NEMA-ASTHO Joint Policy Work Group Meeting Summary
Raleigh, NC
August 12, 2014

Welcome
Provided by Mike Sprayberry, Director, North Carolina Division of Emergency Management, who offered the state's EOC as the site for this meeting of the joint policy work group.

Opening Remarks & Introductions
Dave Maxwell of NEMA thanked the group for attending. Dr. David Lakey of ASTHO commented that all the national/international health events taking place now validate the work of the joint group even more. NEMA Executive Director Trina Sheets thanked the CDC for its on-going grant support and asked the group to complete an evaluation of the meeting afterwards so that both organizations can continually enhanced the quality and depth of discussion.

Building State Mutual Aid Capabilities – Case Study: North Carolina EMAC Deployment of Field Hospitals with Public/Private Medical Personnel
Todd Brown, Emergency Service Program Manager, North Carolina Division of Emergency Management;
Brad Thompson, Healthcare Preparedness Response & Recovery Exercise Specialist, North Carolina Office of Emergency Medical Services
Jim Craig, Director of Health Protection, Mississippi State Department of Health

An overview of the Mobile Disaster Hospital and its recent deployment was provided. The MDH was sent to Mississippi in the spring after a tornado struck the community of Louisville, MS. It is the only facility of its kind and is an asset owned by FEMA and assigned to North Carolina. Designed so that the requesting entity can run it with its own staff/resources, the MDH can be totally operational, including the ICU, within 72 hours after arrival. Prior to the deployment, Mississippi and North Carolina staff had trained together for such a senario, which made the real-event integration go much more smoothly. Besides providing the needed medical care, the mobile facility also allows local healthcare professionals to continue working in the area and earning a living during the disaster recovery phase, rather than being forced to move and the community losing the skill-set as well as the tax base. The MDH will remain in Mississippi 18-24 months. The group discussed the need for similar assets stationed throughout the country –possibly in each FEMA region – but the $17M-$20M price tag for each is a barrier. A NEMA webinar on the MDH will be held in September.

Update on ASTHO Mission Ready Packaging Project
Gerrit Bakker, ASTHO

This project is a direct outgrowth of the NEMA/ASTHO partnership. ASTHO's MRP advisory workgroup was established in January. Members included directors of public health preparedness, local and state emergency management representatives, federal government partners and NEMA representatives. The advisory group held an in-person meeting May 21-22nd and selected 10 MRPs as the finalized list for MRP development. They include Clinical Support Team; Pre-hospital Acute Care Team; Patient Transport Team; Morgue Admitting Team; Behavioral Health Team; Bariatric Ambulance Team; Disaster Portable Morgue Unit; Medical Facility Emergency Water Supply Team; Four-wheel Drive Ambulance Team and

Morgue Triage Team. Each MRP was developed into a full template with suggestions for mission capabilities, personnel, costs, identified ESFs, resource description and more.

The project team is finalizing its approach to sharing the finalized MRPs, including the templates, with the entire public health preparedness community (specifically ASTHO's directors of public health preparedness). A companion document has also been drafted to assist in educating states on each of the MRPs. In addition, the project team would like to evaluate state resources and their potential ability and availability of assets available for EMAC deployment. This will help in determining future MRP development.

Emergency Management Assistance Compact (EMAC) Update
EMAC Committee Chair Dave Maxwell

NEMA is still on target to have five online training courses completed by end of August 2014. The five courses are 1) The Practice and Implementation of EMAC, 2) EMAC Pre-Event Preparation for Resource Providers, 3) EMAC: Just in Time Training for Deploying Personnel, 4) EMAC Reimbursement for State Emergency Management and 5) National Guard and EMAC. In September, NEMA will be completing pilots of the online training courses with the plan to take the courses live in October. By the end of September 2014, NEMA will have the Mutual Aid Support System 2.0 (or MASS 2.0) live. MASS is a database of Mission Ready Packages from across the nation that provides visibility of resource inventories. States can choose whether or not to make resources visible to other states within their resource inventories.

EOC Tour and Break
North Carolina Director Mike Sprayberry provided a tour of the state's EOC.

Strategic Alignment with Homeland Security
FEMA Update on Key Findings from 2014 National Preparedness Report and Inclusion of Public Health in State Risk Assessments
Katie Fox, Acting Assistant Administrator for FEMA's National Preparedness Directorate

The latest iteration of the National Preparedness Report, issued earlier in the year, was reviewed. It identifies five core capability areas for sustainment, including Public Health and Medical Services. The report also identified Health and Social Services as an area for improvement. In addition, DHS identified biological concerns—including bioterrorism, pandemics, foreign animal diseases, and other agricultural concerns—as a top homeland security risk. The state preparedness reports, whose information filters into the larger NPR, contain self-reported gaps in capabilities that provide additional insights. Eighty percent of respondents expect that states will be responsible for addressing these public health and medical services gaps as opposed to the federal government. While the information from the state preparedness reports is valuable, it isn't an ideal mechanism to feed those health risk assessments into the larger risk assessment tool. The group was invited to give that thought and provide feedback.

