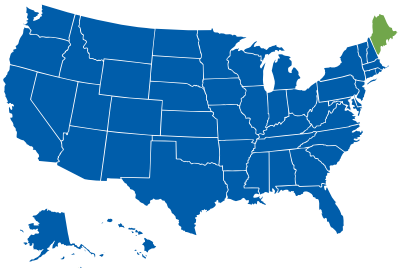
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Baton Rouge, LA (100-point scale)[3]	96	98	97
New Orleans-Metairie-Kenner, LA (100-point scale)[3]	98	99	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Maine

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Maine, 32.0% of households included children and 21.8% included older adults. In addition, 9.7% of adults reported having diabetes, 22.5% a condition that limits activities, and 7.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Emergency Public Information and Warning
4. Medical Countermeasure Dispensing*
5. Medical Materiel Management & Distribution*

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	8 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

*Maine has a tie for the 4th and 5th ranked capability-specific investments

Maine

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	24 (target: 60)	53	9
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,646,029
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

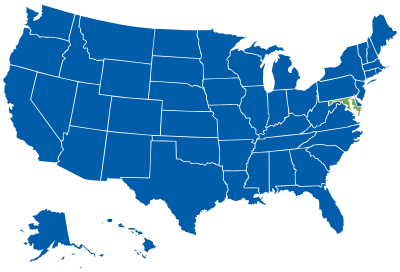
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	96	98	95
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Portland-South Portland-Biddeford, ME (100-point scale)[3]	96	97	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Maryland

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Maryland, 36.3% of households included children and 17.6% included older adults. In addition, 9.8% of adults reported having diabetes, 16.8% a condition that limits activities, and 7.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Medical Countermeasure Dispensing
2. Public Health Laboratory Testing
3. Information Sharing
4. Medical Materiel Management & Distribution
5. Public Health Surveillance & Epidemiologic Investigation

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	3	3	3
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	97% (target: 90%)	96% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	92% (target: 90%)	93% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Maryland

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	15 (target: 60)	19	22
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$10,764,852
CDC preparedness field staff[8, 9, 10]	4*
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	—

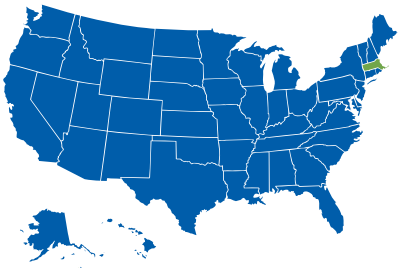
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Baltimore-Towson, MD (100-point scale)[3]	97	99	99
Philadelphia-Camden-Cecil-Wilmington, PA-NJ-MD-DE (100-point scale)[3]	97	98	98
Washington-Arlington-Alexandria, DC-VA-MD-WV (100-point scale)[3]	94	96	99

*One EIS Officer is funded by a federal facility.
Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Massachusetts

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Massachusetts, 35.6% of households included children and 19.0% included older adults. In addition, 8.5% of adults reported having diabetes, 18.5% a condition that limits activities, and 7.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Information Sharing
5. Medical Countermeasure Dispensing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	1
Proportion of LRN-B proficiency tests passed[3]	6 / 6	3 / 3	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	98% (target: 90%)	78% (target: 90%)	83% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Massachusetts

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	15 (target: 60)	11	7
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$12,467,088
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	184

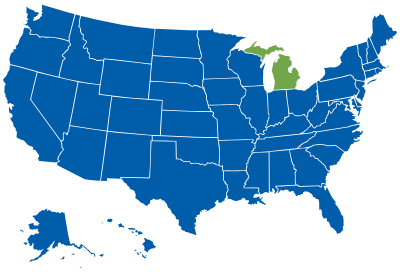
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	89	91	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Boston-Cambridge-Quincy, MA-NH (100-point scale)[3]	76	85	92
Providence-New Bedford-Fall River, RI-MA (100-point scale)[3]	85	90	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Michigan

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Michigan, 34.1% of households included children and 19.5% included older adults. In addition, 10.4% of adults reported having diabetes, 23.0% a condition that limits activities, and 9.6% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Emergency Operations Coordination
4. Medical Materiel Management & Distribution
5. Medical Countermeasure Dispensing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	6	5	5
Proportion of LRN-B proficiency tests passed[3]	4 / 6	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	2
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	87% (target: 90%)	86% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	84% (target: 90%)	82% (target: 90%)	92% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Michigan

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	56 (target: 60)	62	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$16,056,680
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	1

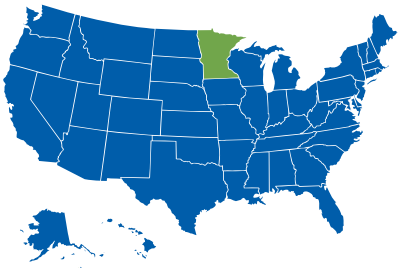
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Detroit-Warren-Livonia, MI (100-point scale)[3]	98	97	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Minnesota

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Minnesota, 36.4% of households included children and 18.4% included older adults. In addition, 7.4% of adults reported having diabetes, 15.8% a condition that limits activities, and 6.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Medical Countermeasure Dispensing
5. Medical Materiel Management & Distribution

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	91% (target: 90%)	99% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	93% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	3	3	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Minnesota

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	7 (target: 60)	39	38
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$10,710,499
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	5

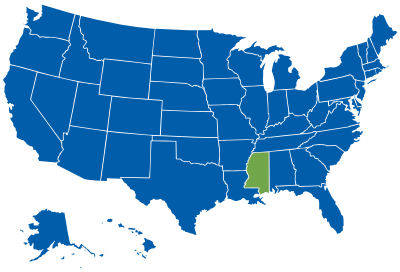
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	93	98	99
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Fargo, ND-MN (100-point scale)[3]	99	99	99
Minneapolis-St. Paul-Bloomington, MN-WI (100-point scale)[3]	90	91	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Mississippi

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Mississippi, 38.0% of households included children and 18.6% included older adults. In addition, 12.9% of adults reported having diabetes, 24.9% a condition that limits activities, and 10.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Emergency Operations Coordination
4. Medical Countermeasure Dispensing
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	2 / 2
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	5 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Mississippi

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	3 (target: 60)	9	7
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,530,372
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	66

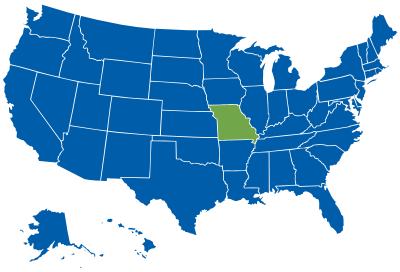
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Jackson, MS (100-point scale)[3]	93	95	98
Memphis, TN-MS-AR (100-point scale)[3]	94	96	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Missouri

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Missouri, 34.1% of households included children and 19.7% included older adults. In addition, 9.6% of adults reported having diabetes, 24.2% a condition that limits activities, and 10.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Emergency Operations Coordination
5. Medical Materiel Management & Distribution

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	2 / 2
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	98% (target: 90%)	97% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Missouri

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	34 (target: 60)	54	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$10,527,224
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

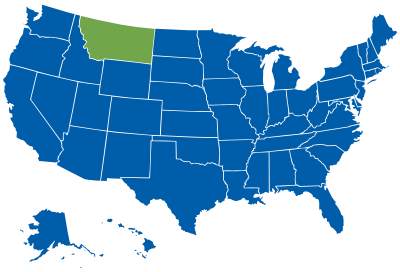
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	92	99	98
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Kansas City, MO-KS (100-point scale)[3]	97	97	98
St. Louis, MO-IL (100-point scale)[3]	95	97	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Montana

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Montana, 31.9% of households included children and 20.9% included older adults. In addition, 7.7% of adults reported having diabetes, 22.6% a condition that limits activities, and 7.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Laboratory Testing 2. Information Sharing 3. Community Preparedness 4. Community Recovery 5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	85% (target: 90%)	92% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	5 / 9	5 / 9	6 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Montana

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	9 (target: 60)	12	9
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,269,302
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	2

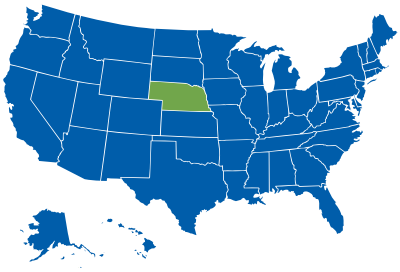
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	87	93	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Billings, MT (100-point scale)[3]	75	92	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Nebraska

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Nebraska, 36.9% of households included children and 19.1% included older adults. In addition, 9.2% of adults reported having diabetes, 18.8% a condition that limits activities, and 6.8% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Community Preparedness
3. Information Sharing
4. Public Health Surveillance & Epidemiologic Investigation
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	2
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	95% (target: 90%)	100% (target: 90%)	96% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	70% (target: 90%)	100% (target: 90%)	0% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Nebraska

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	37 (target: 60)	65	15
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$5,225,461
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	1

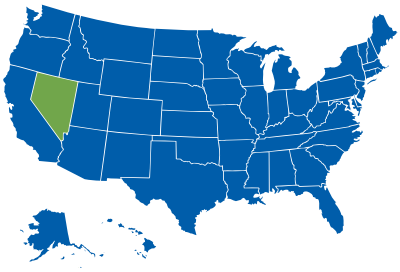
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	98	92	95
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Omaha-Council Bluffs, NE-IA (100-point scale)[3]	88	95	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Nevada

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Nevada, 37.0% of households included children and 17.9% included older adults. In addition, 9.6% of adults reported having diabetes, 18.8% a condition that limits activities, and 7.9% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Emergency Public Information and Warning
2. Medical Countermeasure Dispensing
3. Information Sharing
4. Public Health Surveillance & Epidemiologic Investigation
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	2
Proportion of LRN-B proficiency tests passed[3]	5 / 7	2 / 2	5 / 5
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	2
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	80% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	3 / 9	7 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	1	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Nevada

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	36 (target: 60)	6	40
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,515,662
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	24

