NEMA-ASTHO-GHSAC Joint Policy Workgroup Meeting
Wednesday, January 10, 2018
Meeting Summary

Tri-Chairs: Dr. John Dreyzehner (ASTHO); Director Pete Landon (GHSAC); and Director Michael Dossett (NEMA)
*Mr. Dossett was present to run the meeting

Agenda Topics

- CDC Brief on Current Priorities
- Intra-agency Collaboration: Las Vegas
- ASPR Brief on Puerto Rico Response
- EMAC Brief
- Opioids Case Study: Arkansas
- Federal Opioid Public Health Emergency Declaration and how that has impacted the opioid crisis within the States
- Nursing Home/Facilities requirements of emergency plans for those receiving Medicare & Medicaid Services
- Current Topics to keep in mind

Mr. Dossett opened the meeting with recognition of the other chairs and their apologies for not being able to attend along with a warm welcome to the work group members and guests. In addition, Mr. Dossett provided gratitude to the speakers and to those moderators who will be assisting in specific sessions during the day: Director Brad Richy (ID), Director A.J. Gary (AR), and Director Mike Sprayberry (NC). After a quick overview of the agenda, Mr. Dossett directed the attention to Director Christine Kosmos with the CDC's Division of State & Local Readiness to begin her brief.

CDC Brief on Current Priorities: capability revision update and changes in CDC's risk based state and local medical countermeasure (MCM) strategy
The two goals of the CDC Team brief are to provide the update on the development of the Public Health Awareness Capability Guide; and to update on how the CDC is broadening the MCM (medical countermeasures) initiative to be more inclusive and include large scale initiatives that go beyond and yet still include Anthrax.

Mr. Todd Talbert, Sr. Advisor for the Office of Program Coordination, explained the Public Health Awareness Capability Standards is more of a framework and is not currently tied to PHEP guidance requirements for funding. The CDC is looking at the capabilities to set the standard for public health emergency preparedness (PHEP) programs. The focus of the standards is to help shape public health emergency management programs by having such programs use those standards:

- as a planning framework
- to shape evaluation and exercise requirements
- to ensure the public health consequences of incidents are addressed (ESF-8)
- to establish a common language between the PHEP programs
- and to promote jurisdictional collaboration.

The standards are not designed to conflict with the core capabilities of emergency management. The CDC continues to encourage their public health colleagues to assist in the THIRA assessments. Across the

board there is inconsistency where emergency management and public health work together to identify threats and hazards and prioritize those within the THIRA. In some cases where the State agencies work together, the THIRA captures public health threats but other cases public health officials are not necessarily invited for the THIRA planning. This responded to the ask of the workgroup to seek out model States that have emergency management and public health coordinating on the State's THIRA and share those best practices.

As the CDC develops the capabilities, they have reached out to stakeholder organizations and participants for feedback. The CDC look to have final reviews of each capability conducted by the Spring/Summer of this year and have asked those stakeholders (including ASTHO and NEMA) to provide further input.

In the modification of utilizing a risk-based approach for MCM to be more inclusive, Director Kosmos took the floor to elaborate on the changes to the risk-based approach through reiterating that the CDC is not excluding Anthrax but there is a priority shift within some jurisdictions based on their review of state and local jurisdictional risk assessments (JRAs). Those JRAs highlighted the threat of emerging infectious disease outbreak to be considered a greater concern. Thus, limited resources should be targeted more appropriately and aligned with this view. The CDC looks to maintain baseline planning and operational capacity for both a Category A agent (Anthrax) and an emerging infection disease (pandemic flu) but in exercise demonstrate full operational readiness for one scenario that for some jurisdictions will have an opt in component to match their identified threat.

To determine who would select the 'opt in' portion of the exercise that includes the potential release of anthrax, the CDC proposes the following: All Cities Readiness Initiative (CRI) local planning jurisdictions that have a population of more than 1 million people or have the population density of more than 750 people per square mile will be required to demonstrate a full operational readiness for an intentional release of anthrax. The other planning jurisdictions that do not fall within the criteria will be able to opt-in the scenario. With this proposal, the CDC is gathering feedback on the proposal and considerations for defining realistic planning requirements and evaluation standards as well as how best to prioritize for MCM with limited resources.

Intra-agency Collaboration: Las Vegas

Director Richy introduced Chief Caleb Cage from the Nevada Division of Emergency Management to discuss the impact of public health and emergency management working together to respond quickly to the unexpected shooting at the Route 91 Harvest Festival in October of 2017. Although 58 were killed and countless were injured, through the guise of Chief John Steinbeck, the emergency management director and fire chief of the Las Vegas area, for cross cultural training between police and fire EMS provided a text book approach in response to save more lives than those that were lost. In addition, the persistence of Chief Steinbeck prevailed in finding funding for those trainings and the resources needed. In summary, the lessons learned are listed below not to overshadow the sensitivity of the incident but to highlight what worked well and the takeaways in how response works better when we work together.

