PREPARED
NATIONAL HEALTH SECURITY PREPAREDNESS INDEX

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Suggested Updates for the 2018 Release National Health Security Preparedness Index

Draft for Public Comment

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Contents

From the Program Management Office for the National Health Security Preparedness Index, including: (1) the Center for Public Health Systems and Services Research, Department of Health Management and Policy, University of Kentucky College of Public Health; (2) the Center for Health Services Research, University of Kentucky College of Medicine; (3) the Center for Business and Economic Research, Department of Economics, University of Kentucky Gatton College of Business and Economics; (4) the Applied Statistics Laboratory, Department of Statistics, University of Kentucky; and (5) the Department of Preventive Medicine and Environmental Health, University of Kentucky College of Public Health.

BACKGROUND

The National Health Security Preparedness Index provides a platform for measuring the nation's progress in preparing for, responding to, and recovering from disasters and other large-scale emergencies that pose risks to health and well-being in the United States. The Index measures the strength of the health security system in each U.S. state and for the nation as a whole, allowing annual measures to be compared over time beginning with the baseline year of 2013. Aggregating large volumes of data from national household surveys, medical records, safety inspection results, and surveys of health agencies and facilities, the Index offers a broad, multi-sector view of health security and preparedness. As a measurement tool, the Index can be used to: (1) enhance public awareness and understanding of health security components and capabilities; (2) encourage coordination and collaboration among the multiple sectors and stakeholders that contribute to health security and preparedness; (3) inform planning, policy development, and quality improvement activities across the health security system; and (4) stimulate and guide future research on how to measure and improve health security. New Index results are released annually each April via the website www.nhspi.org.

Each year we solicit ideas for improving the set of measures used in constructing the Index through a public call for new measures and through monthly virtual meetings with workgroup participants. This report summarizes a set of suggested updates to the Index methodology and measures that have been submitted for possible inclusion in the fifth release of the Index to occur in 2018. Public comments about these suggestions will be solicited over a 30-day period after the release of this report. All comments received will be reviewed by the Index National Program Office based at the University of Kentucky, by the National Advisory Committee for the Index, and by the Robert Wood Johnson Foundation (RWJF) as the sponsoring organization for the Index. Final decisions about which suggestions to incorporate into the next release of the Index will be made based on assessments of their expected impact on (1) the validity, reliability, and comprehensiveness of health security measures reflected in the Index; (2) the accuracy and relevance of comparisons made across health security domains, subdomains, states, and years; (3) the usability and utility of the Index for key stakeholders in health security policy, practice and research; and (4) the feasibility of implementing improvements with the time, resources, data, and technology available for production of the fifth release of the Index. Suggestions deemed not to be feasible for incorporation into the 2018 release of the Index may be considered for incorporation into subsequent versions of the Index. Final decisions about updates to the Index will be made by RWJF in consultation with the Index National Advisory Committee and the National Program Office.

METHODS

Suggestions for updates and enhancements to the Index were solicited from a broad array of preparedness stakeholders and from the public at large, using several mechanisms during 2017:

1. Quarterly discussions with members of the National Advisory Committee for the Index, which includes federal, state, local, and nongovernmental representatives with diverse areas of scientific, professional, and community expertise.

2. Monthly discussions held with two standing workgroups established for the Index, including one workgroup focused on Index measures and analytic methodologies and a second workgroup focused on Index stakeholder engagement and communication strategies. Workgroup meetings are held via telephone and internet and are open to the public.

3. An Open Call for Measures announced publicly and solicited during July and August 2017. See Appendix to this document for the response to the open call.

4. Comments received through the Index website and through communications with the Index National Program Office.

5. Briefings held with stakeholder groups, including the Association of Public Health Laboratories, the Association of State and Territorial Health Officials, and the U.S. Centers for Disease Control and Prevention.