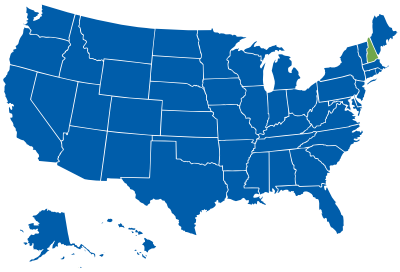
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	90	95	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Las Vegas-Paradise, NV (100-point scale)[3]	99	100	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

New Hampshire

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In New Hampshire, 33.6% of households included children and 19.2% included older adults. In addition, 9.2% of adults reported having diabetes, 19.7% a condition that limits activities, and 6.8% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Information Sharing
5. Community Recovery

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	7 / 9	7 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

New Hampshire

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	20 (target: 60)	35	19
Prepared an after-action report and improvement plan following a real or simulated response[3]	No	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,743,037
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	38

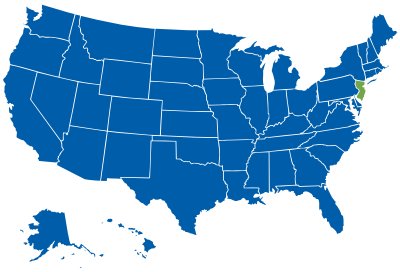
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	92	89
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Boston-Cambridge-Quincy, MA-NH (100-point scale)[3]	76	85	92
Manchester-Nashua, NH (100-point scale)[3]	80	81	90

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

New Jersey

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In New Jersey, 39.1% of households included children and 18.9% included older adults. In addition, 9.2% of adults reported having diabetes, 16.2% a condition that limits activities, and 6.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Community Preparedness
4. Emergency Operations Coordination
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	79% (target: 90%)	90% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	71% (target: 90%)	26% (target: 90%)	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	6 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

New Jersey

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	45 (target: 60)	44	40
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$14,993,348
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	10
Public health personnel who received CDC Strategic National Stockpile training[12]	1

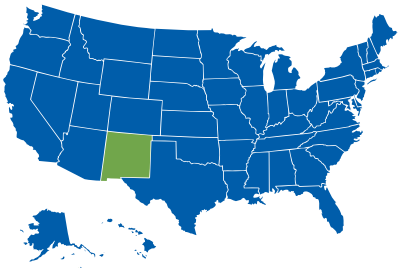
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
New York-Northern New Jersey-Long Island, NY-NJ-PA (100-point scale)[3]	93	95	96
Philadelphia-Camden-Cecil-Wilmington, PA-NJ-MD-DE (100-point scale)[3]	97	98	98
Trenton-Ewing, NJ (100-point scale)[3]	100	100	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

New Mexico

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In New Mexico, 40.1% of households included children and 19.3% included older adults. In addition, 10.7% of adults reported having diabetes, 21.9% a condition that limits activities, and 9.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Information Sharing
5. Emergency Public Information and Warning

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	94% (target: 90%)	85% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

New Mexico

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	37 (target: 60)	30	59
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,494,648
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	74

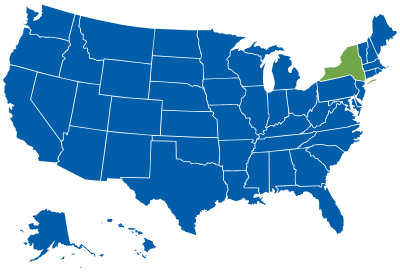
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	94	95
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Albuquerque, NM (100-point scale)[3]	96	92	95

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

New York

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In New York, 37.8% of households included children and 18.7% included older adults. In addition, 10.6% of adults reported having diabetes, 19.4% a condition that limits activities, and 9.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Information Sharing
4. Medical Countermeasure Dispensing
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	3	3	3
Proportion of LRN-B proficiency tests passed[3]	9 / 9	3 / 3	9 / 9
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	2
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	99% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	97% (target: 90%)	96% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

New York

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	41 (target: 60)	20	12
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$18,687,686
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	5

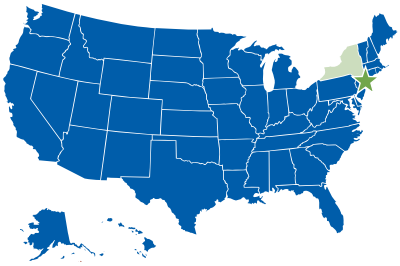
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Albany-Schenectady-Troy, NY (100-point scale)[3]	99	98	99
Buffalo-Niagara Falls, NY (100-point scale)[3]	88	98	99
New York-Northern New Jersey-Long Island, NY-NJ-PA (100-point scale)[3]	93	95	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

New York City

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In New York City, 33.2% of households included children and 13.6% included older adults. In addition, 9.9% of adults reported having diabetes, 17.1% a condition that limits activities, and 8.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Surveillance & Epidemiologic Investigation 2. Public Health Laboratory Testing 3. Emergency Operations Coordination 4. Information Sharing 5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	72% (target: 90%)	94% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	91% (target: 90%)	98% (target: 90%)	91% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

New York City

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	48	60	58
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$17,840,704
CDC preparedness field staff[8, 9, 10]	10
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

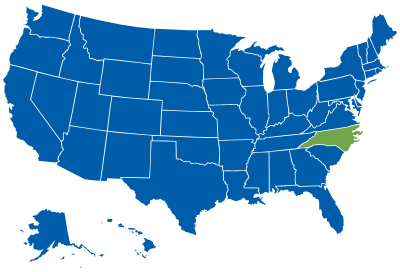
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Directly Funded Locality TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	100	100	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C

North Carolina

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In North Carolina, 32.7% of households included children and 18.6% included older adults. In addition, 11.4% of adults reported having diabetes, 21.2% a condition that limits activities, and 9.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Information Sharing
4. Emergency Operations Coordination
5. Emergency Public Information and Warning

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	4	3	3
Proportion of LRN-B proficiency tests passed[3]	13 / 13	1 / 1	9 / 9
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	97% (target: 90%)	93% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	60% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	1	1	1
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

North Carolina

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	16 (target: 60)	10	10
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$14,008,193
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

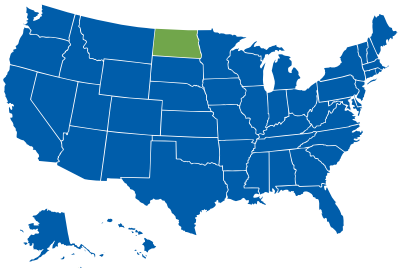
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	92	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Charlotte-Gastonia-Concord, NC-SC (100-point scale)[3]	95	96	99
Virginia Beach-Norfolk-Newport News, VA-NC (100-point scale)[3]	90	90	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

North Dakota

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In North Dakota, 33.0% of households included children and 19.5% included older adults. In addition, 8.9% of adults reported having diabetes, 16.7% a condition that limits activities, and 6.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Medical Materiel Management & Distribution
2. Public Health Laboratory Testing
3. Public Health Surveillance & Epidemiologic Investigation
4. Medical Countermeasure Dispensing
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	2 / 2
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	92% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

North Dakota

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	25 (target: 60)	14	30
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$3,987,619
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	8

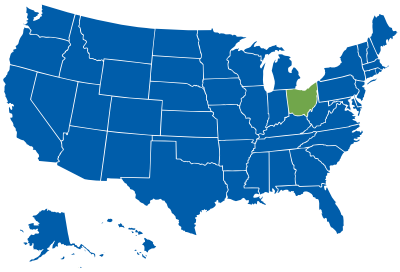
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	97	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Fargo, ND-MN (100-point scale)[3]	99	99	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Ohio

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Ohio, 35.4% of households included children and 19.9% included older adults. In addition, 10.4% of adults reported having diabetes, 20.6% a condition that limits activities, and 8.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Medical Countermeasure Dispensing
3. Community Preparedness
4. Medical Materiel Management & Distribution
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	99% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	—	—
Number of Level 3 LRN-C labs[5]	—	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2 / 9	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	39 (target: 60)	30	52
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$17,281,814
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	62

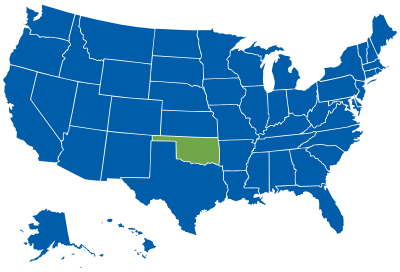
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Cincinnati-Middletown, OH-KY-IN (100-point scale)[3]	90	92	96
Cleveland-Elyria-Mentor, OH (100-point scale)[3]	94	96	99
Columbus, OH (100-point scale)[3]	85	94	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Oklahoma

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Oklahoma, 37.0% of households included children and 19.3% included older adults. In addition, 11.0% of adults reported having diabetes, 24.9% a condition that limits activities, and 9.6% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Community Preparedness
3. Medical Materiel Management & Distribution
4. Medical Countermeasure Dispensing
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Oklahoma

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	8 (target: 60)	15	18
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$7,499,619
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	6

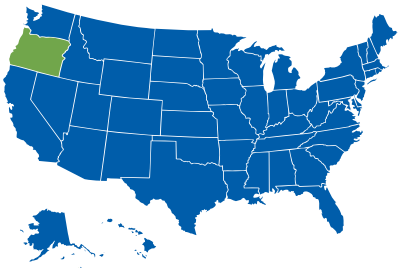
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Oklahoma City, OK (100-point scale)[3]	97	97	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Oregon

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Oregon, 33.8% of households included children and 19.7% included older adults. In addition, 9.2% of adults reported having diabetes, 21.0% a condition that limits activities, and 8.4% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Community Preparedness
2. Medical Countermeasure Dispensing
3. Emergency Public Information and Warning
4. Public Health Laboratory Testing
5. Public Health Surveillance & Epidemiologic Investigation

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	61% (target: 90%)	38% (target: 90%)	65% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Oregon

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	15 (target: 60)	55	57
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$7,729,601
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

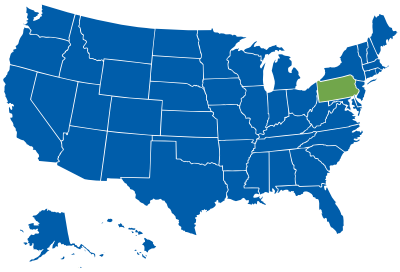
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	98	99	99
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Portland-Vancouver-Beaverton, OR-WA (100-point scale)[3]	93	88	94