The Route 91 Harvest Festival is a run-of-the-mill music festival that sits in the open field close to Mandalay Bay on the Las Vegas Strip. The gunman, later to be identified as Stephen Paddock, utilized bump stocks to create automatic weapons for his spray of bullets on the festival attendees from the 32nd floor of the Mandalay Bay hotel. This triggered the crowd to flee for cover. The chaos of the crowd ran routes to nearby casinos, causing confusion that an active shooter incident was occurring there. About

300 people ran to the secure area of the airport in their attempt to flee. While festival crowd flee; the police and EMS fire representatives worked hand in hand to respond swiftly to the call.

The Response. Police and fire EMS go to the incident's area immediately. EMS is protected by the police as they move in to the field area to find a safe place to immediately tend to the wounded by setting up a quick medic area and begin to escort those wounded to the medics. Another team of police go to the Mandalay Bay hotel to neutralize the assailant. Chief Steinbeck sent 19 Rescue Taskforces (RTFs) to nearby casinos to mitigate the chaos and to serve those that may have been wounded during the active shooting incident. The rescue taskforce concept was another part of the cross-industry training for such an active shooter response and proved success in lessoning the chaotic situation that stemmed from the incident. The emergency management set up a family assistance center in the Las Vegas convention center near the site which proved to be a best practice.

Declarations. A local emergency was declared which activated the multi-agency center where police, fire, and behavioral health set up incident commands that worked together. The Governor of Nevada declared a State of Emergency and a Public Health Disaster Declaration to assist the response effort. The State of Emergency Declaration provided the authority for Chief Cage (as state emergency management director) to respond to local resource requests. The Public Health Disaster Declaration provided the authority to support casualties by providing a method for the medical board to immediately vet licenses to those medics that came from outside the State to assist.

EMAC. Through EMAC, Nevada filled the void of resources with five requests for medical examiners and behavioral health experts. This assisted the support in the identification of casualties and reaching out to the families. In addition, through EMAC, attorneys were sent to assist as victim advocates.

Recovery. As stated above, once the response implemented, Chief Steinbeck immediately coordinated the Family Assistance Center by calling two Captains and instructing to "set up the family assistance plan." In the matter of hours, the Vegas Convention Center was turned into a hub for victims and/or families/friends could go to for support. The center housed representatives from 20 different agencies: airlines; country consulates; hotels; casinos; the DMV (to issue new IDs to replace lost ones); Coroner's Office; VOADs/RedCross; any supporting role that may be able to serve the victims and their loved ones. There were rooms filled with tables that had personal items stacked on them to organize the lost/found items. The center stayed open for 20 days and served 4200 people and are currently continuing that support for those in need through the resilience center. Having the family center set up quickly was crucial to the timing and minimized the backlash of the individual crisis by immediately providing a center for assistance, communication sharing, and most importantly a hub for logistics and volunteer support to the victims. This served as a best practice.

Lessons Learned/Best Practices.

- The joint response tactics from fire and police stemmed from a THIRA identifier the locals established. Las Vegas receives 4 million visitors a year creating a huge population influx to a State that only has 2.9 million in population across the entire State. In 2007, Vegas was reported as the top 10 terrorist target. With that in mind, the threat is concentrated among the Vegas Strip especially as the open spaces mingle with the casinos creating a lack of a locked down event. The (pre-disaster) exercises, standard operating procedures and mission command concept is engrained in the culture of those organizations who would respond and is organically within what Nevada does.

- Mass Casualty Tracking Initiative not funded: Challenge with the inability to share casualty and traffic. Operational wise, when the incident occurred, 22,000 people scattered. For those needed medical treatment, if they went to a hospital or clinic that is not in the system, then zero information was shared concerning that victim. Corporate hospitals were concerned about HIPPA and laws in sharing such information about their patients.
- Coroner's Office: People (news agencies) need to share the list of casualties and the political backlash of getting that information incorrect locked down the office, thus creating a very slow release of information and in certain cases zero information coming out of the office.
- Family Assistance Center. Considered as a best practice not only for the representing agencies, but for the immediate opening of the center during the response.
- EMAC Effectiveness. The functional system was huge for success in teaming up with experienced experts that responded to the most challenging efforts.

Moving Forward. For both mass casualty tracking and the coroner's office, presentations are set for the state legislators to formalize PII and HIPA access for cases of mass casualty. Overall, decision makers and legislatures see this incident as a turning point for Nevada emergency management. An After Action Report is in progress with the hopes to have it complete by late Spring.