The Index National Program Office conducted a preliminary assessment of suggestions for new or modified Index measures using seven key criteria:

1. **Importance**: the measure must reflect an activity, skill, resource or capability that contributes to improved preparedness for minimizing adverse health consequences caused by disasters, outbreaks, and/or other emergencies.
2. **Validity**: the measure must be tested for validity and reliability.
3. **Coverage**: data for the measure must be available for each U.S. state and the nation as a whole, with valid solutions available for resolving missing data problems.
4. **Periodicity**: data for the measure must be collected consistently over time at least once every 3 years.
5. **Timeliness**: the most recent year of data available for the measure must be no more than three years older than the Index release year (2018).
6. **Accessibility**: data for the measure must be in the public domain or agreements must be formed with owners to access data for inclusion in the Index.
7. **Parsimony**: the measure must add new or superior information to the Index compared to that of other measures included in the Index, and should not duplicate or compete with other measures.

The suggestions summarized in this document do not necessarily represent the views or recommendations of the National Program Office, the Index National Advisory Committee, RWJF, nor any of the collaborating and contributing organizations to the Index.

RESULTS: SUGGESTED UPDATES

Two types of suggestions for the 2018 release of the Index are summarized in this report: (1) suggested new measures to be added to the Index; and (2) existing measures to be removed from the Index results. The April 2017 Summary of Key Findings Appendix (page 15) lists the measures included in the 2017 release of the Index.

1. Suggested New Measures to be Added to the Index

The following new measures have been suggested as possible additions to the Index:

- **P1—Health & Safety of First Responders.** Specification: number of nonfatal occupational injuries and illnesses among police and fire department workers. This measure includes both

state and local workers in NAICS codes 92212 and 92216, using the BLS Survey of Occupational Injuries and Illnesses (SOII). Rationale: Protecting first responders from hazards while on the job strengthens a community's ability to prepare for and respond to large-scale emergency events. This measure, while not comprehensive, covers two major categories of first responders who face significant occupational risks.

- **P2—Transportation Structural Integrity.** Specification: percentage of bridges that are not functionally obsolete or structurally deficient. Rationale: Core elements of transportation infrastructure shape many aspects of health security, including mitigation of health and safety risks due to bridge failures, timely mass evacuations, timely emergency responses, and timely restoration of economic and social activity.
- **P3—Surface Water Control Structural Integrity.** Specification: percentage of regulated high-hazard potential dams that are not in poor or unsatisfactory condition. Rationale: Core elements of surface water control infrastructure contribute to health security through mitigation of flood risks and protection of drinking water sources.
- **P4—911 Call Center Cybersecurity.** Specification: state government implements or participates in a cybersecurity program designed to prevent interruption, damage, and unauthorized use of emergency 911 call center infrastructure. Rationale: The 911 Public Safety Answering Points (PSAPs) are essential for marshalling emergency response resources during a disaster or emergency—and are vulnerable to cyber-based threats. This measure is an indicator of cybersecurity risk reduction.
- **P5—Community Water System Compliance with Non-Health Standards.** Specification: Percentage of the population being served by a community water system that did not experience a non-health-based violation of the federal Safe Drinking Water Act (SDWA) (Note: An existing measure, M195, has a similar specification but is focused on health-based violations). Rationale: Non-health violations such as noncompliance with testing procedures and protocols provide early warning signals about weaknesses in capabilities for protecting drinking water safety and security.
- **P7—Community Water System Return to Compliance with Health and Non-Health Standards.** Specification: percentage of health-based violations of the SDWA that return to compliance by the end of the year. This measure can be specified for both health-based and non-health violations. Rationale: Water systems with the capability to quickly return to compliance following a violation offer their communities greater protection against large-scale health threats in the water supply.
- **P8—Housing Buy-Outs for Flood Hazard Mitigation.** Specification: housing units purchased through the FEMA Hazard Mitigation Grant Program (HMGP) as a percentage of total housing units located in floodplains. Rationale: States can reduce health, safety and financial risks posed by flooding through pro-active use of the HMGP to remove high-risk housing units from occupancy.
- **P9—Flood Insurance Coverage.** Specification: FEMA National Flood Insurance Policies (NFIP) in-force as a percentage of total housing units located in floodplains. Rationale: NFIP participation indicates household and community awareness of flood risks and provides financial protections that accelerate community recovery after flood-related disasters.
- **P10—Population Covered by Storm Water Utilities.** Specification: percentage of the population that is covered by a storm water utility. Rationale: Storm water utilities reduce the

environmental health risks caused by sewage overflows into surface waters during storms, especially for populations living in flood-prone areas.

