

Section 1: A National Snapshot of Public Health Preparedness Activities

- Laboratory Capabilities: Identifying and Understanding Emerging Public Health Threats
- Response Readiness Planning: Improving Response to Threats through Planning for Medical Asset Distribution

Laboratory Capabilities: Identifying and Understanding Emerging Public Health Threats

Laboratories are a critical component of rapid response to health threats. They identify disease agents, toxins, and other health threats found in clinical specimens, food, or other substances. Rapid detection and characterization of health threats is essential for implementing appropriate control measures to mitigate the impact of these threats. During the 2009 H1N1 influenza pandemic, for example, laboratories around the country were able to rapidly test for and confirm infections, which supported decisions about treatments and measures to control the spread of disease. The ability to detect and characterize health threats relies on the availability of laboratory resources (including a trained workforce), accurate and consistent methods, and quick data-exchange systems.

CDC manages the Laboratory Response Network (LRN), a group of local, state, federal, and international laboratories with unique testing capabilities for confirming high priority biological and chemical agents. Located strategically across the United States and abroad, LRN member laboratories play a critical role in their state or locality's overall emergency response plan to detect, characterize, and communicate about confirmed threat agents. Members perform standardized tests yielding reliable results within hours. Approximately 90% of the U.S. population lives within 100 miles of an LRN laboratory, decreasing the time needed to begin the response to a terrorist attack or naturally occurring outbreak.

Highlights of state and locality laboratory activities related to preparedness appear on the following pages. See the summary table on pages 14-15 for national-level data on laboratory activities (Table 4).

Nationwide Testing for Responding to Biological Threats

The Laboratory Response Network (LRN) was established in 1999 to create national laboratory capacity for testing biological threat agents and dangerous toxins. Specific examples of biological threats include anthrax, smallpox, plague, and botulism.⁸

LRN biological laboratories are designated as national, reference, or sentinel laboratories.

- *National laboratories*, including those at CDC, have the most advanced capabilities. These laboratories are responsible for specialized strain characterizations, bioforensics, select agent activity, and handling highly infectious agents.
- *Reference 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 in order to either rule out suspicion of a biological threat agent or ship to reference or national laboratories for further testing.

CDC provides funding through the Public Health Emergency Preparedness (PHEP) cooperative agreement to the 50 states and 4 localities to establish and maintain LRN biological public health laboratories. In addition to the laboratories that receive PHEP funding, other laboratories that participate in the LRN include state and locally funded public health laboratories as well as federal, military, international, agricultural, veterinary, food, and environmental testing laboratories.

Laboratories play a critical role in their state or locality's overall emergency response plan to detect, characterize, and communicate about confirmed threat agents.

In 2010, a total of 142 LRN laboratories in the United States could test for biological agents; 139 of these were reference laboratories and 3 were national laboratories.⁹ These laboratories maintain relationships with numerous sentinel laboratories in their jurisdictions that refer suspicious specimens to them for more advanced testing.

Highlights of state and local activities conducted to enhance their laboratory capabilities follow. See individual fact sheets starting on page 20 for specific scores.

Most laboratories passed proficiency tests for detecting biological agents. CDC conducts proficiency testing to evaluate the ability of LRN reference and national biological laboratories to receive, test, and report one or more suspected biological agents to CDC. If a laboratory is unable to successfully test for an agent and report results within a specified period of time, it will not pass the proficiency test. From 2008 to 2010, LRN biological reference and national laboratories successfully maintained a high proficiency test pass-rate to identify biological agents in unknown samples (Table 1).

