NEMA-ASTHO-GHSAC Joint Policy Workgroup Meeting
Wednesday, August 1, 2018
Meeting Summary

Tri-Chairs: Dr. John Dreyzehner (ASTHO); Director Pete Landon (GHSAC); and Director Michael Dossett (NEMA)

Agenda Topics

- CDC Preparedness and Response Update
- Catastrophic Disaster Planning and Capabilities Assessment
- Emergency Repatriation Surge Planning
- Crisis HIPPA Standards
- EMAC
- Regional Disaster Health Response System
- Public/Private Sector Relationships in Hospital Coordination
- Priorities of the Associations

Dr. Dreyzehner opened the meeting with introductions around the room, ending with Director Landon and Director Dossett as the other tri-chairs; concluding with the floor opened to the sessions.

CDC Preparedness and Response Update
Mr. Todd Talbert, Division of State & Local Readiness, CDC
Harald Pietz, Division of State & Local Readiness, CDC

Cooperative Agreement. The CDC has derived an agency-wide mechanism, the Cooperative Agreement for Emergency Response: Public Health Crisis Response. This agreement provides the opportunity to assist jurisdictions with pre-identified and approved list of resources for recovery initiatives, in addition to and separate from the PHEP funding, and is on a one-year cycle. Jurisdictions must apply each year. Through this agreement, the CDC assists jurisdictions directly impacted by the response from the 2017 hurricane season as well as the opioids crisis. In response to the opioids crisis, the agreement bridges gaps for at least 48 states' abilities to start programs. This includes clinical assistance, substance abuse providers support, and stress and coping programs for law enforcement. The program is not intended to enhance treatment programs. The added assistance looks to improve dash board reports on real time data; strengthen lab and medical examiners support; and provide public relations awareness in developing new campaigns. Opioid overdoses that result in death are widely under-reported, thus this support can be a countermeasure by helping teams that assist in overdose cases. Awards should go out the beginning of September.

Influenza Exercise in September. The CDC DSLR will host an influenza exercise in the fall to assist state and local public health officials with the expectations of guidelines and the CDC's resources to a large-scale response.

Public Health Preparedness Capabilities: National Standards for State and Local Planning.
350 stakeholders were involved in sharing ideas for the CDC's framework in preparedness capabilities guidelines. Now that the CDC is in the final phase for the standards, they look to a release date soon. The CDC will provide status updates to the NEMA ASTHO GHSAC policy work group for the rollout of the

guidelines. Key changes within the framework are: expanding on strategies that plan for disproportionately impacted populations; consequences of environmental hazards; maintaining chemical laboratory capacity; data security measures; expand MCM to include vaccination; social media alerts; and stronger responder safety and control measures.

Crisis HIPAA Standards
Caleb Cage, Chief, NV Division of Emergency Management
The Route 91 Harvest Festival's tragic abrupt ending from an active shooter, created an avenue for the State of Nevada to relook at processes involving the Health Insurance Portal and Accountability Act (HIPAA) and ways to be able to streamline such processes during disaster response. The Executive Order created during the event provided the landscape to address certain HIPAA policy procedures in the event of a mass casualty incident or public health emergency. In addition, the executive order helped to create a state disaster identification team and regulations to address the information share on patients.

Specific Recommendations:

- Open meeting records requests does not apply.
- Change the duties/responsibilities to create standardized information requests.
- Provide plans and a means to execute those plans.
- State disaster identification teams coordinates public information to share during a disaster.

The emergency management and public health leads look to pursue these recommendations during legislation that will begin for Nevada in February 2019.

Catastrophic Disaster Planning and Capabilities Assessment
Michael Vineyard, Sr. Advisor, HHS
Anthony Cox, Emergency Management Deputy Director, AZ Division of Emergency Management
Brad Richy, Director, ID Office of Emergency Management

In effort to develop catastrophic response plans to better support potential requests in federal resourcing that go beyond state and EMAC capabilities; public health and emergency management representatives work together to provide plans that focus on patient care and medical surge, patient evacuation, and fatality management. The regional project consists of Arizona, Colorado, Idaho, Utah, and Wyoming. Arizona and Idaho share their insights on the overall project and workshop along with ASPR sharing their lessons learned.

Arizona. The project is timely in their planning efforts and is of great value in the two entities collectively working together. A few takeaways:

- They will incorporate these plans in their Public Health Emergency Playbook for the Governor's Office.
- Appreciation of the knowledge gain on legal authority and resources that they have in state as well as what the federal agencies may provide.
- The planning process elevates how they implement resource management, especially within medical surge, patient evacuation, and fatality management.
- They look to leverage the momentum from the project to elevate their resiliency development and catastrophic planning.

Idaho. This project creates a cultural change in working together for preparedness initiatives with public health/emergency management partners, especially since each agency have new staff members. Looking at the scalability at an ESF 5 and ESF 8 approach is one of the many invaluable aspects of the project. A few takeaways:

- Brought to light the ability to see how thresholds can strain the limited supply. And who has what resources that may become critical during an incident.
- Enhance planning efforts to create dialogue among state and local agencies. Also enhance a method to review and put in place MOUs well in advance.
- How to ask for federal resources. Better to tell them what you lack so that they may decide what to send.
- Create pre-mission planned EMAC requests
- Department of Defense credentialing and how that may be addressed with assisting Tribal or First Nation people.

