Testimony for the State, Local and Private Sector Preparedness and Integration Subcommittee of the Senate Homeland Security and Government Affairs Committee
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In September 2003, the Governor of New Hampshire, the Commissioner of the Department of Safety (DOS) and the Commissioner of the Department of Health and Human Services (DHHS) signed a Memorandum of Understanding that allowed DOS and DHHS to collaborate in the area of emergency preparedness by actually imbedding DHHS staff in the Bureau of Emergency Management. This was an effort to more effectively and efficiently utilize funds from the US Centers for Disease (CDC) and US Department Homeland Security (DHS) to ensure cohesive planning, training and exercising and to minimize any duplication of efforts.

Since that time, the NH Department of Safety, Homeland Security and Emergency Management (HSEM) and the NH Department of Health & Human Services, Division of Public Health Services (DPHS) have been working together on a day-to-day basis in an "all-hazards" approach to emergency preparedness for the state. The HSEM Bioterrorism Preparedness Section staff work on a daily basis with local and state public health officials, public safety officials and other key stakeholders to prepare the state for potential public health emergencies. Some of the specific areas of responsibility for this section include hospital preparedness, disaster behavioral health response, clinic coordination, strategic national stockpile coordination, volunteer coordination, and pandemic planning, training and exercises.

Much of the collaboration between HSEM and DPHS is focused on increasing our capabilities to respond to a public health emergency. NH does not have large built-out county governments similar to other states. NH county's do not have emergency management directors nor do they staff regional Emergency Operations Centers. All 234 communities would report directly to the state during times of statewide disaster. With the release of the Centers of Disease Control (CDC) Pandemic Influenza Funds in 2005 it was evident for the need to develop a regional approach to respond to a pandemic; thus, the development of 19 All-Health Hazards Regions (AHHR) occurred, which includes all 234 NH communities. As of late summer, 14 AHHRs had completed a pandemic influenza annex to their all-hazards public health plan, with the remaining 5 still working on them. The AHHRs have identified Acute Care Centers (ACC), Neighborhood Emergency Help Centers (NEHC), Point of Dispensing (POD) and mass quarantine centers; and they have already developed, or are in the process of developing, plans for how these would be operationalized. All 19 AHHRs have conducted tabletop exercises of their all-health hazards plan for public health response utilizing the US Department of Homeland Security Exercise and Evaluation Program

(HSEEP) guidelines. 95% of Pandemic Phase I funds and over 50% of Phase II funds were distributed to AHHRs to support enhanced regional response plans, including community medical surge. These efforts have increased the capability and capacity of the health care system within these regions, thereby benefiting the hospitals. Several of these regions have purchased medical supplies to support Acute Care Centers to reduce the likelihood that hospitals will be expected to provide them. Because of the number of exercises that have occurred, community-based planners and health care system partners have demonstrated they have a better understanding of the real capacity of hospitals, at this point in time.

The following is a condensed list of cross-cutting lessons learned that have been reported by multiple AHHRs following their tabletop exercises:

1. Increase training to address: continuity of operations planning; municipal health officers' roles; public information planning; NIMS/ICS compliance.
2. Increase knowledge of Multi–Agency Coordination (MAC) center structure and its functions including: activation, staffing, and coordination with local emergency operations centers.
3. Improve planning for populations with functional needs.
4. Improve planning for volunteer recruitment and training.
5. Improve individual and family preparedness.
6. Include applicable state (and federal [?]) statutes in plans.
7. Improve resource listings and contact information in plans.
8. Increase municipalities' engagement in planning and exercising.

Pandemic Influenza Operations Plan:
The State of New Hampshire Pandemic Influenza Operations Plan was submitted to the Centers for Disease Control on April 13, 2007 with input from the following state partners: Department of Health and Human Services, Department of Safety, Department of Administrative Services, Department of Agriculture, Department of Education, Department of Labor, and Department of Resources and Economic Development. The pre-scripted format for the Pandemic Influenza Operations Plan from CDC was followed. On August 10, 2007 we were notified by CDC that six priority areas had been reviewed and their feedback on those areas are as follows:

1. Antiviral Distribution – few major gaps in planning
2. Communications – no major gaps in planning
3. Surveillance/Laboratory – few major gaps in planning
4. Continuity of Operations – few major gaps in planning
5. Mass Vaccination - few major gaps in planning
6. Community Containment/Mitigation – no major gaps in planning

It is unknown at this time when feedback on the remaining parts of the Plan from the other federal partners involved in the review process will be forthcoming. With that information, we will be able to further refine those sections and subsequently schedule exercises to validate our ability to operationalize those areas. At the same time, we

continue to work on our Antiviral Distribution Plan, Medical Surge Plan, Mass Fatality Management Plan and the development of the AHHR capability to respond to pandemic influenza.