Training and outreach to sentinel laboratories continues. Sentinel laboratories play a key role in the early identification and response to emerging infectious diseases including potential bioterrorism events. From August 10, 2009 to August 9, 2010, 43 state public health laboratories (84%) reported sponsoring sentinel

laboratory training in their state. It is important to note that state public health laboratories continued to communicate emerging health information with sentinel laboratories from 2008 to 2010. For example, in 2008 and 2010, 47 out of 51 state public health laboratories (including the District of Columbia) used CDC's Health Alert Network (HAN) or other rapid method (blast email or fax) to communicate with sentinel laboratories and other partners for outbreaks, routine updates, training events, and other applications.¹⁰

Laboratories improved their abilities to rapidly identify disease-causing bacteria.

Public health officials must be able to quickly and accurately detect and determine the extent and scope of potential outbreaks and minimize their impacts. In 2011, for example, public health officials in several states worked with CDC to investigate a multistate outbreak of human infections linked to eating a type of sausage contaminated with the bacteria *Escherichia coli* O157:H7. The investigation led to the recall of some 23,000 pounds of the product, preventing additional illnesses and hospitalizations.

States and the District of Columbia receive CDC PHEP funding and are required to demonstrate that they can identify specific strains of *E. coli* O157:H7 and *Listeria monocytogenes* – both associated with foodborne disease outbreaks – and report results to CDC's PulseNet database within a target timeframe of 4 working days of receiving the samples.

Table 1: Proficiency Tests Passed by LRN Reference and/or National Laboratories; 2008-2010

Number of proficiency tests passed by LRN reference and/or national laboratories		
2008	2009	2010
261 out of 277 (94%)	195 out of 204 (96%)	312 out of 327 (95%)

Source: CDC, OI (NCEZID); 2008 data: 1/08-9/08; 2009 data: 1/1/09-12/31/09; 2010 data: 1/1/10-12/31/10

Table 2: Rapid Identification of Disease-Causing Bacteria by PulseNet Laboratories; 2008-2010

Disease-Causing Bacteria	Number of states submitting at least 90% of test results to CDC's PulseNet database within 4 working days		
	2008*	2009**	2010**
<i>Escherichia coli</i> O157:H7	29 out of 50 (58%)	32 out of 51 (63%)	38 out of 50 (76%)
<i>Listeria monocytogenes</i>	18 out of 32 (56%)	18 out of 28 (64%)	21 out of 31 (68%)

Source: CDC, OPHPR (DSLRL); 2008 data: 8/31/07-8/9/08; 2009 data: 8/10/08-8/9/09; 2010 data: 8/10/09-8/9/10

*Data for the 50 states; **Data for the 50 states and District of Columbia

PulseNet is a national network of public health and food regulatory agency laboratories coordinated by CDC. Participant laboratories perform DNA “fingerprinting” of bacteria by pulsed-field gel electrophoresis, which distinguishes strains of these bacteria.

States have improved their abilities to rapidly identify these bacteria. The number of states that submitted at least 90% of *E. coli* and *L. monocytogenes* test results to CDC’s PulseNet database within 4 working days increased

between 2008 to 2010 (Table 2). For those states that missed the 4-day benchmark for *E. coli* in 2010, the most commonly reported reason was laboratory workforce issues. Specifically, seven states reported issues such as staff shortages and lack of trained staff. Similarly, five states reported in 2010 that their *L. monocytogenes* data submission was affected by staffing issues such as staff turnover and furloughs. For additional information regarding laboratory workforce issues, see the box below.

States Facing Challenging Workforce Issues

From 2008 to 2010, more than 44,000 jobs were lost in state and local health departments, reducing staff such as public health physicians and nurses, laboratory specialists, and epidemiologists. Laboratorians provide critical expertise to effectively identify and respond to public health emergencies. According to a 2010 national survey, public health laboratories across the country are experiencing significant difficulties maintaining the highly skilled workforce of laboratorians necessary to ensure an effective response. State public health laboratories reported that the factors most severely impacting their workforce were non-competitive salaries (52%), lack of funding (48%), and hiring freezes (43%). From 2009 to 2010, the number of states reporting furloughs as a major workforce barrier increased from 32% to 39%. In addition, CDC found that despite the overall progress reported by states in identifying specific bacteria associated with foodborne disease outbreaks, many states reported being unable to achieve performance measure benchmarks in 2010; workforce issues were among the reasons cited for missing the benchmark. As budget cuts continue, more state public health services and functions will likely be impacted, affecting states’ ability to respond rapidly and effectively to public health threats.