- **P11—Registered Environmental Health Specialist/Registered Sanitarian (REHS /RS) Credential.** Specification: Number of REHS/RS Credential holders as a percentage of environmental and health scientists and specialists. Rationale: Professionals with this credential conform to national standards in environmental health training and practice, including the ability to respond to emergency environmental health situations.
- **P12—Access to Pediatric Medical-Surgical Hospital Care.** Specification: Percentage of the population 18 years of age and younger who reside within 50 miles of a hospital facility that provides pediatric medical-surgical care. Rationale: Children are often more vulnerable than adults to health risks during disasters and disease outbreaks, and many of these events increase the demand for timely medical-surgical care for children.
- **P13—Participation in National Syndromic Surveillance Program (BioSense).** Specification: proportion of emergency department visits within the state that are represented in data that are in production through the NSSP. Rationale: States with broader emergency department coverage within the NSSP are able to conduct more accurate and complete syndromic surveillance using NSSP, resulting in faster detection and response to health security events. Use this new measure to replace the more limited measure M22 State Health Department Electronic Syndromic Surveillance.

2. Existing Measures to be Dropped from the Index

- **M172—Percentage of Residents Doing Favors for Neighbors**. These data from the U.S. Census, Current Population Survey have not been updated since 2013. The CPS Civic Engagement Survey is currently in the field (Sept. 2017) to be updated, but results will not be available for the 2018 release. Other Index measures of volunteerism provide better representation of this health security construct.
- **M340—Number of Entities Required to Report Foodborne Illness: clinical laboratories, physicians, hospitals, nurses, physician assistants, and/or other healthcare providers (e.g., chiropractors, veterinarians).** This data source has not been updated since 2013 [Public Health Law Research (PHLR), Temple University. Robert Wood Johnson Foundation (RWJF), LawAtlas: State Foodborne Illness Reporting Laws Map]. Furthermore, there is little empirical evidence suggesting that more reporting source types results in more complete surveillance.
- **M22—State Health Department has an Electronic Syndromic Surveillance System that Can Report and Exchange Information.** This data source from the 2012 ASTHO State Health Profile is limited to syndromic systems maintained by the state agency, and does not account for state ability to use other systems such as the CDC's BioSense and NSSP. Replace this measure with the new proposed measure P13 described above.

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APPENDIX: NATIONAL HEALTH SECURITY PREPAREDNESS INDEX, RESPONSE TO CALL FOR MEASURES FOR 2018 RELEASE, JULY-AUGUST 2017

Note: See the April 2017 Summary of Key Findings Appendix (page 15) to review the description of all measures included in the 2017 release of the Index (https://nhspi.org).

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Okey Enyia	Analyst	Dep't. of Health & Human Services	New Measure	Health Equity Index

Author and source of the measure (if different from Submitter):
http://www.cadh.org/health-equity/health-equity-index.html;
http://www.cadh.org/emergency-preparedness.html

Description of the measure:
The Health Equity Index provides community-specific scores on seven social determinants of health and thirteen health outcomes, the correlations between them, and GIS maps that illustrate community-specific scores. Scores range from one to ten, with a ten being the best possible score. Each social determinant of health and each health outcome score is calculated by considering several types of data.

Program Office Response:
The Health Equity Index aggregates a rich set of social and health outcome data and profiles these data at the neighborhood level across the state of Connecticut. It is unclear how the HEI's broad measures of health determinants and outcomes relate to specific health security capabilities as measured in the Index. Additionally it is unclear whether constructs measured in the HEI would have the same validity and reliability when aggregated to the state level. Finally, it is unclear whether the HEI measures and data sources are readily available for all U.S. states and updated at least every three years. Given these uncertainties, we suggest that a more valid and reliable approach is to explore and analyze relationships between the HEI and the Index rather than attempting to incorporate the HEI into the Index.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Okey Enyia	Analyst	Dep't. of Health & Human Services	New Measure	Health Disparities Calculator

Author and source of the measure (if different from Submitter):
https://seer.cancer.gov/hdcalc/

Description of the measure:
HD*Calc supports the use of a range of health disparities measures, allowing researchers to select and apply different measures to their data. HD*Calc was originally developed to expand the range of measures for evaluating health disparities related to cancer. However, since it can be used with any dataset, HD*Calc can be used in any research arena. Cross-sectional and trend data (e.g., cancer rates, survival, stage at diagnosis) categorized by disparity groups (e.g., area-socioeconomic status, race/ethnicity, geographic areas) can be imported into HD*Calc to generate four absolute and seven relative summary measures of disparity.