ASPR. Having the opportunity to engage in the planning process is invaluable to ASPR. Especially in understanding how the States operate and figuring out ways to better utilize the resources that may be readily available and those that may be requested by outside sources. Looking at the broader picture helps ASPR decide who they may need to partner with to elevate their own resource management.

Repatriation Adaptive Planning
Joe Laman, Repatriation Lead Planner, ASPR
Michael Vineyard, Sr. Advisor, HHS

ASPR will lead all matters related to federal public health and medical response in the Continental United States for the return of all American citizens per the requests of the Department of State (DoS) or the Department of Defense (DoD). With this activation, ASPR does not intend to utilize DoD resources for operational mission sets but will activate the National Disaster Management System (NDMS) to deploy teams and other federal partners to support patient movement operations and facilities (zero impact on DoD logistics). Evacuation areas may be when countries have civil unrest or natural disasters. As such, any unprecedented response will exceed capabilities and has the potential to overwhelm U.S. medical infrastructure. Thus, requiring a tremendous amount of interagency support, coordination and "adaptive planning" and can possibly exceed state planning efforts.

To proceed if such a mission occurs, ASPR designs operational mission sets for pre-identified relocation centers set in the country where citizens will be first transported. Medical screening is the number one objective to ensure all the people coming into the centers are properly screened. The centers may also receive third country nationals (citizens from other countries). Case management is another mission set that will continue from the medical screening to assist in tracking people and follow up on health needs and/or disease monitoring. Tracking will be helpful to make sure families reunite and for ASPR to always know the location of those individuals.

Moving forward with adaptive planning, gaps have been identified:

- State emergency repatriation plans (SERP) are not standardized and need thorough assessments.
- Dependence on NDMS medical facility network and coalitions to support influx of casualties.
- Not a lot of resources for patient transport – also the logistical supply chain is huge concern in the number of supplies needed for the centers to be sustainable.

- Staffing shortfalls for federal medical support (identifies a challenge in medical screening).
- Fatality management.
- Command and control – 10 centers are identified; need to include those overseas.
- Overall communication with Governors and state partners (awareness, process, education).

ASPR's first goal is to get the primary ERCs (emergency repatriation centers) up to speed by October 1 and then will phase in tier two and then tier three centers.

EMAC
Brian Satula, Director, WS Division of Emergency Management and EMAC Committee Chair

The 2017 season was the most logistically challenging event in EMAC's history. The term "submarine support" was the best description for how compromised communications were in trying to assist those states that were impacted. Meaning that once you were able to get through to devastated areas such as USVI and Puerto Rico, you only had moments to converse before the system would shut down. Thus, placing a challenge on an already compromised situation. In just the hurricane response alone, EMAC deployed over 16,000 personnel; including the movement of supplies. Add that to the wildfires out west that occurred almost simultaneously, 19,196 personnel from 16 different states are the final number of deployments from August 2017 – to July 2018.

In reflection, what worked well:

- First in teams assisted requesting state in crafting new request for the next rotation of personnel; providing better situational awareness.
- Licensing and reciprocity issues were not common from deploying personnel creating zero lapse in service
- Robust pre-deployment briefings allowed teams to plan for conditions and understand operations – managed expectations.
- Relationship building of deployed personnel elevated logistical need support.
- Participation in FEMA town hall meetings was invaluable.

What may be needed:

- Additional education on EMAC provisions (liability, immunity, licensing, reciprocity)
- Additional education on EMAC process (mobilization, response, reimbursement)

When diving into the findings from the after-action review, a disconnect was found between emergency management and ESF8 resulting in requesting and receiving resources that did not match the need. To counter that, the recommendation is to work with ASTHO in taking a lead role in educating EMAC to their members. In addition, recommend for ASTHO to develop a working group to continue to focus on mission ready packages development.

Another finding was that EMAC was under-utilized. To enhance the network, more education needs to occur on EMAC within states and HHS for a better understanding of how the EMAC system works and is beneficial in states supporting states.

Other areas of improvement stemmed from the need for more EMAC training. EMAC looks to market the online EMAC courses to help better prepare personnel for future missions, whether from a request or as assistance. In addition, urge the states to include all disciplines into the training and exercises to

maintain that awareness across the board. For reimbursement strategy, EMAC found that the reimbursement process stalled. To provide a smoother process, the recommendation is to have the National Coordinating State develop a working group to look at the process and identify improvements.

When the system is used correctly, it works! Learn more at www.emacweb.org

Regional Disaster Health Response System (RDHRS)
Melissa Harvey, Director, National Healthcare Preparedness Programs, ASPR

ASPR aims to better address gaps in coordinated patient care during disasters. The RDHRS has four main goals: 1. Better organize and coordinate across local, state, regional, and federal healthcare response assets; 2. Improve communication and situational awareness of the medical needs and issues in response; 3. Develop highly specialized clinical capabilities critical to hazards or catastrophic events; and 4. Increase healthcare coalition participation – ensure response ready clinical capabilities.