Sources: National Association of County & City Health Officials and Association of State and Territorial Health Officials, Letter to Congress Regarding Cuts Proposed in H.R. 1363 (April 7, 2011); Association of Public Health Laboratories, Response by the Numbers: The Nation’s Public Health Laboratories Protect the Country (2011); and CDC, OPHPR (DSLRL); 2010 data: 8/10/09-8/9/10

Nationwide Testing for Responding to Chemical Threats

In 2003, the LRN started testing clinical specimens to measure human exposure to toxic chemicals. LRN chemical laboratories are designated as Level 1, 2, or 3.

- *Level 1 laboratories* have the most advanced capabilities. These are surge-capacity laboratories that can test for an expanded number of agents, including nerve agents, mustard agents, and toxic industrial chemicals. They also maintain the capabilities of Level 2 laboratories.
- *Level 2 laboratories* test for a limited number of toxic chemical agents. They also maintain the capabilities of Level 3 laboratories.
- *Level 3 laboratories* work with hospitals and other first responders to maintain competency in clinical specimen collection, storage, and shipment.

In 2010, a total of 57 LRN laboratories in the United States could handle and/or test for chemical agents; 10 of these were Level 1 laboratories, 36 were Level 2 laboratories, and 11 were Level 3 laboratories. Illinois reported downgrading its Level 2 laboratory to a Level 3 that year due to funding issues, and Florida reported adding a Level 3 laboratory during that same time period.

CDC conducts annual proficiency testing for Level 1 and Level 2 chemical laboratories to

determine their abilities to use core and additional methods to rapidly detect and measure chemical agents that can cause severe health effects. These methods are considered important because they can help determine the scope of a real incident, identify those requiring long-term treatment, assist with non-emergency medical guidance, and help law enforcement officials determine the origin of the chemical agent. The core methods are significant as they offer new technical fundamentals in the methods that provide the foundation of LRN-C laboratory capabilities. The number of core methods increased from six in 2009 to eight in 2010.

The majority of LRN laboratories undergo proficiency testing in additional methods as well. These methods build upon the foundation established by the core methods, providing modifications to core techniques that allow for laboratories to test for additional agents and thereby expand their testing capabilities. Proficiency in additional methods is required for Level 1 laboratories and optional for Level 2 laboratories. In 2009, there were six additional methods for Level 1 laboratories and up to five additional methods for Level 2 laboratories, depending on the state or locality needs. In 2010, there were five additional methods in which Level 1 laboratories should have demonstrated proficiency, and up to four additional methods in which Level 2 laboratories could have chosen to become proficient.

Illinois reported downgrading its Level 2 laboratory to Level 3 in 2010 due to funding issues.

Table 3: Evaluating LRN-C Capabilities Through Proficiency Testing; 2009-2010

Methods successfully demonstrated by Level 1 and Level 2 laboratories to rapidly detect chemical agents	
2009	2010
<p>Average number of methods: 6.7 total methods</p> <ul style="list-style-type: none"> • 5.3 core methods (maximum: 6) • 1.4 additional methods (maximum: up to 6) 	<p>Average number of methods: 8.9 total methods</p> <ul style="list-style-type: none"> • 7.1 core methods (maximum: 8) • 1.7 additional methods (maximum: up to 5)

Source: CDC, ONDIEH (NCEH); 2009 data: 1/1/09-9/14/09; 2010 data: 1/1/10-12/31/10

Level 1 and 2 laboratories increased their abilities to rapidly detect and quantify chemical agents. The average total number of methods (including both core and additional methods) successfully demonstrated by Level 1 and Level 2 laboratories rose from 6.7 methods in 2009 to 8.9 methods in 2010 (Table 3) – an increase of more than 30% in two years. In 2010, 28 out of 46 Level 1 and/or Level 2 LRN chemical laboratories were able to demonstrate proficiency in all eight core methods. In 2010, 27 out of 46 Level 1 and/or Level 2 LRN chemical laboratories demonstrated proficiency in at least one additional method to rapidly detect chemical agents.