Program Office Response:
See similar comments above regarding the HEI. Given uncertainties about how cancer disparities relate to key health security constructs we suggest it is better to explore and analyze relationships between cancer disparities measures and the Index rather than attempting to incorporate these disparity measures into the Index.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Margaret Kitt	Deputy Director	NIOSH	New Measure	Health of responders and recovery workers

Author and source of the measure (if different from Submitter):

NIOSH as well as other agencies have been very active in responder safety and health but this measure is put forward by NIOSH. Please see the following site www.cdc.gov/niosh/erhms. This measure can also be verified in the CDC Public Health Emergency Preparedness (PHEP) cooperative agreement through Capabilities 14 (Responder Safety and Health) and 15 (Volunteer Management) found at: https://www.cdc.gov/phpr/readiness/00_docs/DSLR_capabilities_July.pdf.

Description of the measure:

Domain 6: Environmental and Occupational Health Subdomain 6.3: Responder Safety and Health proposed. Responder Safety and Health is currently missing from the Index and yet is critical to preparedness planning and health security as responders and recovery workers are on the front line of response. State response plans contain details on protecting the health of responders and recovery workers before, during, and after an event. This includes training, availability of personal protective equipment, and exposure monitoring for workers. Some aspects of this measure such as training may be verified through CDC sources, and training is documented through various sources. Self-reporting by states on content of plans is also a source. This would likely be an evolving measure over the coming years but needs to be a first step to address Responder Safety and Health in the Index.

Program Office Response:

We have yet to identify established and verified national data sources for these constructs that are updated regularly. See the proposed measure above, P1—Health & Safety of First Responders, for a related measure that can be constructed from existing data sources. .

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
David T. Dyjack, Dr.PH, CIH	Executive Director, CEO	National Environmental Health Association	New Measure	REHS/RS Credential Holder

Author and source of the measure (if different from Submitter):

www.neha.org

Description of the measure:

Nationally recognized credential for environmental health practice, in industry and government. Approximately 8% of the REHS/RS credential examination is dedicated to emergency preparedness and response. The location of each REHS/RS, in the US, and its territories, can be geocoded and mapped. The REHS/RS is a fully validated, nationally recognized credential. It represents the gold standard for environmental health practice.

Program Office Response:

We have included this measure on the list of suggested measures for 2018 (see above P11—Registered Environmental Health Specialist/Registered Sanitarian (REHS/RS) Credential).

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	New Measure	Continuity of Operations Plans (COOP)
Author and source of the measure (if different from Submitter): None provided; possibly CDC OEPR or EM.				
Description of the measure: Percent of states with COOPs. We at the local level are asked to submit an updated plan yearly.				
Program Office Response: We have yet to identify an established and verified national data source for this measure that is updated regularly.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	New Measure	NIMS compliant
Author and source of the measure (if different from Submitter): DHHS				
Description of the measure: States whose plans are NIMS compliant. Shows that states using an incident management system to respond; it's been proven successful. HHS issues a NIMS survey to states every year.				
Program Office Response: We have yet to identify an established and verified national data source for this measure that is updated regularly.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	New Measure	Cyber security plans
Author and source of the measure (if different from Submitter): None Provided				
Description of the measure: Cybersecurity is a real important component to protection of our systems we need for response.				
Program Office Response: We have included this measure on the list of suggested measures for 2018 (see above P4—911 Call Center Cybersecurity.).				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Modified Measure	M18. Number of Epidemiologists

Author and source of the measure (if different from Submitter):
None Provided

Description of the measure:
Specify disease investigative epidemiologist as there are lots of epidemiologists, but some have nothing to do with disease investigation or surveillance. Some just look at data on other unrelated topics.

Program Office Response:
This data source does not capture information on the types of work performed by epidemiologists (U.S. Department of Labor Bureau of Labor Statistics). This general measure of epidemiologist workforce supply provides a global characterization of a state's capabilities in epidemiological investigation relevant to emergencies recognizing that many workers may contribute capabilities outside their day-to-day responsibilities in the event of an emergency.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Modified Measure	M9032. Percent of Hospitals that participate in HCCs

Author and source of the measure (if different from Submitter):
CMS audits/surveys should give this information.