ASPR Brief on Puerto Rico

As the path of Hurricane Maria became clear of landing on Puerto Rico, Director Don Boyce, had the foresight to go to the island and assist with the preplanning efforts which turned into a full recovery mission after the hurricane hit landfall. The first 48 hours prior, Director Boyce along with 12 public health employees flew to Puerto Rico to assist with patient transport supported by the Department of Defense (DoD) for those on critical dialysis. Those patients were flown to Atlanta until they can return to Puerto Rico (currently ASPR is still assisting those patients in the long term). To say the hurricane destroyed the island is an understatement; no communications – what was on the island pre-disaster was there for days after. Due to this, Director Boyce created a spoke to hub model for the hospitals on the island and utilized clinics for areas where the hospitals were not ready for treating people. The medical assets came underneath the ESF 8 umbrella with ASPR, Veterans Administration (VA), CDC and the DoD. The first major problem was no communications, seconded by logistics in movement. The only fuel on the island was owned by the federal government and so with the help of FEMA, they kept medical centers operable. ASPR closed hospitals until the generators were installed and then would reopen them for patient care. A significant maneuver was the ability to create medical shelters that assisted with discharge. When a patient could leave, they would go to the medical shelter for the discharge process which allowed room within the hospital to take care of more patients. As the response prolonged, the federal medical resource capability depleted so Director Boyce utilized EMAC to fill the gap for medical staff, thus State medical staff were deployed with federal medical staff to work hand in hand to the response efforts. During the on-site of the response and recovery, they utilized a model where the Deputy of Response is the Director of Recovery and vice-verse. This model proved very successful because as the recovery phase began to blend within the response, there was no question to what happened nor was there a gap in information flow because both co-leads were briefed at the same time. In total 36,000 patients were cared for.

Lessons Learned:

- Need a core structure; How to capitalize the needed resources: Some teams deployed 4 times – this is not a way to build success when you are overusing the same people. The federal medical response to a significant event does not have enough resources.

- Reconstitute what ASPR looks like with the emergency management underneath it to be able to utilize those assets internally more efficiently.
- ASPR changed the EMAC request to a minimum of 30-days due to the 7-8 day timeframe of getting help in and out of Puerto Rico. Director Boyce reported that people were stuck for 8 days before he could get them off the island. This minimum was a reality to the logistics of assisting the island. Initially, in managing the expectations: the medical asset came in; ASPR picked them up; briefed them; then moved them to their location. All the ESF 8 received the same treatment and information. Those who were not under the ESF 8 stayed separate but still critical to the mission because they were able to run the shelter operations. They will do better to re-address the request as more transport opened as well as work with EMAC to assist in the communications.
- In addition to manage expectations: Director Boyce did an excellent job in painting the picture of what the conditions looked like to those who wanted to deploy as a volunteer to assist.

EMAC Brief

Director Trina Sheets reported a brief update on the EMAC response to the 2017 hurricanes effectively highlighting for every major disaster there is a public health element alongside the resounding gratification to those who assisted. The quick facts were out of 418 missions, 15,781 personnel were deployed from 45 States. Of those personnel: 357 were medical; 361 were public health; 50 were EMS; and 28 assisted in mass care. In the example of Hurricane Maria, EMAC EMS stepped in to assist emergency calls for all calls that occurred after 6 pm local time because of how stretched the local emergency resources (people) were. The territory mandated a rest beginning at 6 pm for their personnel.

EMAC requests are made through the operating system and can be tailored by the requester to be broadcast to certain States, a region, or nationally. The emergency management agency receives the request and then works with their ESF partners to fill the need. It is legal to conduct a verbal confirmation if the contract is executed within 30 days of the request. Some States may not see all requests due to how the requester has chosen the broadcast within the system. Requests are state owned which means that NEMA may not share those requests publicly. It's a rarity, but if a request is not met then NEMA will step in as an administrator to reach out to see that the request is filled.

As an advisory and stakeholder perspective, EMAC developed a situational awareness report that they look to share with their stakeholders as well as outside organizations to provide more information. This report divides the disciplines per disaster to show the amount of personnel that are being directed for aid and assistance. EMAC looks forward to an after-action report published in late spring or early summer that composes survey data from the requesters as well as the deployed teams including FEMA and NORTHCOM representatives. With each discipline, EMAC looks to conduct a face-to-face hotwash to learn from their experiences. EMAC will share the findings and recommendations that stem from this after-action reporting.

Opioids Case Study: State of Arkansas

Director Gary introduced the Arkansas Drug Czar, Kirk Lane, who was instrumental in stakeholder buy-in for key legislation to be passed in the State. Regarding the prescription monitoring program (PMP), Arkansas is the second in the Nation to amend language to strengthen the response and minimize the opioid crisis. Such language includes State access to the PMP without a search warrant in certain cases. The legislation also defined the role of the prescription drug diversion investigator providing criteria of certification for an investigator through a qualified law enforcement agency. The training course is

offered through the criminal justice institute and is encouraged for attorney prosecutors and other stakeholders to take the course as well. An evaluation of the program was compiled early last year to milestone the program's success. Tools provided to the public includes the website www.artakeback.com that provides education and guidance, FAQs, videos, and how best to prevent the use of opioids; commercials teach the community in how to discuss other options with subscribers of the prescriptions to avoid using opioids. Currently, the State is researching in lawsuits against the pharmaceutical companies to see if that will be a way to also minimize the crisis.