Level 1 laboratories greatly reduced the amount of time needed to process large volumes of samples during a CDC exercise.

The LRN Surge Capacity Exercise demonstrates the ability of each of the ten Level 1 laboratories to test and report on 500 samples (a total of 5000 samples) on a 24/7 basis. This exercise demonstrates the ability of our nation to respond to a large-scale chemical incident like the Tokyo sarin subway attack of 1995. The response time for the exercise is determined from the time the 500 samples are received to the time the last test result is reported to CDC. Between 2009 and 2010, the average hours to process and report on 500 samples by Level 1 laboratories during the LRN Surge Capacity Exercise decreased from 98 hours to 56 hours.

National Snapshot of Laboratory Activities

A summary table of national-level data on laboratory activities in 2008, 2009, and 2010 appears below (Table 4). Note that these items represent available data for preparedness activities and do not fully represent all state and

locality laboratory efforts. For individual state and locality information in the area of laboratory activities, see individual fact sheets starting on page 20. See appendix 1 for an explanation of data points.

Table 4: National Snapshot of Laboratory Activities; 2008-2010

Laboratories: Biological Capabilities						
	2008		2009		2010	
Laboratory Response Network (LRN) reference and/or national laboratories that could test for biological agents <small>Source: CDC, OID (NCEZID); 2008 data: 9/30/08; 2009 data: 12/31/09; 2010 data: 12/31/10</small>	151 total LRN reference and national laboratories		135 total LRN reference and national laboratories		142 total LRN reference and national laboratories	
	148 LRN reference laboratories		132 LRN reference laboratories		139 LRN reference laboratories	
	3 LRN national laboratories		3 LRN national laboratories		3 LRN national laboratories	
Proficiency tests passed by LRN reference and/or national laboratories <small>Source: CDC, OID (NCEZID); 2008 data: 1/08-9/08; 2009 data: 1/1/09-12/31/09; 2010 data: 1/1/10-12/31/10</small>	261 out of 277 tests (94%)		195 out of 204 tests (96%)		312 out of 327 tests (95%)	
LRN laboratory ability to contact the CDC Emergency Operations Center within 2 hours during LRN notification drill <small>Note: One LRN laboratory in DC and in each state is eligible to participate in this drill, with the exception of CA, IL, and NY, where two can participate.</small> <small>Source: CDC, OID (NCEZID); 2008 data: 3/08; 2009 data: 7/09; 2010 data: 4/10 and 6/10</small>	39 out of 54 laboratories participated (72%)		54 out of 54 laboratories participated (100%)		Apr	Jun
	35 out of 39 laboratories passed (90%)		51 out of 54 laboratories passed (94%)		44 out of 54 laboratories participated (81%)	54 out of 54 laboratories participated (100%)
					39 out of 44 laboratories passed (89%)	52 out of 54 laboratories passed (96%)
Number of states submitting at least 90% of test results to CDC's PulseNet database within 4 working days <small>Source: CDC, OPHPR (DSLRL); 2008 data: 8/31/07-8/9/08 (50 states); 2009 data: 8/10/08-8/9/09 (50 states and DC); 2010 data: 8/10/09-8/9/10 (50 states and DC)</small>	<i>Escherichia coli</i> O157:H7	29 out of 50 states (58%)	<i>Escherichia coli</i> O157:H7	32 out of 51 states (63%)	<i>Escherichia coli</i> O157:H7	38 out of 50 states (76%)
	<i>Listeria monocytogenes</i>	18 out of 32 states (56%)	<i>Listeria monocytogenes</i>	18 out of 28 states (64%)	<i>Listeria monocytogenes</i>	21 out of 31 states (68%)