Description of the measure:
Hospitals needs to be defined (some are rehab and some state hospitals, etc.) and participation needs to be defined.

Program Office Response:
In collecting the data for this measure, ASPR distinguishes among 14 different types of health care coalition participant entities, including short-term acute-care hospitals, Skilled Nursing Facilities, Ambulatory Surgical Centers, and Psychiatric Residential Treatment Facilities. The Index relies on ASPR's definitions of coalition participant entities and its measures of the prevalence of each type of entity within the state and within each coalition. The Index's measure of hospital participation in HCC is based on ASPR's recommended approach for measuring HCC organizational composition.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Modified Measure	M266. Percent of state population who live in county with CERT

Author and source of the measure (if different from Submitter):
None provided

Description of the measure:
Some counties don't have CERTS, but have other groups like MRC or DART, etc. Maybe measure should just say 'counties that have some sort of volunteer management agency.'

Program Office Response:
The Index includes measures for CERT coverage and MRC membership. We are not aware of a national data source that measures MRC membership by county nor a data source that measures DART by county.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Modified Measure	M346. Total number of MRC members

Author and source of the measure (if different from Submitter):
None provided

Description of the measure:
Change this to total number of EM registered volunteers as they may come from many different kinds of volunteer groups.

Program Office Response:
The national data source used for measuring MRC membership does not include information about emergency management expertise.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Delete measures	MRC members who are: M176. physicians M179. volunteers that are nurses/NPs M186. volunteers that are other health professionals

Author and source of the measure (if different from Submitter):
N/A

Description of the measure:
MRC consists of all types of volunteers not just medical. Studies show that need 2:1 at least of non-medical support staff to medical support staff to run a clinic or POD or anything.

Program Office Response:
The Index includes a measure of total MRC volunteers as well as individual measures of health professional MRC volunteers.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Tiffany Turner	Program Manager Public Health & Healthcare Prep. Program	Spokane Regional Health District and Region 9 Healthcare Coalition	Modified measure	M107. Percent of LHDs with EP coordinator

Author and source of the measure (if different from Submitter):

None provided

Description of the measure:

This tells us nothing as some have a full FTE or more and some have .25 FTE, but both considered EP coordinators. Maybe ask about how many FTEs devoted to this role or program.

Program Office Response:

The data source for this measure does not capture information on full-time or part-time appointment status (i.e. the intensive margin). However, research shows that the presence or absence of a coordinator (i.e. the extensive margin) is itself an important predictor of local public health emergency preparedness capability. For example see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758413/

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Rachel Herlihy	State Epidemiologist	Colorado Dept. of Public Health & Environment	Modified measure	M18. Epidemiologists per 100,000 population

Author and source of the measure (if different from Submitter):

Description of the measure:

Unclear why Colorado data was missing in previous index. The BLS OES data is available for 2014-2016 on the BLS website and CO is one of the top states in terms of numbers of epidemiologists. It looks like CO data was missing for 2012-2013 so perhaps that resulted in missing value? Suggest use of most recent year or two of data, not historic data because missing older data will result in permanent 'data missing' value. Suggest methodology to deal with single year of missing data for measures that include multiple years of data.

Program Office Response:

These data are missing for Colorado for two years and available for two years. Selected states have missing data in the OES for a variety of reasons, including low sample sizes and response rates in selected years, and responses that do not meet BLS data quality standards in selected years. For confidentiality reasons, BLS does not disclose the reasons for data missingness. For states with missing data in selected years, the Index uses a widely accepted statistical imputation method to estimate single years of missing data for measures. Imputed data generally include greater measurement error than directly reported data, so results should be interpreted with these caveats in mind. We will explore the use of rolling averages to reduce non-informative year-to-year fluctuations in these estimates due to sampling error and imputation error.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Rachel Herlihy	State Epidemiologist	Colorado Dept. of Public Health & Environment	Modified measure	M22. State health electronic syndromic surveillance

Author and source of the measure (if different from Submitter):
Suggest using CDC information on which states report data into BioSense. https://www.syndromicsurveillance.org

Description of the measure:
Some states like Colorado have syndromic surveillance systems in place that aren't based at the state health department. Suggest a data source that would identify all syndromic surveillance systems in operation.