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Pennsylvania

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Pennsylvania, 33.7% of households included children and 21.1% included older adults. In addition, 10.1% of adults reported having diabetes, 20.2% a condition that limits activities, and 9.2% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Information Sharing
4. Community Preparedness
5. Responder Safety and Health

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	2	2	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	91% (target: 90%)	99% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	91% (target: 90%)	56% (target: 90%)	93% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	1	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Pennsylvania

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	42 (target: 60)	45	31
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$18,810,406
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	47

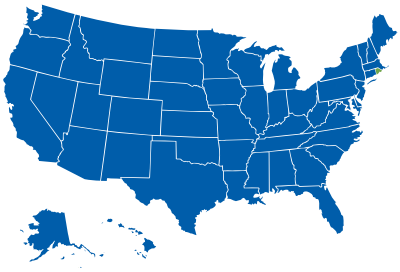
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	97	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
New York-Northern New Jersey-Long Island, NY-NJ-PA (100-point scale)[3]	93	95	96
Philadelphia-Camden-Cecil-Wilmington, PA-NJ-MD-DE (100-point scale)[3]	97	98	98
Pittsburgh, PA (100-point scale)[3]	98	99	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Rhode Island

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Rhode Island, 33.1% of households included children and 19.6% included older adults. In addition, 9.3% of adults reported having diabetes, 20.6% a condition that limits activities, and 8.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Medical Countermeasure Dispensing
4. Emergency Operations Coordination
5. Emergency Public Information and Warning

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	7 / 9	7 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Rhode Island

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	4 (target: 60)	7	5
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	No
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,447,206
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	1

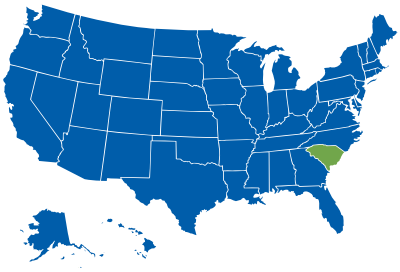
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Providence-New Bedford-Fall River, RI-MA (100-point scale)[3]	85	90	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

South Carolina

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In South Carolina, 35.2% of households included children and 19.8% included older adults. In addition, 12.5% of adults reported having diabetes, 23.3% a condition that limits activities, and 10.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Emergency Operations Coordination
4. Medical Countermeasure Dispensing
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	67% (target: 90%)	80% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	83% (target: 90%)	88% (target: 90%)	90% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

South Carolina

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	55 (target: 60)	7	30
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$9,289,583
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	12

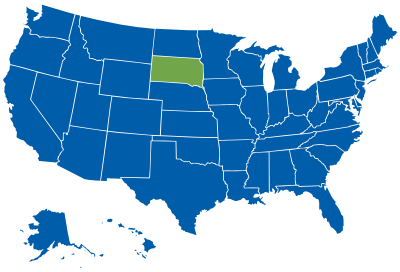
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	87	90	91
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Charlotte-Gastonia-Concord, NC-SC (100-point scale)[3]	95	96	99
Columbia, SC (100-point scale)[3]	86	89	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

South Dakota

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In South Dakota, 35.2% of households included children and 20.1% included older adults. In addition, 9.1% of adults reported having diabetes, 18.9% a condition that limits activities, and 7.9% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Information Sharing
4. Medical Countermeasure Dispensing
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	61% (target: 90%)	89% (target: 90%)	91% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	8 / 9	8 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

South Dakota

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	35 (target: 60)	15	15
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$4,074,534
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	—

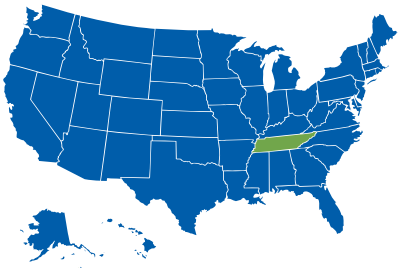
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	87	89	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Sioux Falls, SD (100-point scale)[3]	93	94	96

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Tennessee

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Tennessee, 32.0% of households included children and 19.3% included older adults. In addition, 12.2% of adults reported having diabetes, 25.1% a condition that limits activities, and 11.0% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Community Preparedness
3. Public Health Laboratory Testing
4. Volunteer Management
5. Mass Care

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	4	4	4
Proportion of LRN-B proficiency tests passed[3]	9 / 9	1 / 2	7 / 7
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	96% (target: 90%)	99% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	89% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2 / 9	3 / 9	4 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Tennessee

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	15 (target: 60)	52	35
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$10,742,988
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	3

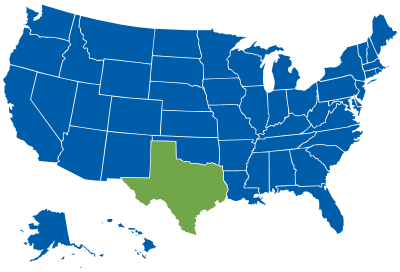
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	94	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Memphis, TN-MS-AR (100-point scale)[3]	94	96	99
Nashville-Davidson-Murfreesboro, TN (100-point scale)[3]	90	92	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Texas

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Texas, 44.2% of households included children and 15.5% included older adults. In addition, 11.0% of adults reported having diabetes, 15.7% a condition that limits activities, and 7.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Community Preparedness
2. Public Health Surveillance & Epidemiologic Investigation
3. Public Health Laboratory Testing
4. Medical Countermeasure Dispensing
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	11	11	10
Proportion of LRN-B proficiency tests passed[3]	26 / 29	5 / 7	22 / 25
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	3	3	3
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	97% (target: 90%)	75% (target: 90%)	99% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	90% (target: 90%)	68% (target: 90%)	87% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Texas

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	45 (target: 60)	4	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$34,758,426
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	9
Public health personnel who received CDC Strategic National Stockpile training[12]	68

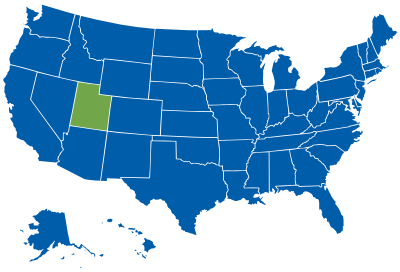
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	96	97	95
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Dallas-Fort Worth-Arlington, TX (100-point scale)[3]	98	96	99
Houston-Baytown-Sugar Land, TX (100-point scale)[3]	87	88	96
San Antonio, TX (100-point scale)[3]	89	89	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Utah

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Utah, 48.0% of households included children and 14.1% included older adults. In addition, 7.1% of adults reported having diabetes, 17.2% a condition that limits activities, and 5.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Emergency Public Information and Warning
4. Medical Materiel Management & Distribution
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	1 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	98% (target: 90%)	96% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	6 / 9	7 / 9	8 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	5 (target: 60)	9	60
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,368,151
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	61

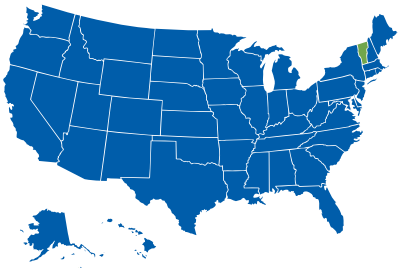
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	99	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Salt Lake City, UT (100-point scale)[3]	97	96	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Vermont

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Vermont, 30.9% of households included children and 20.2% included older adults. In addition, 7.8% of adults reported having diabetes, 20.6% a condition that limits activities, and 7.3% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Public Health Laboratory Testing
3. Community Preparedness
4. Medical Materiel Management & Distribution
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	0 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	50% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	2	2	2
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	18 (target: 60)	28	10
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$3,987,619
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	3

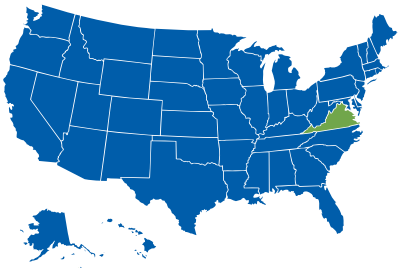
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	97	97	99
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Burlington-South Burlington, VT (100-point scale)[3]	98	95	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Virginia

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Virginia, 37.9% of households included children and 17.5% included older adults. In addition, 9.8% of adults reported having diabetes, 17.7% a condition that limits activities, and 7.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Surveillance & Epidemiologic Investigation
2. Community Preparedness
3. Public Health Laboratory Testing
4. Emergency Public Information and Warning
5. Volunteer Management

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	4 / 4	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	98% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	97% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Virginia

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	28 (target: 60)	25	52
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$14,188,481
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	3

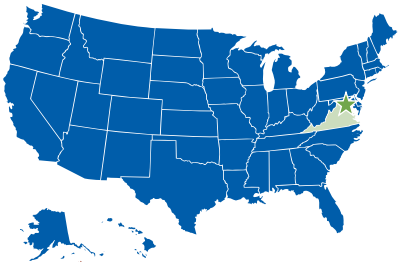
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	100	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Richmond, VA (100-point scale)[3]	89	82	95
Virginia Beach-Norfolk-Newport News, VA-NC (100-point scale)[3]	90	90	97
Washington-Arlington-Alexandria, DC-VA-MD-WV (100-point scale)[3]	94	96	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Washington, D.C.

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Washington, D.C., 25.2% of households included children and 14.9% included older adults. In addition, 7.8% of adults reported having diabetes, 17.7% a condition that limits activities, and 10.1% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Surveillance & Epidemiologic Investigation 2. Medical Materiel Management & Distribution 3. Medical Countermeasure Dispensing 4. Emergency Operations Coordination 5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	1 / 2	Did not participate	2 / 2
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	N/A	N/A
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	0% (target: 90%)	0% (target: 90%)	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0 / 9	3 / 9	5 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Washington, D.C.