This new approach extends the preparation for disaster/emergencies to be more prepared on a full spectrum (hospitals, clinics, all facilities). Thus, further enhancing the hospital preparedness program (HPP). Through the HPP, the goal is to develop and sustain health care coalitions (a group defined in a geographic area), that will leverage health care preparedness and response. Areas like behavioral and mental health centers, emergency medical services, physicians, hospitals, and local health departments as well as partners like emergency management. Emerging from this idea are the core capabilities helped to deliver a 'ready nation': foundation for health care and medical readiness; health care and medical response coordination; continuity of health care service delivery; and medical surge.

From these goals, the RDHRS will

- Build regional surge capacity
- Improve regional coordination (resource share, medical EMAC, common plans/procedures)
- Expand response capabilities through partnership (NDMS hospital membership, State Medical Assistance Teams, telemedicine, training, better engagement of VA and DoD)
- Enhance situational awareness through more informed, data-driven communications
- Ensure readiness through standard achieving and exercises
- Improve NDMS program; integrate Medical Reserve Corps; and Update HPP

There is a unity of command between RDHRS and NDMS as they are interoperable at all levels to provide a faster response. Current DMATs will remain federal assets complimenting the NDMS assets. NDMS will not be used as a regional resource unless requested.

Public/Private Sector Relationships in Hospital Coordination
Kelly Parker, Director, Virginia Hospital and Healthcare Association
Nicolette Louissaint, Executive Director, Healthcare Ready

The Virginia Healthcare Emergency Management Program is a partnership between the VA Department of Health and the VA Hospital & Healthcare Association. The Virginia Health Department invest 50% of staffing of the 32 healthcare coalitions across the commonwealth. The authority relies with the healthcare directors within the districts. The program helps to bridge the gap between private sector and public-sector emergency response agencies due to the education on ensuring the coalitions speak both emergency management and public health. Currently, the association has observed a huge jump in

assistance in healthcare facilities. Other means where the program is helpful is in patient transport that at times can be across the state border. The program is an asset to the healthcare system but allows healthcare to support themselves. They also have the flexibility to engage with non-traditional partners such as labor unions. The public/private partnerships proved most effective during the response to events and leverage the importance of the partnerships within mutual aid.

Healthcare Ready is a non-profit organization that fosters public/private partnerships and maintains those relationships through engagement and collaboration. Across the organization, they leverage unique relationships with government, nonprofit, and medical supply chains to build capabilities before, during and after a disaster. 92% of healthcare is owned by the private sector, thus highlighting the importance of forging those relationships. They host an information and analysis center (ISAC) that assists in providing the landscape analysis to stakeholders during a disaster. The focus of the center is business continuity, supply chain considerations, impacts to healthcare capacity, engaging public health partners, and community resilience. During a disaster, their system can provide detailed information such as pharmacy status so that citizens know which pharmacies are open for business. Healthcare Ready looks to provide the same information for other facilities soon as well as present material in other languages (Spanish). Another priority is access and re-entry. When not responding, the center is used for situational awareness, education and promotion of strengthening supply chains. Finally, they look to facilitate and assist private sector partners that want to incorporate public sector within their business continuity plans. As they advance in analytics, Healthcare Ready leverages the facilitation of bringing private and public partners together to be a more prepared community.

Priorities of the Associations
Gerrit Bakker, Sr. Director, Public Health Preparedness, ASTHO
Maggie Bruner, Sr. Policy Analyst, NGA
Trina Sheets, Executive Director, NEMA

ASTHO.

- Improve public health tactical leadership
- Improve health and well being
- Pursue engagement with ASPR on national stockpile
- Public health national security
- Rethinking health care preparedness and what that picture looks like

GHSAC/NGA

- Gubernatorial elections this year is top of mind for turnover. Will enhance the new Governor training that will encompass emergency management; HSAs; and public health preparedness
- Mental health
- Cybersecurity
- Other focus: nuclear preparedness; environmental quality – impacts; growth in HSAs prevention in boom space; catastrophe planning; bio-terrorism; and school safety intervention campaigns

NEMA

- Turnover in the organization: Already have 10 new directors with additional people looking to retire. Anticipate challenges and will rely more on existing directors for knowledge transfer.
- Work with Governors' transition teams with letters to suggest skill set for state emergency management directors' appointments and orientation.

- EMAC implementation of the after-action review.
    - A-team not as effective as it needs to be, thus turning the training into an on-line course. The online training provides opportunities from other disciplines to get the EMAC A-Team training whether in-state or deployed.
- States take on more responsibility for disaster management

Other topics for further discussion

- Crisis NOFOs, opioids movement now that funding occurs.
- State chemical labs across the country
- Fatality management (CDC Research)
- Repatriation efforts
- Dedicated session on water toxicity (EPA)