Program Office Response:
We have included this measure on the list of suggested measures for 2018 (see above P13— Participation in National Syndromic Surveillance Program (BioSense)).

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Rachel Herlihy	State Epidemiologist	Colorado Dept. of Public Health & Environment	Modified measure	M217. State Lab Information Management System

Author and source of the measure (if different from Submitter):
None provided

Description of the measure:
Colorado is listed in previous survey as having "data missing". Unclear why this is the case when we have fully participated in the CLSS. Suggest distinguishing "no" from "data missing" where relevant.

Program Office Response:
Colorado's CLSS data are correctly coded and counted in the Index. However, a website display glitch caused some measures coded with values of "zero" or "no" to be displayed erroneously as "missing" on the website. A fix for this display problem is being implemented.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Rachel Herlihy	State Epidemiologist	Colorado Dept. of Public Health & Environment	Modified measure	M23. Foodborne illness outbreaks reported for which etiologic agent is confirmed

Author and source of the measure (if different from Submitter):
Data source: CDC published annual summary: https://www.cdc.gov/foodsafety/fdoss/data/annual-summaries/index.html or CDC FOOD tool: https://wwwn.cdc.gov/foodborneoutbreaks

Description of the measure:
Suggest that this measure be changed to: State rate (per 1 million population) of foodborne illness outbreaks reported to CDC. Reason for suggested change: The current measure penalizes states that investigate and report outbreaks that are detected after persons are no longer shedding etiologic agents and/or after food items are no longer available for testing. It is important to report outbreaks that are investigated retrospectively and changing this measure to capture overall state rates of foodborne outbreak reports is a better reflection of a state's epidemiologic detection and response capability.

Program Office Response:
As currently specified, this measure assesses a state's ability to confirm an etiology agent, which is influenced in part by the timeliness with which outbreaks are detected and investigated. The alternative measure you propose reflects a different construct: the incidence of reported foodborne illness outbreaks. The extent to which this alternative measure indicates underlying disease burden and risks vs. epidemiological detection and reporting capabilities is a matter of considerable debate. As a consequence, it is unclear whether a high rate signals strong or weak health security, or some combination of the two. We will continue to explore this issue and alternative measure specifications.

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M275_DW. Testing of drinking water

Author and source of the measure (if different from Submitter):
APHL survey should be revised so a question is asked confirming another state agency had legal responsibility.

Description of the measure:
The measure should be worded to not take away points for a PH lab that does not have statutory responsibility for testing water. This is currently listed as a limitation. Maybe add a statement 'Responsibility of another state agency.' Georgia PH like many states is not responsible for testing drinking water. This falls to our sister Environmental Protection agency that serves as primacy for EPA.

Program Office Response:
This measure is one of a series of measures included in the Index that indicate whether or not the state public health laboratory "provides or assures" specific laboratory testing capabilities, based on data reported to APHL by state public health laboratory directors during regularly recurring surveys. The "provide or assure" standard used in these measures indicates that a state public health agency can achieve the capability either by directly performing the test in its lab, or by assuring that another laboratory entity performs the test and reports the results adequately. State public health labs that indicate neither providing nor assuring the test are coded as not having the testing capability. In some states, selected laboratory tests are performed not by the state public health laboratory but by an alternative state government laboratory located outside the state health agency, such as an environmental lab or agricultural lab. In these cases, the public health laboratory must assure that the testing is performed adequately and that the results are reported adequately by the alternative lab in order to meet the "provide or assure" standard.

Importantly, the "provide or assure" standard in public health laboratory testing reflects long-standing federal recommendations and national consensus expert opinion about the nation's public health laboratory system. Specifically, this "provide or assure" standard is recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services, and is reflected in the nation's Healthy People 2020 goals concerning access to comprehensive public health and environmental health laboratory testing. These national recommendations specify that health-related laboratory testing capabilities are strongest when the designated state public health authority is engaged in the testing and reporting process at some level – either by directly performing the tests or by assuring that alternative labs perform the tests adequately. According to these recommendations, the "provide or assure" standard ensures that health-related laboratory testing and reporting is guided by appropriate levels of specialized public health knowledge and expertise found within the state public health agency. This standard provides protection against the possibility that laboratory test results could be misinterpreted as to their public health implications, or that delays could occur in implementing effective public health interventions based on reporting of laboratory test results. These measures have been included in the Index since its inception in 2013. By continuing to include these measures, we ensure that the Index is consistent with current national expert opinion and federal recommendations concerning comprehensive public health laboratory testing capabilities. See for example: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2846798/