Group discussion: Federal Opioid Health Emergency Declaration

Director Dossett led the group in the discussion concerning the impact of the federal health declaration to the opioid crisis. The consensus settles that overall the declaration sets the stage for the next cycle in the attempt to gain grant funding. Immediately after the declaration, it was decided within the public health industry that there was no reason to involve all agencies, only the ones that were already involved in the State centric responses. The major setback was the little funding attached to the federal declaration. In moving forward, however it provides an awareness to leverage congressional action for assistance to resources and through that push provide realistic resources. Specific success stories shared: Arizona incorporated continuing education credits for their training; and Tennessee is currently testing a process of identifying measurable impacts that can be made in a strategic planning process. The federal declaration has strengthened customs at the border to reduce drugs coming in from China. The CDC PHEP continues to capture best practices and provide comparison data especially involving the prevention side of the crisis. A setback not resolved by the declaration was that there is no visibility on the drug company orders; meaning there is not a system in place that monitors opioids within the wholesalers of the supply chain. The States continue to share their practices with one another to strengthen the knowledge of the crisis and how to resolve it.

Group discussion: Nursing Homes/Facilities are required by the Centers for Medicare & Medicaid Services to have emergency preparedness plans in place

Director Sprayberry monitored the session and began with a brief description of the current outlook to the new requirements for service providers that accept Medicare/Medicaid funding along with the solution that North Carolina has created for their public. Due to the new request of having an emergency plan and the opportunity to exercise those plans, the North Carolina Division of Emergency Management anticipates an increase in customer service needs that includes phone calls and time spent sharing guidance to those who will need to create and execute the plans. The solution was a portal from the Division's website that produces a plan by answering questions, just like Turbo Tax® software does when people complete their taxes. The automated feel to the software was designed to make it look and be easy for anyone to maneuver through the portal. The target for this design caters to smaller facilities that take care of up to 5 people as well as larger facilities that may require a more robust plan. The product is an official plan the facility may save, print out, and submit to the proper authorities for their funding. The portal takes the angst away from people who do not have any training on how to create an emergency plan. With the customer service aspect, it also eases the tension in exercising the plan and provides great thought and guidance to assist the facility in provoking thought on the 'what ifs.' In moving forward, North Carolina researches in utilizing the opportunity for one of their monthly WebEOC exercises for the entire State to switch to those facilities to be able to practice an exercise. Suggestions from the group were if North Carolina is looking for piloted states, Nevada would be interested. HHS/ASPR has a tool called emPOWER via their website that assists on power outages, this may be something NC would want to incorporate as information as guidance within their portal. Director Boyce directed the group's attention to the emPOWER map: https://empowermap.hhs.gov/. Even though the new CMS (Centers for Medicare and Medicaid) rules are included in the plan that is

created by the portal, a suggestion to work with a federal CMS representative may also add a layer of security to ensure the plans hit all the marks within the content. Director Boyce requested to first connect with the Regional Health Administrator with ASPR who can assist in this regard.

Topics for the Workgroup to consider for next meeting:

- Threat intelligence and how it impacts public health – DHS is willing to share information in this regard
- Cross reference the CDC Public Health Awareness Capability Standards with the Emergency Management Standards to make sure that public health and emergency management are consistent in preparedness initiatives especially within planning efforts.
- Potential best practice to share: Tennessee is piloting an HHS threat hazard assessment module that feeds the local and county information to the state to assist in identifying risks to inform emergency management for the THIRA.
- EMAC
    - How can public health better prepare their subject matter experts to participate as well as the cultural of their workplace to encourage employee participation.
    - After Action Review from the 2017 Hurricanes
- Nuclear Readiness Plan (the public health aspect)
    - EMAC deployment and assistance with radiation, concerning the health aspect
    - HHS/ASPR is working on a plan and will soon be reaching out
    - Along in the emergency plan should be repatriation, public messaging – a mutual discussion between emergency management and public health
- Repatriation for disasters: if you are working on/with your agencies on a plan, please share it with ASPR. Consideration for this topic with a panel for the next meeting (ASPR will be happy to assist).
- Seek out model States that have emergency management and public health coordinating on the State's THIRA and share those best practices.
- Mass shootings
- Mass Casualty Tracking and what States may need to do to formalize PII and HIPA access for cases of mass casualty
- MCM – coordination on all levels
- Opioids best practices