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	5	N/A	17
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$6,277,908
CDC preparedness field staff[8, 9, 10]	1
CDC Emergency Management Program activities[11]	10
Public health personnel who received CDC Strategic National Stockpile training[12]	4

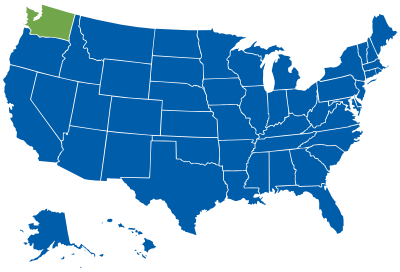
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Directly Funded Locality TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	93	96	98

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C

Washington

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Washington, 35.2% of households included children and 17.8% included older adults. In addition, 8.6% of adults reported having diabetes, 24.1% a condition that limits activities, and 8.5% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Medical Countermeasure Dispensing
2. Community Preparedness
3. Information Sharing
4. Medical Surge
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	3	3	2
Proportion of LRN-B proficiency tests passed[3]	6 / 6	2 / 2	4 / 4
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	91% (target: 90%)	93% (target: 90%)	97% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	72% (target: 90%)	87% (target: 90%)	88% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Washington

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	29 (target: 60)	6	18
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$11,495,351
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	8
Public health personnel who received CDC Strategic National Stockpile training[12]	3

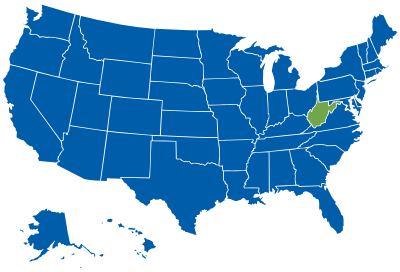
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	94	98	97
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Portland-Vancouver-Beaverton, OR-WA (100-point scale)[3]	93	88	94
Seattle-Tacoma-Bellevue, WA (100-point scale)[3]	90	96	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

West Virginia

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In West Virginia, 32.0% of households included children and 21.9% included older adults. In addition, 13.0% of adults reported having diabetes, 27.6% a condition that limits activities, and 11.7% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Emergency Operations Coordination
2. Public Health Laboratory Testing
3. Public Health Surveillance & Epidemiologic Investigation
4. Emergency Public Information and Warning
5. Information Sharing

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	2 / 2	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	N/A	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	5 / 9	6 / 9	6 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

West Virginia

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	2 (target: 60)	2	15
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$5,243,236
CDC preparedness field staff[8, 9, 10]	4
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	1

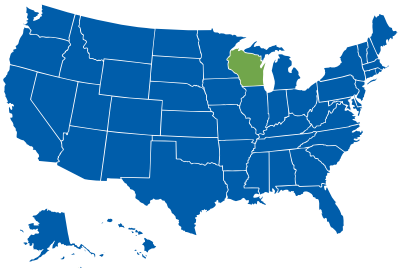
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	93	96	96
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Charleston, WV (100-point scale)[3]	83	93	95
Washington-Arlington-Alexandria, DC-VA-MD-WV (100-point scale)[3]	94	96	99

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Wisconsin

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Wisconsin, 35.1% of households included children and 19.2% included older adults. In addition, 8.2% of adults reported having diabetes, 19.0% a condition that limits activities, and 7.9% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Community Preparedness
4. Information Sharing
5. Emergency Operations Coordination

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	2	2	2
Proportion of LRN-B proficiency tests passed[3]	5 / 6	2 / 3	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	94% (target: 90%)	90% (target: 90%)	98% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	1	1	1
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	9 / 9	9 / 9	9 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	4	4	4
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Wisconsin

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	17 (target: 60)	40	18
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$11,128,783
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	7
Public health personnel who received CDC Strategic National Stockpile training[12]	—

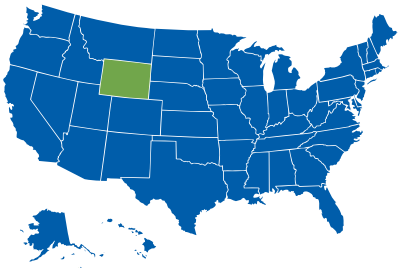
States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	98	82	90
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Chicago-Naperville-Joliet, IL-IN-WI (100-point scale)[3]	95	95	89
Milwaukee-Waukesha-West Allis, WI (100-point scale)[3]	89	95	99
Minneapolis-St. Paul-Bloomington, MN-WI (100-point scale)[3]	90	91	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Wyoming

Successful planning for and response to public health emergencies require protecting the health and safety of all people, especially those who are most vulnerable to the impact of an event. Children, older adults, and people with certain chronic conditions may require additional care such as specialized medications, equipment, and other assistance. States and localities must consider the unique needs of their own population. In Wyoming, 34.8% of households included children and 18.2% included older adults. In addition, 8.6% of adults reported having diabetes, 19.5% a condition that limits activities, and 8.1% a health problem that required the use of specialized equipment.[1]



CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Emergency Operations Coordination
3. Emergency Public Information and Warning
4. Responder Safety and Health
5. Community Preparedness

Laboratory Response Network biological (LRN-B) labs and PulseNet laboratories independently and rapidly identify and notify CDC of potential biological health threats to minimize disease outbreaks.
CDC manages the LRN-B, a group of 99 public health labs with testing capabilities to confirm the presence of hazardous biological agents. CDC also coordinates PulseNet, a national network of labs that analyzes and connects foodborne illness cases together to facilitate early identification of outbreak sources. The performance indicators below demonstrate these specific labs' readiness to respond to a biological public health emergency. See Appendix B for a detailed description of each performance indicator.

Biological Laboratory Testing: LRN-B	2012	2013	2014
Number of LRN-B labs[3]	1	1	1
Proportion of LRN-B proficiency tests passed[3]	3 / 3	0 / 1	3 / 3
Biological Laboratory Testing: PulseNet	**2012**	**2013**	**2014**
Number of PulseNet labs[4]	1	1	1
Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	100% (target: 90%)	100% (target: 90%)
Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within 4 working days[4]	100% (target: 90%)	N/A	N/A

LRN chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	—	—	—
Number of Level 3 LRN-C labs[5]	1	1	1
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	N/A	N/A	N/A
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Wyoming

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	13 (target: 60)	14	6
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$3,987,619
CDC preparedness field staff[8, 9, 10]	3
CDC Emergency Management Program activities[11]	6
Public health personnel who received CDC Strategic National Stockpile training[12]	13

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency for the state overall and localities in the Cities Readiness Initiative (CRI). See Appendix B for a detailed description of TAR scores.

State TAR Score	2011–2012	2012–2013	2013–2014
TAR score (out of 100-point scale)[3]	99	100	100
CRI Metropolitan Statistical Area (MSA) TAR Score(s)	**2011–2012**	**2012–2013**	**2013–2014**
Cheyenne, WY (100-point scale)[3]	82	91	97

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

American Samoa

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Community Preparedness 2. Public Health Surveillance & Epidemiologic Investigation 3. Public Health Laboratory Testing 4. Information Sharing 5. Community Recovery

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	N/A
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$373,838
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	65	50	69

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Fed States of Micronesia

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Emergency Operations Coordination 2. Community Preparedness 3. Medical Countermeasure Dispensing 4. Emergency Public Information and Warning 5. Public Health Laboratory Testing

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	N/A
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	No
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	No
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$419,098
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	60	50	65

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Guam

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Laboratory Testing 2. Public Health Surveillance & Epidemiologic Investigation 3. Community Preparedness 4. Medical Countermeasure Dispensing 5. Medical Materiel Management & Distribution

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	Yes
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$501,025
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	85	75	90

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Northern Mariana Islands

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Medical Countermeasure Dispensing 2. Public Health Surveillance & Epidemiologic Investigation 3. Emergency Operations Coordination 4. Medical Surge 5. Responder Safety and Health

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	N/A
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$353,703
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	69	50	85

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Puerto Rico

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness.
The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]

1. Public Health Laboratory Testing
2. Public Health Surveillance & Epidemiologic Investigation
3. Information Sharing
4. Medical Countermeasure Dispensing
5. Community Preparedness

Laboratory Response Network chemical (LRN-C) laboratories rapidly identify exposure to toxic chemicals, aid diagnosis, and minimize further human exposure.
CDC manages the LRN-C, a group of 56 labs with testing capabilities to confirm the presence of chemical agents. LRN-C labs are designated as Level 1, 2, or 3, with Level 1 labs demonstrating the most advanced capabilities. The performance indicators below demonstrate these specific labs' readiness to respond to a chemical public health emergency. See Appendix B for a detailed description of each performance indicator.

Chemical Laboratory Testing: LRN-C	2012	2013	2014
Number of Level 1 LRN-C labs[5]	—	—	—
Number of Level 2 LRN-C labs[5]	1	1	1
Number of Level 3 LRN-C labs[5]	—	—	—
Proportion of **core** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0 / 9	0 / 9	0 / 9
Number of **additional** chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs[3]	0	0	0
Result of LRN-C exercise to collect, package, and ship samples[3]	Passed	Passed	Passed

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2012	2013	2014
Number of minutes for public health staff with incident management lead roles to report for immediate duty[3]	45	4	45
Prepared an after-action report and improvement plan following a real or simulated response[3]	Yes	Yes	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

Puerto Rico

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$7,141,090
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	1
Public health personnel who received CDC Strategic National Stockpile training[12]	5

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	97	100	100

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Republic of the Marshall Islands

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Surveillance & Epidemiologic Investigation 2. Emergency Operations Coordination 3. Emergency Public Information and Warning 4. Information Sharing 5. Community Preparedness

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	N/A
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	No
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	No
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$373,200
CDC preparedness field staff[8, 9, 10]	—
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	65	67	66

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

Republic of Palau

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Public Health Surveillance & Epidemiologic Investigation 2. Responder Safety and Health 3. Emergency Public Information and Warning 4. Community Preparedness 5. Public Health Laboratory Testing

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	N/A
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	Yes
Reduced the cycle time for hiring and/or reassignment of staff[6]	Yes

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$323,206
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	51

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	66	79	79

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

U.S. Virgin Islands

CDC identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. The list to the right reflects the 5 capabilities with the largest Public Health Emergency Preparedness (PHEP) investments during 2014.[2]	1. Emergency Operations Coordination 2. Community Preparedness 3. Volunteer Management 4. Medical Countermeasure Dispensing 5. Information Sharing

Public health agencies deploy resources and personnel to address public health needs arising from emergencies.
The performance indicators below demonstrate the ability to coordinate a response to a public health incident. See Appendix B for a detailed description of each performance indicator.