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M275_Rec. Testing of recreational water
Author and source of the measure (if different from Submitter): APHL survey should be revised so a question is asked confirming another state agency had legal responsibility.				
Description of the measure: Georgia gets 0 points for this measure every year, but tests recreational water.				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M275_Sur. Testing of surface water
Author and source of the measure (if different from Submitter): Revise APHL survey to laboratories to include a question about other state labs that test surface water.				
Description of the measure: Measure should be reworded to reflect other agencies that have statutory authority to test surface water. Georgia like many states gives statutory authority to its Environmental Protection agency for testing surface water.				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M275_UST. Testing of underground storage tanks
Author and source of the measure (if different from Submitter): Revise questions on APHL survey.				
Description of the measure: Revise measure to include "...or another state laboratory tests for USTs..." Responsibility in Georgia lies with its Environmental Protection agency for this measure.				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M275_WST. Testing of waste water
Author and source of the measure (if different from Submitter): Revise APHL survey to labs to include a question about other labs testing				
Description of the measure: Revise measure to include "...or another state laboratory test wastewater." Wastewater is typically tested at wastewater treatment plants, or other state environmental labs.				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M202. Testing of air
Author and source of the measure (if different from Submitter): Revise APHL survey to labs to include a question about other labs testing				
Description of the measure: Does your state public health laboratory "or another state environmental laboratory" provide or assure testing for air? Georgia like many states gives statutory authority to its agency of primacy for EPA. Not PH in Georgia.				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M257_NELAC. National Environmental Laboratory Accreditation Conference
Author and source of the measure (if different from Submitter): APHL				
Description of the measure: Georgia PH lab is certified by NELAC, but received 0 points each year. As EH Director, I'm not in the loop with the APHL survey. Maybe we can be copied to ensure its completed.				
Program Office Response: Measures obtained from the recurring APHL surveys reflect in information that is self-reported by state public health laboratory directors. Reporting errors are possible. We will notify APHL about this possible reporting error for Georgia.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M272. Test for contaminants in environmental samples
Author and source of the measure (if different from Submitter): APHL survey should be revised to capture other labs that test for environmental contaminants.				
Description of the measure: Does your state public health lab "or another state environmental lab".....				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Dr. Chris Rustin	Director, Environmental Health	Georgia Department of Public Health	Modified measure	M273. Testing for hazardous waste
Author and source of the measure (if different from Submitter): Revise APHL survey to capture new information				
Description of the measure: Does your state public health lab "or another state environmental lab..."				
Program Office Response: See comments above regarding the laboratory "provide or assure" standard.				

Submitter			Recommendation	
Name	**Title**	**Organization**	**Type**	**Measure Name**
Charles Macias MD MPH	Executive Director EMS for Children Innovation and Improvement Center	EMS for Children Innovation and Improvement Center	New measure	Percentage of hospital facilities in the state that provide pediatric services
Author and source of the measure (if different from Submitter): American Hospital Association Annual Survey of Hospitals; https://www.ahadataviewer.com/additional-data-products/AHA-Survey http://www.sgim.org/communities/research/dataset-compendium/american-hospital-association-annual-survey#DatasetSummary				
Description of the measure: The EIIC Program proposes the addition of a measure that reflects the availability of healthcare delivery services for the pediatric population. While the 2017 index accounts for the special healthcare delivery needs of the geriatric population (M296 'Hospitals providing geriatric services'), there is no measure which reflects the similarly specialized needs of the pediatric population. The unique medical needs of children in an emergency have been well-documented, and the ability to care for this population is critical to preparedness and health security - particularly for those events which may disproportionately affect children. Therefore, we propose the addition of the measure, 'hospitals providing pediatric medical-surgical care' which is available from the same source as M296, 'hospitals providing geriatric services.'				
Program Office Response: We have added this measure to the list of suggested new measures for 2018 (see above P12—Hospitals Providing Pediatric Medical-Surgical Care.).				