Laboratories: Chemical Capabilities

	2009		2010
<p>LRN-C laboratories with capabilities for responding if the public is exposed to chemical agents</p> <p>Source: CDC, ONDIEH (NCEH); 2009 data: 9/14/09; 2010 data: 12/31/10</p>	<p>56 LRN-C laboratories:</p> <ul style="list-style-type: none"> • 10 out of 56 were Level 1 laboratories • 37 out of 56 were Level 2 laboratories • 9 out of 56 were Level 3 laboratories 		<p>57 LRN-C laboratories:</p> <ul style="list-style-type: none"> • 10 out of 57 were Level 1 laboratories • 36 out of 57 were Level 2 laboratories • 11 out of 57 were Level 3 laboratories
<p>Methods successfully demonstrated by Level 1 and/or Level 2 laboratories to rapidly detect chemical agents during proficiency testing</p> <p>Source: CDC, ONDIEH (NCEH); 2009 data: 1/1/09-9/14/09; 2010 data: 1/1/10-12/31/10</p>	<p>Average number of methods:</p> <ul style="list-style-type: none"> • 6.7 total methods • 5.3 core methods • 1.4 additional methods <p>34 out of 47 Level 1 and/or Level 2 laboratories successfully demonstrated all six core methods (72%)</p> <p>26 out of 47 Level 1 and/or Level 2 laboratories successfully demonstrated at least one additional method (55%)</p>		<p>Average number of methods:</p> <ul style="list-style-type: none"> • 8.9 total methods • 7.1 core methods • 1.7 additional methods <p>28 out of 46 Level 1 and/or Level 2 laboratories successfully demonstrated all eight core methods (61%)</p> <p>27 out of 46 Level 1 and/or Level 2 laboratories successfully demonstrated at least one additional method (59%)</p>
<p>LRN-C laboratories ability to collect, package, and ship samples properly during LRN exercise</p> <p>Source: CDC, ONDIEH (NCEH); 2009 data: 2/10/09-11/9/09; 2010 data: 1/1/10-12/31/10</p>	<ul style="list-style-type: none"> • 53 out of 56 laboratories participated (95%) • 49 out of 53 laboratories passed (92%) 		<ul style="list-style-type: none"> • 56 out of 57 laboratories participated (98%) • 56 out of 56 laboratories passed (100%)
<p>Number of chemical agents detected by Level 1 and/or Level 2 laboratories during the LRN Emergency Response Pop Proficiency Test (PopPT) exercise</p> <p>Note: Not all Level 1 and Level 2 laboratories were eligible to participate in this exercise</p> <p>Source: CDC, ONDIEH (NCEH); 2009 data: 8/24/09 and 10/05/09; 2010 data: 9/13/10</p>	Aug	Oct	Sep
	<p>589 out of 658 agents (90%)</p> <p>Note: A total of 14 agents per laboratory could have been detected by the 47 laboratories participating in this exercise.</p>	<p>31 out of 32 agents (97%)</p> <p>Note: A total of 1 agent per laboratory could have been detected by the 32 laboratories participating in this exercise.</p>	<p>664 out of 731 agents (91%)</p> <p>Note: A total of 17 agents per laboratory could have been detected by the 43 laboratories participating in this exercise.</p>
<p>Average hours to process and report on 500 samples by Level 1 laboratories during the LRN Surge Capacity Exercise</p> <p>Source: CDC, ONDIEH (NCEH); 2009 data: 1/13/09-1/18/09; 2010 data: 5/18/10-5/22/10</p>	<p>98 hours (range was 71 to 126 hours)</p>		<p>56 hours (range was 38 to 86 hours)</p>

Response Readiness Planning: Improving Response to Threats through Planning for Medical Asset Distribution

Responding effectively to a public health emergency often requires complex logistical planning for activities such as the distribution of medicines or other supplies to a community. Because these activities involve many different community agencies, everyone involved in emergency response must plan strategies and regularly exercise (practice) them together. Many of the skills and resources needed for these activities – such as use of the Incident Command System (to define roles and responsibilities), communications, planning, and exercising – are also core needs for responding to day-to-day public health threats.