Emergency Operations Coordination	2014
Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid[3]	No
Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center[3]	Yes

Administrative preparedness was highlighted as a key challenge during the 2009 H1N1 influenza pandemic.
In response, CDC developed standards and requirements for administrative and fiscal processes, which state and local health departments have now incorporated into their incident action plans. These processes, which differ from normal operations, include emergency procurement, contracting, and hiring processes. See Appendix B for a detailed description of administrative preparedness.

Administrative Preparedness	2014
Expedited procedures for receiving emergency funds[6]	Yes
Reduced the cycle time for contracting and/or procurement of necessary goods and services[6]	No
Reduced the cycle time for hiring and/or reassignment of staff[6]	No

CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities.
CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts. See Appendix B for a detailed description of each CDC resource.

CDC Resources Supporting Preparedness	2013–2014
CDC PHEP cooperative agreement funding provided[7]	$421,983
CDC preparedness field staff[8, 9, 10]	2
CDC Emergency Management Program activities[11]	—
Public health personnel who received CDC Strategic National Stockpile training[12]	—

States, localities, and insular areas ensure medicine, vaccines, and medical supplies are available to the public during large-scale public health emergencies by supplementing local supplies with assets from CDC's Strategic National Stockpile (SNS).
The technical assistance review (TAR) scores below demonstrate readiness to receive, distribute, and dispense SNS assets to the public during an emergency. See Appendix B for a detailed description of TAR scores.

Island TAR Score	2011–2012	2012–2013	2013–2014
TAR score (100-point scale)[3]	67	83	58

Note: All data furnished by the Centers for Disease Control and Prevention. For more detail on specific data sources, see Appendix C.

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Appendices

Appendix A: Emergency Management Program Activities

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Alabama n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Alaska n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Arizona n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Arkansas n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, federal request process for SNS support, LRN Emergency Contact Drill (2)
California n=9	HAN Notification-Recognizing and Reporting Serogroup B Meningococcal, HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Colorado n=9	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), SITREP-Primary Pneumonic Plague, Incident Notice-HAN to be issued for tularemia, PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Connecticut n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Delaware n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Florida n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Georgia n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), EOC COOP Exercise (02 Nov 13), EOC COOP Exercise (06 Dec 13 – 07 Dec 13)
Hawaii n=8	HAN 356-Acute Hepatitis and Liver Failure the Use of a Dietary Supplement, HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), IHR PHEIC Assess- Acute Liver Failure Associated with a Dietary Supplement
Idaho n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Illinois n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Incident Notice-Request for assistance and potential Exposure, PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Indiana n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, federal request process for SNS support, LRN Emergency Contact Drill (2)

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Iowa n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Kansas n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Kentucky n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Louisiana n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Maine n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Maryland n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Massachusetts n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Michigan n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Minnesota n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Mississippi n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Incident Notice-White Powder Isolate Inquiry
Missouri n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Montana n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Nebraska n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Nevada n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
New Hampshire n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
New Jersey n=10	HAN Notification-Recognizing and Reporting Serogroup B Meningococcal, HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Meningitis Outbreak-Princeton University, Norovirus Outbreak on Cruise Ship, Superbowl XLVIII

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
New Mexico n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Incident Notice-Human Plague
New York n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
North Carolina n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
North Dakota n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Ohio n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), SITREP-Loss of Potable Water Source, PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Oklahoma n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Oregon n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Pennsylvania n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Puerto Rico n=1	IHR Public Health Emergency of International Concern-Chikungunya Virus

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Rhode Island n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
South Carolina n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), SITREP-Smallpox-Era Vaccine Vial Purchased At Yard Sale, Call Center-Bat Exposure in Hospital
South Dakota n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Tennessee n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Texas n=9	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Unaccompanied Alien Children (UAC) Level III Activation, SITREP-Contact Vaccinia in Military Personnel, PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Utah n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, federal request process for SNS support, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Vermont n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)

PHEP Awardee	Domestic Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations, Engagements, and Exercises), 2014*
Virginia n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)
Washington n=8	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg, SITREP—Vaccinia Vaccine Adverse Event
Washington, D.C. n=10	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, 2014 National Exercise Program Capstone Exercise, HHS Notification Drill Coordination Exercise, LRN Emergency Contact Drill (2), NBIS Protocol Activation Drill, Presidential State of the Union Address
West Virginia n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), Chemical Leak
Wisconsin n=7	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2), PHEIC-International investigation of Salmonella Newport, Hartford, and Oranienburg
Wyoming n=6	HAN Notification-Early Reports of pH1N1 Illnesses for 2013–14 Influenza Season, HAN Notification-Guidelines for Evaluation of US Patients Suspected of Having EVD, HAN Notification-Summarizing key messages of Ebola outbreak, HAN: Guidance to U.S. Clinicians Regarding WHO Polio Vaccination Requirements, LRN Emergency Contact Drill (2)

Source: CDC, Division of Emergency Operations, 2014.

* The three activities are defined as follows: **Activation:** a variety of activities such as initiating a preliminary assessment team, developing incident objectives and an Incident Action Plan, activating the incident management structure and deploying personnel. Activations normally include opening the EOC. **Engagement:** assistance provided to address a public health threat that is not expected to require activation. **Exercise:** a simulated emergency situation which allows responders to practice and evaluate use of their emergency response plans.

Country	International Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations and Engagements), 2014*
Algeria	Middle East Respiratory Syndrome (CoV) Level III Activation
Austria	Middle East Respiratory Syndrome (CoV) Level III Activation
Bulgaria	SITREP-Unknown Substance at U.S. Embassy
Cameroon	SITREP-Suspect Monkey pox in Chimpanzees at a Rescue Center
Canada	SITREP-White Powder Incident at U.S. Embassy
Egypt	Middle East Respiratory Syndrome (CoV) Level III Activation
France	HAN Notification-Recognizing/Managing/Reporting Chikungunya Virus in Travelers, Middle East Respiratory Syndrome (CoV) Level III Activation
Germany	SITREP-Unknown Substance Discovered at U.S. Consulate
Greece	Middle East Respiratory Syndrome (CoV) Level III Activation
Guinea	Ebola Level I Activation
Iran	Middle East Respiratory Syndrome (CoV) Level III Activation
Italy	Middle East Respiratory Syndrome (CoV) Level III Activation
Jordan	Middle East Respiratory Syndrome (CoV) Level III Activation
Kuwait	Middle East Respiratory Syndrome (CoV) Level III Activation
Lebanon	Middle East Respiratory Syndrome (CoV) Level III Activation
Liberia	Ebola Level I Activation
Malaysia	Middle East Respiratory Syndrome (CoV) Level III Activation
Netherlands	Middle East Respiratory Syndrome (CoV) Level III Activation
Oman	Middle East Respiratory Syndrome (CoV) Level III Activation
Philippines	Middle East Respiratory Syndrome (CoV) Level III Activation, SITREP-White Powder Incident at U.S. Embassy
Qatar	Middle East Respiratory Syndrome (CoV) Level III Activation

Country	International Public Health Threat Events Supported by OPHPR Emergency Management Program Activities (Activations and Engagements), 2014*
Saudi Arabia	Middle East Respiratory Syndrome (CoV) Level III Activation
Sierra Leone	Ebola Level I Activation
Tunisia	Middle East Respiratory Syndrome (CoV) Level III Activation
Turkey	Middle East Respiratory Syndrome (CoV) Level III Activation
United Arab Emirates (UAE)	Middle East Respiratory Syndrome (CoV) Level III Activation
United Kingdom (UK)	Middle East Respiratory Syndrome (CoV) Level III Activation
Yemen	Middle East Respiratory Syndrome (CoV) Level III Activation
Zambia	Middle East Respiratory Syndrome (CoV) Level III Activation

Source: CDC, Division of Emergency Operations, 2014.

*The two activities are defined as follows: **Activation:** a variety of activities such as initiating a preliminary assessment team, developing incident objectives and an Incident Action Plan, activating the incident management structure and deploying personnel. Activations normally include opening the EOC. **Engagement:** assistance provided to address a public health threat that is not expected to require activation.

Appendix B: Explanation of Fact Sheet Data Points

The data points that appear in the national and individual fact sheets are included below with an explanation of their significance.

Public Health Emergency Preparedness Investments

CDC has identified 15 public health preparedness capabilities as the basis for state and local public health preparedness. Each of the public health capabilities identifies priority resource elements that contribute to routine public health activities and essential public health services, as well as preparedness and response functions. CDC prioritized these capabilities into two tiers, with an emphasis on those that provide a strong basic foundation for public health preparedness (Tier 1). Public Health Emergency Preparedness (PHEP) cooperative agreement awardees are encouraged to develop the Tier 1 capabilities prior to significantly investing in Tier 2 public health preparedness capabilities. The 15 public health preparedness capabilities are noted below (grouped in their corresponding domains):[8]

Biosurveillance

- Public Health Laboratory Testing (Tier 1)
- Public Health Surveillance and Epidemiological Investigation (Tier 1)

Community Resilience

- Community Preparedness (Tier 1)
- Community Recovery (Tier 2)

Countermeasures and Mitigation

- Medical Countermeasure Dispensing (Tier 1)
- Medical Materiel Management and Distribution (Tier 1)
- Non-Pharmaceutical Interventions (Tier 2)
- Responder Safety and Health (Tier 2)

Incident Management

- Emergency Operations Coordination (Tier 1)

Information Management

- Emergency Public Information and Warning (Tier 1)
- Information Sharing (Tier 1)

Surge Management

- Fatality Management (Tier 2)
- Mass Care (Tier 2)
- Medical Surge (Tier 2)
- Volunteer Management (Tier 2)

The fact sheets present information on the public health preparedness capabilities in which awardees are making their largest reported PHEP cooperative agreement investments. Note that these investments include federal PHEP funds only and do not include any additional funds that may be invested in state and local preparedness activities. The investment ranking is based on budget data provided with awardees' cooperative agreement applications.