CDC Update and Discussion
HHS/DOT/DHS Alignment update
Melissa Harvey and Jennifer Hannah, HHS/ASPR

A second MOU was signed in April 2014 to continue alignment. Input is needed on whether the focus should include certain UASI regions and develop common core elements for these. Also, what else can the federal government do to assist in alignment efforts, steps that would remove obstacles and reduce repetitive requirements?

Operational Readiness Review for Large Scale MCM Dispensing and Distribution: Executive Order 13527 and Opportunities for Collaborative Planning – Jeff Bryant, CDC

The Cities Readiness Index, as an extension of Executive Order 13527, currently remains one of the largest CDC initiatives. Medical countermeasure distribution for the most populated cities is either complete or nearing completion. Other Tier 1 UASIs are in earlier stages of planning. CDC hasn't conducted this level of in-depth planning before and the process is identifying gaps, mainly in staffing. The center is now exploring the creation of a rapid federal surge workforce and considering whether the initiative should expand beyond Tier 1 cities. Suggestions from the group included working more closely with the private sector as well as enhanced training and exercises with states/locals. The discussion moved into the larger issue of demonstrating the true impact of preparedness grants and steps to get governors and other elected officials more interested/engaged in strategic preparedness efforts. One idea was for the group to develop a specific scope of work that focused on open information sharing among officials, etc.

Case Study: West Virginia Water Crisis and Importance of Interagency Information Sharing
Melissa Kinnaird, Deputy Director, West Virginia Department of Health and Human Resources, Bureau for Public Health – Center for Threat Preparedness

An overview of the Elk River chemical spill in early January 2014 was provided. This represented the third significant spill in the river during the past five years. The public health response, with its full gamut of responsibilities, required immediate and on-going coordination among various state agencies. This included including homeland security and emergency management, health and human resources and its complement of departments, as well as local health entities and other healthcare partners. The situation was complicated by 1) conflicting messages regarding the safety of the drinking water, 2) the ensuing public's mistrust of what they were being told 3) the rapid bankruptcy of the company responsible for the leak and 4) the movement of the leak into the larger Kanawha and Ohio rivers. Long term impacts of the spill continue, with individuals still seeking medical compensation and questions about the overall safety of chemical storage. For the state, the event raised issues about adequate funding for planning and response. The group commented that this discussion also connected with earlier comments about communicating risk effectively.

FEMA Risk Based Funding
Katie Fox – FEMA; Melissa Harvey and Jennifer Hannah – HHS, ASPR

Currently, the Hospital Preparedness Program funding formula is based on a combination of threat, vulnerability and consequence. Specifically, it includes a base amount, two portions determined by population and the FEMA State Homeland Security Program Risk Score plus additional funding. ASPR is seeking additional input on the funding formula and suggestions for improvement

Fusion Centers – What's Working Well and What Challenges Remain
Group Discussion

Trina Sheets shared that in the most recent NEMA Biennial Survey, only two percent of personnel in fusion centers were from public health. There are growing efforts, however, to physically locate public health in these centers. The Illinois Statewide Terrorism and Intelligence Center (STIC) is a fusion center model that other states might want to review. It includes an integration of multiple state agencies/resources. The group discussed the need for a greater understanding of what fusion centers should be providing in health emergencies/disasters.

National Health Security Preparedness Index Update
Gerrit Bakker, ASTHO

The 2014 version will be released in December. At the end of 2014, the Index will transition to the Robert Wood Foundation for coordination. In the meantime, the NHSPI is open to having additional NEMA membership on its emergency management task force. It's currently chaired by Erin Sutton of the City of Virginia Beach Fire Department. Link: http://www.nhspi.org/content/emergency-management-task-force-members

Open Topic – Around the Table Interests and Priorities

1) Develop a strategy aimed at Congress to advocate on behalf of tactical, emergency preparedness issues.
2) Work to enhance real time situational awareness for a common operating picture.
3) Determine method to identify pre-emergency those costly, scarce resources, i.e. potable water purification system potable water for half million people.
4) Continue with interagency grant alignment along complementary policy issues.
5) Conduct a survey soliciting ideas for better grant guidance/alignment.
6) Provide feedback on risk-based funding.
7) In light of November elections, provide public health/emergency management education for new governors, EM directors, etc.
8) Use FEMA's National Advisory Council as an additional mechanism to provide feedback on collaboration/alignment between HHS, DHS, FEMA.
9) Invite representative from the DHS Office of Health Affairs to future joint work group meeting.
10) Hold summit for health commissioners and EM directors.

Identification of Priorities, Action Items and Next Steps
Dave Maxwell, NEMA; Dr. David Lakey, ASTHO

1. Recommendation to HHS to develop capacity in each region for a National Disaster Mobile Hospital similar to that in North Carolina as a regional mutual aid resource.
2. ASTHO to continue with Phase 2 of MRP project.
3. Provide feedback to ASPR/FEMA on what can be done better at the federal level to help enhance state and local relationships, remove barriers and obstacles.
4. Explore opportunities for collaboration between public health and EM on "messaging" for the public.
5. ASTHO to provide feedback to ASPR on risk funding formula methodology.