All 50 states and the 4 localities funded by the Public Health Emergency Preparedness (PHEP) cooperative agreement have plans for receiving, staging, storing, distributing, and dispensing medical assets from CDC's Strategic National Stockpile (SNS). Assets include antibiotics, chemical antidotes, antitoxins, vaccines, antiviral drugs, and other life-saving medical supplies. These assets are designed to supplement and resupply state and local public health agencies in the event of a large-scale public health emergency.

Building the capability to ensure that key medical supplies are available during emergencies is a continuous process of acquiring and managing assets, providing technical assistance, and evaluating readiness. When certain SNS assets are deployed, CDC provides technical assistance support teams to work with state and local officials to ensure their efficient receipt and distribution upon arrival. Highlights of state and local activities conducted to enhance their response readiness planning follow. See individual fact sheets starting on page 20 for specific scores.

States improved their abilities to receive, distribute, and dispense medical assets. CDC conducts annual technical assistance reviews (TARs) to assess state and locality plans to receive, stage, store, distribute, and dispense SNS assets during a public health emergency. Areas of assessment for the TAR focus on key elements that are regarded as either critical or important planning steps within a variety of functions (see box below). CDC technical experts routinely consult with state, local, and large metropolitan health departments to assist them in developing plans specific to their jurisdictional needs and to identify and address gaps.

CDC conducts annual reviews to assess state plans to receive and manage Strategic National Stockpile (SNS) assets. Plans are assessed by evaluating performance in the functional areas below. (See appendix 1 for function descriptions.)

- Developing a Plan with SNS Elements
- Management of SNS
- Requesting SNS
- Communications Plan (Tactical)
- Public Information and Communication
- Security
- Receipt, Stage, Store
- Controlling Inventory
- Repackaging
- Distribution
- Dispensing Prophylaxis
- Hospital and Alternate Care Facilities Coordination
- Training, Exercise, and Evaluation

Everyone involved in emergency response must plan strategies and regularly exercise (practice) them together.

Using a scale from 0 to 100, a TAR score of 69 or higher in 2007-08 and 2008-09 indicated that a state performed in an acceptable range in its planning to receive, stage, store, distribute, and dispense SNS medical assets. The acceptable threshold score increased to 79 or higher for 2009-10. The national average for state TAR scores increased from 87 in 2007-08 to 94 in 2009-10. Functional areas showing the largest improvement over the past three years include repackaging; hospital and alternative care facilities coordination; training, exercise and evaluation; and dispensing (Table 5).

Major metropolitan statistical area (MSA) TAR scores improved over time.

The Cities Readiness Initiative (CRI) focuses on enhancing preparedness in major U.S. metropolitan areas where more than 50% of the U.S. population resides.¹¹ Through CRI, state and large metropolitan area public health departments have developed plans to respond to a large-scale bioterrorism incident by dispensing antibiotics within 48 hours to the entire population of an identified MSA. The program was originally established in 2004 with 21 cities that were

selected based on criteria such as population and potential vulnerability to a bioterrorism threat. The program has grown to include a total of 72 MSAs, with at least one in every state. (MSAs can consist of one or more jurisdictions and can extend across state borders, resulting in the representation of several states within one MSA. See appendix 2 for a listing of the individual MSA jurisdictions within each state.)