Exercises:

Bio-Response 2005 - Pandemic Influenza Exercise – November 2005

New Hampshire Bio-Response 2005, was the Nation's first multi-day exercise series to evaluate a multifaceted, statewide response to a pandemic (avian) influenza outbreak. The New Hampshire Bio-Response 2005 series included two primary focus areas: Strategic National Stockpile (SNS) and pandemic influenza. Each of the exercises in this series were designed and conducted based on Homeland Security Exercise and Evaluation Program (HSEEP) guidelines, as developed by the U.S. Department of Homeland Security (DHS) and adopted by the CDC. All exercises were conducted as "no-fault events," meaning that they were not graded, per se.

1. The SNS National Guard Workshop was successful in accomplishing its objectives to familiarize Receipt, Stage, Store (RSS) warehouse personnel with (1.) the State's SNS Plan, and (2.) their roles and responsibilities, planning, and available resources for setup and sustaining warehouse operations. The workshop brought together State agency representatives from the DHHS, National Guard, State police, and CDC who may respond to a public health emergency requiring request, receipt and distribution of SNS assets.

   This workshop presented a key opportunity for application and refinement of principles and details outlined in the New Hampshire SNS Plan. Workshop discussions occurred, and collaborative relationships were defined, to better prepare New Hampshire for requesting and receiving SNS assets, establishing and maintaining warehouse operations, and responding to and delivering material requests. By participating in this workshop, represented agencies affirmed their commitment to fulfilling a critical emergency response role and to enhancing response capabilities for successful SNS RSS warehouse operations.

2. The SNS Senior Leaders Workshop brought together emergency management, public health, and other government representatives who would be critical responders in a major public health emergency. It effectively achieved its objectives to better inform key decision-makers of their roles and responsibilities for requesting SNS assets, of the communication and decision-making process and how the SNS Plan assists and informs them.

3. The New Hampshire Bio-Response 2005 RSS SNS Warehouse Drill successfully achieved its goals and objectives. Participants were professional in their respective roles and were responsive to exercise challenges. The evaluation of this drill will offer a variety of lessons that each organization can take away as a

positive learning experience. Implementation of the suggested recommendations will serve to strengthen each discipline's proactive and reactive methods regarding future SNS RSS warehouse operations.

4. The Point of Distribution (POD) exercises supporting Bio-Response 2005 were held in Colebrook, Manchester and Portsmouth. The POD sites distributed actual flu vaccine to over 2,000 community members as part of this exercise. Community participants were professional and committed to these exercises and demonstrated the ability to set up their PODs in a timely, effective and efficient manner. Many lessons were learned during this exercise that will be incorporated into their POD plans such as: signage, flow of patients, staffing requirements, security, transportation and communication.

Issues Related to the Statewide Strategic National Stockpile Exercise – April 2007

The New Hampshire Statewide SNS Exercise included a 2-day epidemiological "build-up phase" and three, 1-day exercises designed to prepare New Hampshire for a bioterrorism incident, or other outbreak of infectious disease, by evaluating the readiness and ability of State and local entities to respond to the need to distribute antibiotics to the affected population, in accordance with the *New Hampshire Strategic National Stockpile Deployment and Management Plan*. These exercises were also conducted as "no-fault events."

The major strengths identified during this exercise are as follows:

1. The State of New Hampshire and local participants showed professionalism and commitment in their exercise response.
2. Senior Leadership demonstrated the ability to coordinate the receipt of SNS assets.
3. Personnel received the SNS shipment and disseminated the contents to the appropriate receiving facilities.
4. The three participating towns (Berlin, Concord and Rochester) successfully demonstrated the ability to set up, staff and operate POD sites.
5. The towns engaged their communities in the SNS exercise and identified future partners for emergency response efforts.
6. The Public Health Network served as a model for providing support to cities and towns in public health emergency response efforts.

New Hampshire was able to demonstrate the ability to receive an SNS shipment from the CDC and distribute prophylaxis to the affected public. Based on the areas identified for improvement, future exercises should focus on the following:

1. New Hampshire's ability to provide prophylaxis to first responders and SNS support staff.

2. The State's ability to notify affected towns of the need to activate PODs and provide general information and situational awareness regarding the event.
3. The State's ability to prepare and distribute dosage information and other support materials to the PODs.