[8] For more information about the public health preparedness capabilities, visit http://www.cdc.gov/phpr/capabilities/dslr_capabilities_july.pdf.

Biological Laboratory Testing Performance Indicators: LRN-B

The public health laboratory testing capability is the ability to conduct rapid detection, characterization, confirmatory testing, data reporting, investigative support, and laboratory networking to address actual or potential exposure to all hazards. Because the information provided by these laboratories is essential for response to public health threats, these resources play a critical role in emergency response planning and activities.

CDC manages the Laboratory Response Network (LRN), a group of local, state, federal, and international laboratories. CDC funds a subset of LRN laboratories through the PHEP cooperative agreement. The funding is provided to the 50 states and 3 localities (Los Angeles County, New York City, and Washington, D.C.), enabling these public health laboratories to establish and maintain the capability to respond to biological threats and emerging infectious disease events. (The laboratory located in Chicago is operated by the state of Illinois.) The LRN is not limited to laboratories that receive PHEP funding. Other laboratories that participate include state and locally funded public health laboratories as well as federal, military, international, agricultural, veterinary, food, and environmental testing laboratories. LRN provides a critical laboratory infrastructure to detect, characterize, and communicate about imminent threats to public health, decreasing the time needed to begin the response to an intentional act or naturally occurring outbreak.

Number of LRN-B labs

LRN biological (LRN-B) laboratories are designated as national, reference, or sentinel laboratories. National laboratories, including those at CDC, have the most advanced capabilities and are responsible for specialized strain characterizations and bioforensics. Reference laboratories, primarily local, county, and state public health laboratories, perform tests to detect and confirm the presence of a threat agent. Sentinel laboratories are commercial, private, and hospital-based laboratories that test clinical specimens to either rule out suspicion of a biological threat agent or determine whether to ship to reference or national laboratories for further testing.

The fact sheets present the total number of local, county, and state public health laboratories supported by the LRN program office at CDC that have selected to test for one or more biological threat agents. The fact sheets exclude the number of national, federal, military, agricultural, veterinary, food, environmental testing, and sentinel laboratories in each state.

In previous years, the fact sheets presented the total number of LRN national and reference laboratories. For some states and localities, the total number of reference laboratories consists exclusively of public health laboratories, as this is the only type of laboratory that is a part of the LRN for these states. In contrast, other states and localities have both public health and other types of laboratories (federal, military, agricultural, veterinary, food, and environmental testing laboratories) that are a part of the LRN. These other laboratories may not participate in the state's preparedness mission but may be involved in the overall federal preparedness mission.

Proportion of LRN-B proficiency tests passed

The LRN evaluates laboratory capabilities through proficiency testing. LRN-B laboratories must demonstrate the ability to receive, test, and report on one or more suspected biological agents from unknown samples. Proficiency test results are presented in the fact sheets as the proportion of proficiency tests passed to the total number of proficiency tests participated in by LRN-B public health laboratories each year.

If a laboratory is unable to successfully test for an agent within a specified period of time and submit results, then the laboratory will not pass the proficiency test. If a laboratory

fails a proficiency test, it is required to go through remediation proficiency testing to ensure that any problems are corrected. If a laboratory does not pass remediation testing, then it can no longer perform testing in the LRN-B for that specific agent.

Due to decreases in LRN program funding the number of proficiency tests offered to the laboratories has decreased since 2012. The reduced number of proficiency tests participated in and passed by LRN-B laboratories does not reflect decreased laboratory performance. If a laboratory did not participate in proficiency testing, the result is "Did not participate."

Laboratories may not have participated in proficiency testing if they are unable to test for the specific agents or are closed for scheduled maintenance during the unannounced proficiency test. The results include first-round proficiency tests only; follow-up remediation tests are not included in the totals.

The fact sheets present results for local, county, and state public health labs only. Previous years' fact sheets, presented proficiency test results for all types of LRN-B laboratories (federal, military, agricultural, veterinary, food, and environmental).

Biological Laboratory Testing Performance Indicators: PulseNet

CDC coordinates the PulseNet Network, which consists of local, state, and federal public health and food regulatory agency laboratories. PulseNet plays a vital role in monitoring and investigating foodborne illness outbreaks, strengthening national efforts to combat infectious disease outbreaks.

Number of PulseNet labs

The fact sheets present the number of laboratories in the PulseNet network. States and select localities must be able to detect and determine the extent and scope of potential outbreaks and to minimize their impacts. The intent of these performance indicators is to determine if a laboratory can rapidly receive, identify, and report disease-causing bacteria within four working days of receiving the samples.

Laboratories in the PulseNet network use CDC's pulsed-field gel electrophoresis (PFGE) protocols to rapidly identify specific strains of *Escherichia coli* O157:H7 (*E. coli*) and *Listeria monocytogenes* (*L. monocytogenes*). *L. monocytogenes* is referred to as "*Listeria*" in the fact sheets. The percentages in the report are limited to human isolates. For all samples on which a state or locality performs tests, the target for this indicator is to submit 90% of tests to the PulseNet national databases within four working days. This timeframe allows states, Los Angeles County, New York City, and Washington, D.C., to demonstrate their ability to analyze samples and submit results in a timely manner to the PulseNet database. The laboratory located in Chicago is operated by the state of Illinois. Therefore, no data for these indicators are presented in the Chicago fact sheet.

Percentage of *E. coli*-positive tests analyzed and uploaded into PulseNet national database within four working days

The fact sheets present the percentage of *E. coli*-positive tests analyzed and uploaded into the PulseNet national database within four working days. If a state or locality did not receive samples or did not perform testing, "N/A" is listed in the fact sheets for the percentage of "tests analyzed and uploaded into PulseNet national database within four working days."

Percentage of *Listeria*-positive tests analyzed and uploaded into PulseNet national database within four working days

The fact sheets present the percentage of *Listeria*-positive tests analyzed and uploaded into the PulseNet national database within four working days. If a state or locality did not receive samples or did not perform testing, "N/A" is listed in the fact sheets for the percentage of "tests analyzed and uploaded into PulseNet national database within four working days."

Chemical Laboratory Testing Performance Indicators

CDC funds, through the PHEP cooperative agreement, the 50 states, 4 localities, and 8 insular areas (territories and freely associated states) to establish and maintain LRN chemical (LRN-C) public health laboratories. LRN-C laboratories have capabilities for identifying and rapidly responding if the public is exposed to chemical agents.

Number of LRN-C labs

The fact sheets present the number of LRN-C labs by level. There are three levels of LRN-C labs. The number of LRN-C labs is limited to those directly funded by the PHEP cooperative agreement (for example, state public health lab).

Level 1 laboratories are national surge capacity laboratories that maintain the capabilities of Level 2 and Level 3 laboratories, can test for an expanded number of agents using highly automated analysis methods, maintain an adequate supply of materials to analyze 1,000 patient samples for each method, and can operate 24/7 for an extended period of time.

Level 2 laboratories maintain the capabilities of Level 3 laboratories, have, or are in the process of obtaining, the capability to test for a limited panel of toxic chemical agents, and stock materials and supplies for the analysis of at least 500 patient samples for each qualified analysis method.

Level 3 laboratories work with hospitals, poison control centers, and first responders within their jurisdictions to maintain competency in clinical specimen collection, storage, and shipment to more advanced LRN-C laboratories for testing.

Proportion of core chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs

Analytical testing using LRN methods can help determine the scope of an incident, identify who needs long-term treatment, assist with non-emergency medical guidance, and help law enforcement officials determine the origin of the agent. Level 1 and Level 2 laboratories undergo proficiency testing to demonstrate that they can use these methods to (1) rapidly detect and accurately measure chemical agents that can cause severe health effects and (2) report patient results consistent with Clinical Laboratory Improvement Amendments (CLIA) quality assurance requirements. To be fully qualified for a method both characterization and a successful proficiency testing challenge are required.

The fact sheets present final proficiency testing results as the proportion of these core methods successfully demonstrated by the laboratories in each state or locality to the total number of core methods identified by CDC. From 2012 to 2014, CDC identified nine core methods for detecting and measuring chemical agents and conducted testing to determine LRN-C labs' proficiency in these methods. The core methods are significant as they use technical fundamentals that provide the foundation of chemical analysis capabilities. However, it should be noted that the states and localities with Level 1 and Level 2 laboratories that are not proficient in all core methods may have completed extensive work in the two steps that precede proficiency testing: training and validation in the core methods.

Number of additional chemical agent detection methods demonstrated by Level 1 and/or Level 2 labs

In addition to proficiency in core methods, certain LRN-C laboratories demonstrate proficiency in additional methods. These methods build upon the foundation established by the core methods—providing modifications to core techniques—which allows laboratories to test for additional agents, thereby expanding their testing capabilities. Level 1 laboratories are required to gain proficiency in these additional methods; Level 2 labs may choose to pursue additional methods but availability may be limited based on network need and individual laboratory capability.

The figures presented in the fact sheets represent the number of additional methods for which Level 1 and Level 2 laboratories in the state or locality demonstrated proficiency. From 2012 to 2014, CDC identified four additional methods for Level 1 laboratories and up to three additional methods for Level 2 laboratories. A successful demonstration of these methods during testing indicates ongoing proficiency. However, it should be noted that while laboratories may not have demonstrated proficiency in these additional methods, they may have trained and undergone validation for additional methods, which are steps that precede proficiency testing.

Result of LRN exercise to collect, package, and ship samples

This exercise evaluates LRN-C labs' ability to collect relevant samples for clinical chemical analysis and ship those samples in compliance with International Air Transport Association regulations. At least one laboratory located in each PHEP-funded state or locality should participate and pass. For states or localities with multiple participating laboratories, all results are reported.

The fact sheets reflect the outcome of the exercise. If the awardee passed the drill, the result is "Passed." If the awardee failed the drill, the result is "Did not pass." For states or localities with multiple laboratories, the results are listed by lab level.