To ensure continued readiness, CDC and state public health personnel conduct annual TARs to assess the plans for each local jurisdiction within a state’s CRI MSAs and measure capacity for functions considered critical. Scores (ranging from 0 to 100) for each planning jurisdiction are combined to compute an average score for the CRI MSA. The national average for the 72 CRI MSAs increased from 68 in 2007-08 to 88 in 2009-10. A score of 69 or higher in 2007-08 and 2008-09 indicated that the CRI location performed in an acceptable range its plan to receive, distribute, and dispense SNS medical assets. The acceptable threshold score increased to 79 or higher for 2009-10.

Table 5: Technical Assistance Review Functional Areas That Demonstrated Improvement; 2007-2010

State Improvements in Response Readiness Functions	
2007-08 to 2008-09	2008-09 to 2009-10
<p>Functions with largest improvement:</p> <ul style="list-style-type: none"> • Repackaging (<i>increase of 11 points</i>) • Hospital and Alternative Care Facilities Coordination (<i>increase of 9 points</i>) • Distribution (<i>increase of 6 points</i>) • Dispensing Prophylaxis (<i>increase of 5 points</i>) • Controlling Inventory (<i>increase of 5 points</i>) • Receipt, Stage, Store (<i>increase of 5 points</i>) • Training, Exercise, and Evaluation (<i>increase of 5 points</i>) 	<p>Functions with largest improvement:</p> <ul style="list-style-type: none"> • Training, Exercise and Evaluation (<i>increase of 6 points</i>) • Dispensing Prophylaxis (<i>increase of 4 points</i>) • Public Information and Communication (<i>increase of 4 points</i>) • Controlling Inventory (<i>increase of 3 points</i>) • Security (<i>increase of 3 points</i>) • Hospital and Alternative Care Facilities Coordination (<i>increase of 3 points</i>)

Source: CDC, OPHPR (DSNS); 2007-08 data: 8/10/2007-8/9/2008 performance period; 2008-09 data: 8/10/2008-8/9/2009 performance period; 2009-10 data: 8/10/2009-8/9/2010 performance period

National Snapshot of Response Readiness Planning Activities

A summary table of national-level data on response readiness planning activities from 2007 to 2010 appears below (Table 6). Note that these items represent available data for preparedness

activities and do not fully represent all state and locality response readiness planning efforts. For individual state and locality information in the area of response readiness planning activities, see individual fact sheets starting on page 20. See appendix 1 for an explanation of data points.

Table 6: National Snapshot of Response Readiness Planning Activities; 2007-2010

		2007-08	2008-09	2009-10
Assessing plans to receive, distribute, and dispense medical assets from the Strategic National Stockpile (SNS)	Technical Assistance Review Scores – National Average for States	87	91	94
	Function:			
	Developing a Plan with SNS Elements	93	96	95
	Management of SNS	92	95	96
	Requesting SNS	98	100	99
	Communications Plan (Tactical)	93	94	96
	Public Information and Communication	87	91	95
	Security	88	90	93
	Receipt, Stage, Store	91	96	97
	Controlling Inventory	88	93	96
	Repackaging	76	87	88
	Distribution	87	93	94
	Dispensing Prophylaxis	83	88	92
Hospital and Alternate Care Facilities Coordination	80	89	92	
Training, Exercise, and Evaluation	84	89	95	
Source: CDC, OPHPR (DSNS); 2007-08 data: 8/10/2007-8/9/2008 performance period; 2008-09 data: 8/10/2008-8/9/2009 performance period; 2009-10 data: 8/10/2009-8/9/2010 performance period	Scoring Note: A score of 69 or higher in 2007-08 and 2008-09 indicated performance in an acceptable range. The acceptable threshold score increased to 79 or higher for 2009-10.			
	Technical Assistance Review Scores – National Average for the 72 Metropolitan Statistical Areas in CDC's Cities Readiness Initiative	68	80	88
	Scoring Note: A score of 69 or higher in 2007-08 and 2008-09 indicated performance in an acceptable range. The acceptable threshold score increased to 79 or higher for 2009-10.			