Are there outstanding issues from the Nov '05 or April '07 Pan Flu and SNS Exercises that are hampering our efforts to get things done/move forward?

1. The current lack of a statewide reverse notification system was identified as hampering our ability to respond to an emergency in the most efficient and effective manner possible. However, it should be noted that we expect to have such a system on-line with the next few years.
2. The Health Alert Network system needs to be revitalized.
3. Liability and Workers' Compensation for volunteers during drills needs to be addressed.

Issues Related to Interstate and International Regionalization

The State of New Hampshire is proud of its independence and the resiliency of its residents. However, like all small states, we also recognize that we do not have the appropriate resources to deal with every emergency, disaster or catastrophe that we might face. In fact, all of the New England states recognized this many years ago. Together, an organization of emergency managers was formed to address the common issues and concerns of our states; and, in fact, the organization has expanded to now include the states of New York and New Jersey. This organization is the North Eastern States Emergency Consortium, commonly referred to as NESEC. NESEC permits regional problems to be addressed in a regional fashion—with a solution that best fits all. Too often in the past, states have planned as if an event doesn't cross a state's border, or as if a neighboring state won't be impacted by the results of an event. Also, too often, resources have been identified in state emergency operations plans that may also have been identified by other states. Although NESEC partners with FEMA Region I, it is independent; i.e., the agenda and discussion focuses on the states' initiated topics and the respective directors' concerns.

NESEC is such a successful organizational model that the state public health community identified it as the most appropriate with whom to become an adjunct for continued progress in planning, preparing, responding and mitigating public health crises. This identification occurred during a regional pandemic flu exercise held in Rhode Island in 2006. How to find and procure needed resources, how to communicate with each other and how to totally integrate with emergency management prompted their request to be affiliated with NESEC. Although the Board of Directors has approved that affiliation, the financial resources needed to conduct the responsibilities associated with this group have not, yet, been acquired.

Just as emergencies, disasters and catastrophic events don't recognize state borders, they also don't recognize international borders, particularly where the border exists as part of the same land mass. The International Emergency Management Group (IEMG) was formed at the behest of Northeastern States' Governors and the Eastern Canadian Provinces' Premiers, following a devastating ice storm. This group was charged with finding and developing a way to provide mutual assistance among the jurisdictions for managing any type of emergency or disaster. It was charged with developing plans and training and exercising those plans for events that could affect the region.

There is, now, an operational manual, which was successfully exercised in the Fall of 2006 in Vermont. The scenario had a bio-terrorism, public health basis and involved all of the participating states and provinces. A subsequent Improvement Plan was developed in the HSEEP format. Communications exercises also occur prior to each meeting, i.e., twice a year. And, a formal means/process to share resources has been developed, following the model of the Emergency Management Assistance Compact, commonly known as EMAC, which falls under the auspices of the National Emergency Management Association.

The member states and provinces include: Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, Quebec, New Brunswick, Nova Scotia, Prince Edward Island and Labrador/Newfoundland. Their bi-annual meetings are split between the United States and Canada. The governance includes US-Canadian Co-Chairs for the group, as well as for each committee. And they focus on topics such as: expediting assistance at the border during an emergency; partnering with the EMAC; and finding funding sources to defray the costs of administrative support.

At one point, a grant had been secured through FEMA to assist in these efforts. That grant paid the costs of administrative support staff that NESEC graciously hosted and assisted. That funding has not been available for the last few years. In partnering with our neighboring country, we have also learned that money from either federal government cannot be expended, or be construed as being expended, in/for the partner nation. This, too, has made cost-sharing between the entities very difficult.

In addition, the United States contingent has been seeking Congressional approval for many years for the IEMG Assistance Memorandum of Understanding, also known as the International Emergency Management Assistance Compact, which would give it the full force of law. Although this has been attempted a number of times, it still has not received the needed notice to move it through both the House and Senate for approval.

It is interesting to note that even without Congressional approval, the IEMG has served as a model for other cross-border states and provinces. The international side of FEMA has even brought representatives from California and Arizona to a meeting, to explore a similar partnership along our southern border. And, we have also provided a copy of the by-laws to a Guam emergency management representative, who wants to explore

whether this type of agreement could be crafted between themselves and Japan—their closest neighbor who might be able to quickly provide resources during a disaster.