Emergency Operations Coordination Performance Indicators

The emergency operations coordination (EOC) capability is essential to direct and coordinate the implementation of other public health preparedness capabilities during a public health emergency. This capability allows public health agencies to make informed, timely, and effective decisions that direct resources and personnel to adaptively address ongoing and evolving health needs arising from emergencies. The EOC capability is the ability to direct and support an event or incident with public health or medical implications by establishing a standardized, scalable system of oversight, organization, and supervision consistent with jurisdictional standards and practices and with the National Incident Management System (NIMS).

Number of minutes for public health staff with incident management lead roles to report for immediate duty

This performance indicator demonstrates the ability to immediately assemble public health staff with incident management lead roles to ensure a timely response to an incident. Specifically, this indicator captures an agency's ability to assemble key decision-makers who are responsible for leading and managing a response. In 2012, this indicator was slightly modified to specify "lead" incident management roles. The response time was determined from the time that a designated official began notifying staff to report for immediate duty to cover activated incident management lead roles to the time that the last staff person notified to cover an activated incident management lead role reported for immediate duty. In 2012 and 2013, this exercise must have occurred during a drill, a functional exercise, a full-scale exercise, or a real incident. In 2014, this indicator was modified to include exercises that occurred during a real incident or drill only. In addition, the staff assembly must have been unannounced and immediate.

For 2012, the ability to assemble staff covering activated public health agency incident management lead roles in a timely manner was a Department of Health and Human Services (HHS) Priority Goal. The performance target of 60 minutes or less was established for states only. "No reportable time" is listed in the fact sheets for states that did not provide verifiable documentation that supported meeting the intent of the performance measure. For 2013 and 2014, the HHS Priority Goal performance target of 60 minutes does not apply; however, state data reflect the quickest reported time.

For the four localities and Puerto Rico, the HHS Priority Goal target of 60 minutes or less does not apply. Therefore, their data may not reflect the quickest time but instead may reflect a more complex or comprehensive incident. If an awardee did not submit data for this indicator, a dash is listed in the fact sheet. If an awardee did not have an incident meeting requirements, "N/A" is listed in the fact sheet.

The fact sheets include results for the states, localities, and Puerto Rico. Previous years' fact sheets presented staff assembly results for 50 states, 4 localities, and 8 insular areas. Due to modified PHEP requirements, insular areas (except for Puerto Rico) were not required to report on this measure for 2014.

Prepared an after-action report and improvement plan following a real incident or simulated response

This performance indicator demonstrates the awardees' ability to analyze real or simulated response actions, describe needed improvements, and prepare a plan for making improvements within an acceptable timeframe. The after-action report (AAR) and improvement plan (IP) must have been drafted as a result of an exercise (tabletop exercise, drill, functional exercise, or full-scale exercise) or real incident.

"Yes" is listed in the fact sheets for awardees who completed a draft AAR and IP as a result of an exercise or real incident. If the awardee did not have an exercise or real incident that resulted in the completion of a draft AAR and IP, the result is "No." If an awardee did not submit data for this indicator, a dash is listed in the fact sheet.

The fact sheets include results for the states, localities, and Puerto Rico. In previous years, the fact sheets presented AAR and IP results for 50 states, 4 localities, and 8 insular areas. Due to modified PHEP requirements, insular areas (except for Puerto Rico) were not required to report on this measure for 2014.

Developed Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid

The fact sheets present whether Guam and the U.S. Virgin Islands have an Emergency Management Assistance Compact or other mutual aid agreements for medical and public health mutual aid. "N/A" is listed for the remaining insular areas as they are not required to develop these resources.

Conducted call down drills to document the ability to contact responders to activate the emergency operations coordination center

The fact sheets present whether the eight insular areas maintained and exercised a role-based activation list at least semi-annually. The activation list must have current names and phone numbers of responders.

Administrative Preparedness

The 2009 H1N1 influenza pandemic highlighted the need to establish efficient and effective methods for distributing emergency response funds from the federal government to state and local health departments where a majority of response activities are managed. This pandemic resulted in the public health preparedness community examining administrative preparedness barriers more closely. Administrative preparedness is the process of ensuring that fiscal and administrative authorities and practices that govern funding, procurement, contracting, hiring, and legal capabilities necessary to mitigate, respond, and recover from public health threats and emergencies can be accelerated, modified, streamlined, and accountably managed. The goal of administrative preparedness is advance planning to remove administrative barriers that prevent timely distribution and utilization of funds during a public health emergency for the purpose for which they are intended—to save lives, reduce morbidity and minimize disruption of the public health and medical systems. These processes, a subset of which are described below, include emergency procurement, contracting, and hiring processes. If an awardee did not submit data for these data points or were not applicable, a dash is listed in the fact sheet.

Expedited procedures for receiving emergency funds

The fact sheets present whether an awardee developed expedited procedures for receiving emergency funds. Examples of expedited procedures may include governor-declared emergency orders or non-emergency declaration expedited procedures. "Yes" is listed in the fact sheets for awardees who reported having expedited processes for receiving emergency funds. If an awardee did not report having an expedited process for receiving emergency funds, "No" is listed in the fact sheets.

Reduced the cycle time for contracting and/or procurement of necessary goods and services

The fact sheets present whether awardees have established expedited processes and mechanisms to reduce the cycle time (i.e., time from the beginning to the end of the process) for contracting and/or procuring necessary goods and services. Examples of expedited processes and mechanisms may include procurement card programs, statutes for necessary supplies, contracts for medical supplies, or emergency clauses in pre-existing contracts. "Yes" is listed in the fact sheets for awardees who reported having expedited processes and mechanisms to reduce the cycle time for contracting and/or procuring necessary goods and services. If an awardee did not report having an expedited processes and mechanisms to reduce the cycle time for contracting and/or procuring necessary goods and services, "No" is listed in the fact sheets.

Reduced the cycle time for hiring and/or reassignment of staff

The fact sheets present whether awardees have established emergency authorities and mechanisms to reduce the cycle time for hiring and/or assignment of staff. Examples of emergency authorities and mechanisms may include engaging key staff in human resources, legal, procurement, information technology, communications, and financial management roles in discussions about available authorities and procurement options to augment staffing. "Yes" is listed in the fact sheets for awardees who reported having emergency authorities and mechanisms to reduce the cycle time for hiring and/or assignment of staff. If an awardee did not report having emergency authorities and mechanisms to reduce the cycle time for hiring and/or assignment of staff, "No" is listed in the fact sheets.

CDC Resources Supporting Preparedness in States, Localities, and Insular Areas in 2013–2014

In addition to the activities listed above, CDC provides funding and technical assistance to help states, localities, and insular areas build public health preparedness and response capabilities. CDC provides funding to the 50 states, 4 localities, and 8 insular areas through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts.

CDC PHEP cooperative agreement funding provided

The fact sheets present the fiscal year 2013 funding CDC provided each awardee through the PHEP cooperative agreement. In addition to PHEP funding, CDC provides training and personnel to support awardee preparedness and response efforts.

CDC preparedness field staff

The fact sheets present the total number of CDC-funded personnel working in preparedness assigned to each awardee. CDC provides preparedness support to states, localities, and insular areas through various field placement programs.

The Epidemic Intelligence Service (EIS) program expands the epidemiology workforce through a two-year epidemiology training modeled on a traditional medical fellowship. EIS officers are epidemiologists who serve as a critical component of CDC's support of states during responses to routine public health incidents and large-scale national emergencies. Officers are assigned to CDC or to state and local health departments.

The mission of the Career Epidemiology Field Officer (CEFO) Program is to strengthen state, local, tribal, and territorial epidemiologic capability for public health preparedness and response. CDC places experienced, full-time epidemiologists in state and local public health departments to enhance and build epidemiologic capacity for public health preparedness and response. (States and localities use PHEP funds to support CEFO positions.) CEFOs also serve as liaisons and consultants between CDC and public health departments as well as mentors for state and local public health department staff and EIS officers assigned to state or local health departments.

CDC's Public Health Associate Program (PHAP) and Public Health Prevention Service (PHPS) program place associates in states, tribal governments, localities, and insular areas for two years to receive hands-on, frontline experience. These field placements are designed to provide job experience and competency development for the associate as well as meet the needs of the host site. Only PHAPs working in preparedness are included in the field staff count. Some graduates of the PHAP program continue to work as Preparedness Field Assignees (PFAs) in state and local health departments to develop and enhance key preparedness capabilities. CDC also employs public health advisors (PHA) who provide direct and onsite technical assistance to state and local health departments. Technical assistance ranges from program and/or grant management, strategic and emergency planning, exercise development and implementation, review of medical countermeasure planning and readiness at state and local levels, training, and operational response during real-time incidents. The PHAs serve an integral role in providing onsite technical assistance to states to build preparedness and response readiness.

CDC Emergency Management Program activities

The CDC Emergency Operations Center (EOC), managed by OPHPR, functions as the command center for monitoring and coordinating CDC's emergency response to national and international public health threats. Both training exercises and real-event responses are managed by the EOC

through the Emergency Management Program. Staffed around the clock and supported by OPHPR, the EOC organizes CDC subject matter experts in one location during an emergency response to centralize information exchange and to connect with response partners.

The fact sheets present the number of Emergency Management Program activities supporting awardees (activations, engagements, and exercises). Activations include a variety of activities such as initiating a preliminary assessment team, developing incident objectives and an incident action plan, activating the incident management structure, and deploying personnel. Activations normally include centralizing subject matter experts and preparedness staff in the EOC to improve response coordination. Engagements include any assistance in addressing a public health threat that is not expected to require activation. Exercises are simulated emergency situations which allow responders to practice and evaluate use of their emergency response plans.

Public health personnel who received CDC Strategic National Stockpile training

The fact sheets present the number of public health personnel receiving SNS training for each awardee. OPHPR helps prepare state and local health departments to respond during an emergency when SNS assets are deployed. OPHPR offers state and local planners trainings and exercises designed to prepare responders to manage SNS materials during an emergency. The number of personnel receiving SNS training is limited to those that participated in instructor-led training either in-person or online.