Progress in NH

To provide you with an overall consensus of our progress and concerns in New Hampshire, we requested input from our local All-Health Hazard Regions and Emergency Management Directors, as well as our staff. They have identified the successes, as follows:

1. Training of health professionals in emergency preparedness and response topics, especially increasing familiarity with ICS and NIMS on the medical side.
2. Building cooperation, collaboration and partnerships among municipal departments and health and human service agencies through planning, educational opportunities, networking and exercising.
3. The development and acceptance of the State Functional Needs Guidance. This Guidance supports Emergency Operations Plans at both the state and local levels by providing ways to build the capability to accommodate and assist individuals with everyday functional challenges in an emergency.
4. The development and use of the State Disaster Animal Response Guidance.
5. 10 logistics trailers, each with supplies needed to mount an emergency prophylaxis/vaccination clinic, have been strategically located throughout the state.
6. The number of identified sites for rapid medication/vaccination dispensing has increased from approximately 25 to over 70.
7. Regional planning has improved.
8. Exercising plans to identify potential issues.
9. Creating educational opportunities for business and non-profit communities in the region.
10. Increased individual preparedness.
11. Strengthening the state's ability to respond to any emergency.
12. Establishment of All Health Hazard Regions has improved our planning efficiency.
13. Becoming more proactive.
14. Better access to state resources/experts, etc.
15. Ability to address gaps in "regular day-to-day" needs of responders (e.g., development of CERT teams, etc).

The successes for hospitals include:

1. Implementing Hospital Incident Command System (HICS).
2. Implementing decontamination & First Receiver programs.
3. Doubling isolation capacity statewide.
4. Procuring Personal Protection Equipment caches.
5. Conducting state-wide hospital exercises.
6. Continually working toward improving hospital surge capacity.
7. Implementing communications upgrades.

8. Ongoing commitment to community collaboration
9. Procuring evacuation equipment.
10. Procuring pharmaceutical caches
11. Developing an MOU for a Hospital Mutual Aid Network.

What do we need from the federal government to improve our efforts at the local/state level?

1. Support for small towns to up-date/develop their Local Emergency Operations Plans, either directly to the community for hiring a consultant or other staff member, or to the state to provide someone to put the plan on paper and organize the meetings and information.
2. Ear-mark funding for disability agencies and organizations to participate in planning and exercises. (For example, interpreters for deaf and hard-of-hearing individuals to participate in a 90-minute, planning meeting can cost between $200 and $250.)
3. Cooperative funding between DHHS and Homeland Security to fund POD's where communities share a border with other states (or Canada). It is extremely difficult to prepare, plan and fund for POD activations without cross-border funding.
4. One of the biggest issues that needs to be resolved at the State/Federal level is liability, malpractice and workers' compensation coverage for events and for non-events, e.g., training, drills and exercises. This is a large hindrance at present and prevents the recruitment and retention of Medical Response Corps personnel, engineers and other volunteers.
5. Consistent and effective funding, including for the purchase of needed supplies and equipment for response.
6. Better federal guidance and communication, especially involving standardization of common tasks, procedures and forms and organization and rationalization of available resources, both print and online.
7. Confidence from the federal government that the SNS assets can be delivered in a timely manner (12 hrs) in the middle of the winter during a large snowstorm, or other weather event.
8. Clear understanding of goals specific to healthcare that recognizes their unique role in community response.
9. Targeted funding for varied public awareness campaigns.
10. Guidance on how to store items purchased.
11. Inventory Management Systems and training.

In addition to what has already been covered, input has also told us that the state, if not the federal government, should look at:

1. Permitting the temporary relaxation of mandated "standards of care" and the associated documentation, if necessary, to reduce total processing time and increase POD throughput.

2. Waiving certain licensing requirements temporarily to allow non-medically trained personnel to carry out essential POD functions.
3. Relaxing the “scope of practice” requirements in order to provide more flexibility in the use of available medically-trained personnel.
4. Relaxing or waiving medication labeling requirements to support efforts to reduce processing times.
5. Provide storage for cots and other undated supplies and equipment at or near the planned Acute Care Center site.
6. Provide funding for ventilators.
7. Ensure consistent guidance relative to needed supplies, as well as to the command and control of public health emergencies.

Local governments, states and the private sector have made great strides in their preparedness and response capabilities in public health crisis. However, we are still not at the acceptable level of readiness that our citizens expect and deserve. States and local governments continue to need funding and leadership from the federal government as we continue to build these capabilities.