Technical Assistance Review (TAR) Scores

CDC's Strategic National Stockpile (SNS) is a repository of antibiotics, chemical antidotes, antitoxins, vaccines, antiviral drugs, and other life-saving medical supplies that are placed in strategic locations around the nation. These assets are designed to supplement and resupply state and local public health agencies in the event of a large-scale public health emergency. All 50 states, 72 Cities Readiness Initiative (CRI) metropolitan statistical areas (MSA) (including the 4 directly funded localities), and the 8 insular areas funded by the PHEP cooperative agreement have plans for receiving, staging, storing, distributing, and dispensing medical assets from CDC's SNS. Historically, CDC conducted annual technical assistance reviews (TARs) to assess these plans to ensure continued readiness; however, beginning in July 2014, CDC implemented a new method of reviewing state and local medical countermeasure operational readiness the Medical Countermeasure (MCM) Operational Readiness Review (ORR). The MCM ORR builds on the progress jurisdictions have made over the years and is designed to better determine the ability of a jurisdiction to implement their plans in response to an incident or exercise requiring distribution and dispensing of medical countermeasures.

For fiscal year 2013, CDC administered a modified TAR, which served as an interim assessment of medical countermeasure planning in preparation for the MCM ORR implementation the following year. The modified TAR progress report included the same elements and scoring as the traditional TAR.

TAR elements that received a full-credit score without recommendations the previous year received full credit in the TAR Progress Report with no additional jurisdictional response or CDC review required in fiscal year 2013. Awardees were required to address TAR elements that did not receive a full-credit score or had recommendations for change or improvement actions the previous year and to submit validating documentation to CDC for review and assessment.

Awardees were also required to submit validating documentation for drill and exercise elements for assessment by CDC.

The TAR focuses on key elements that are regarded as either critical or important planning steps within a variety of functions. The 13 functions include:

Developing a Plan with SNS Elements. A comprehensive, written plan is essential to facilitate the receipt, distribution, and dispensing of SNS assets quickly and efficiently. This plan should be incorporated as part of a state's comprehensive emergency operations plan.

Management of SNS. The way a state, region, or community manages its response to a public health emergency is considered a program management and command-and-control function. Command-and-control is how political leadership, emergency management, public health, law enforcement, and other groups coordinate their response to an emergency.

Requesting SNS. The decision to deploy SNS assets will be a collaborative effort among local, state, and federal officials. It will start at a local level when officials identify a potential or actual situation they believe has the potential to threaten the health of their community. SNS assets are requested from CDC by the affected state's governor (or the governor's designee). Alternatively, the state may request assets from HHS or request a capability (not asset) and HHS will determine best way to source the request.

Communications Plan (Tactical). The availability of robust and redundant communication systems is critical to coordinating response functions during an emergency. Effective and timely communications between emergency response staffs, operation centers, receiving sites, points of dispensing, and hospitals will be needed to meet and resolve the demands of a mass distribution and dispensing emergency. The choice of communication support devices (e.g. two-way radios, satellite telephones) and support of technologies (e.g. non-telephone based internet, e-mail and web-based communication systems, broad notification systems) used to tether state, regional, and local networks will be key elements in meeting the need for timely flow of assets to distribution points, dispensing centers, and health care facilities.

Public Information and Communication. During an emergency where medical countermeasure assets are to be dispensed to the public, effective and timely public health communications are needed to ensure the public is informed and guided to appropriate locations to receive them. The development and dissemination of effective messages, methods, and materials to inform, educate, and mobilize the public will be critical to the success of a mass dispensing effort.

Security. The security of the medical countermeasures and safety of staff involved in the receipt, distribution, and dispensing operations is essential. The arrival and transport of scarce resources will be newsworthy and may draw attention from persons unwilling to wait for the organized dispensing of prophylactic or treatment medicines. The development of a comprehensive security plan through coordination with law enforcement is essential to maintaining control and order during this period.

Receipt, Stage, and Store (States and Insular Areas). The size, location, and characteristics of warehouse facilities used to receive, stage, and store medical countermeasures are important factors that will determine the effectiveness of an emergency response. CDC has established minimum criteria for sites designated to receive, stage, and store federal assets received from the SNS. The development of distribution strategies, site-specific plans, and the assignment and training of staff will determine the ability of jurisdictions to meet the demand for distribution of assets to local populations.

Regional/Local Distribution Site (Local). The size, location, and characteristics of warehouse facilities used to receive countermeasures from the state to distribute them to the identified

local population are important factors that will determine the effectiveness of an emergency response. CDC has established minimum criteria for regional and/or local sites designated to receive and distribute federal assets received from the state. The development of distribution strategies, site-specific plans, and the assignment and training of staff will determine the ability of jurisdictions to meet the demand for distribution of assets to local populations.

Inventory Management. State and local jurisdictions must possess a robust inventory management system to monitor the receipt of medical countermeasures, track their distribution, and record dispensing during a public health emergency. SNS inventory must be properly apportioned and configured in the quantities necessary for points of dispensing and health care facilities to successfully respond in an emergency.

Repackaging. Repackaging of bulk medications for public dispensing remains an SNS function that may be needed in an emergency. In the past, a significant amount of planning and preparation was required to repackage bulk oral drugs contained in the SNS before dispensing them to the public. Much of that effort is no longer necessary since the majority of oral medicines in the SNS now come in prepackaged unit-of-use regimens. However, states may still have to repackage bulk items under some circumstances.

Distribution. The distribution function refers to the physical delivery of SNS assets from the receipt, stage, and store (RSS) facility to dispensing sites, treatment centers, and regional distribution sites. States are responsible for developing distribution networks that account for challenges and barriers unique to their areas. Clear communication between RSS and local and regional planners is paramount to a good distribution plan.

Medical Countermeasure Dispensing. The dispensing function was originally designed with the focus of providing initial prophylaxis to 100% of the population within 48 hours (U.S. Department of Homeland Security's Target Capabilities List performance measure for mass dispensing). Dispensing planning, however, should be flexible and scalable so that the infrastructure built for meeting this capability can be used for any incident as part of an all hazards plan.

Hospitals and Treatment Centers Coordination. A large-scale emergency event can quickly overwhelm available resources at hospitals and other acute care providers. This function stresses the need for and measures the degree of coordination among public health, emergency management, and hospitals or alternative care sites to manage and respond to materiel needs at healthcare facilities.

Training and Exercise. This function serves to highlight and document the development of emergency response training and exercise and evaluation programs that are compliant with guidelines set forth by the Homeland Security Exercise and Evaluation Program. Emergency response exercises are intrinsic to the transition of plans to operational response.

Technical Assistance Review (TAR) Scores—States

The fact sheets present the CDC state TAR score. Using a scale from 0 to 100, a CDC state TAR score of 89 or higher indicated that a state had an acceptable plan to receive, distribute, and dispense medical assets from the SNS.

Technical Assistance Review (TAR) Scores—Insular Areas

The fact sheets present the CDC island TAR score. The island technical assistance review includes the full 13 functional areas but has a streamlined and combined focus of receipt, distribution, and dispensing of countermeasures. Using a scale from 0 to 100, a CDC score of 60 or higher indicated that the awardee had an acceptable plan to receive, distribute, and dispense countermeasures.

Technical Assistance Review (TAR) Scores—CRI Metropolitan Statistical Areas

The fact sheets present the CDC Cities Readiness Initiative (CRI) TAR score. The CRI focuses on enhancing preparedness in the nation's metropolitan statistical areas (MSAs), where more than half of the U.S. population resides. A CRI location is a MSA composed of multiple counties based on U.S. Census Bureau data. MSAs can consist of one or more jurisdictions (e.g., counties, cities, and municipalities) and can extend across state borders. CRI TARs are conducted annually in each MSA planning jurisdiction and those scores are then combined to compute an average score for the entire MSA. In its annual review, CDC assesses local CRI plans on 12 of the 13 functions listed above (no repackaging). Using a scale from 0 to 100, a CDC CRI TAR score of 69 or higher indicates that a local jurisdiction has an acceptable plan to receive, distribute, and dispense countermeasures. In 2013–2014, the acceptable threshold score increased for the four directly funded localities of Chicago, Los Angeles County, New York City, and Washington, D.C., to 89 or higher.

Appendix C: Fact Sheet Endnotes

6. CDC, Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), Behavioral Risk Factor Surveillance System (BRFSS); 2012 and 2013 BRFSS Annual Survey Data
7. CDC, Office of Public Health Preparedness and Response (OPHPR), Division of State and Local Readiness (DSLR); 2014 data: 7/1/2013–6/30/2014
8. CDC, Office of Public Health Preparedness and Response (OPHPR), Division of State and Local Readiness (DSLR); 2012 data: 8/10/11–8/9/12; 2013 data: 7/1/2012–6/30/2013; 2014 data: 7/1/2013–6/30/2014
9. CDC, Office of Infectious Diseases (OID), National Center for Zoonotic Infectious Diseases (NCEZID); 2012 data: 8/10/11–8/9/12; 2013 data: 1/1/12–12/31/12; 2014 data: 1/1/13–12/31/13
10. CDC, Office of Noncommunicable Diseases, Injury and Environmental Health (ONDIEH), National Center for Environmental Health (NCEH); 2012 data: 8/9/2012; 2013 data: 6/30/2013; 2014 data: 6/30/2014
11. CDC, OPHPR, DSLR; 2014 data: 7/1/2013–6/30/2014
12. CDC, OPHPR, DSLR; 2013 Public Health Emergency Preparedness Cooperative Agreement Funding Opportunity Announcement, Budget Period 2
13. CDC, OPHPR, DSLR; 2013–2014 data: 10/1/14–9/30/15
14. CDC, OSELS, Scientific Education and Professional Development Program Office; 2013–2014 data: 9/30/14
15. CDC, Office for State, Tribal, Local and Territorial Support, Office of the Director (OD); 2013–2014 data: 10/1/14–9/30/15
16. CDC, OPHPR, Division of Emergency Operations; 2013–2014 data: 10/1/13–9/30/14
17. CDC, OPHPR, Division of the Strategic National Stockpile; 2013–2014 data: 10/1/13–9/30/14

For more information on CDC's preparedness and emergency response activities, visit the website of the Office of Public Health Preparedness and Response at www.cdc.gov/phpr

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