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# **Public Health and Emergency Preparedness Systems and Resources: Issues and Status in 2004**

Background Information for . . .

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**Issues: Federal responses to the states were swift in allocating public health and emergency preparedness funds in the wake of September 11, 2001 and the subsequent anthrax attacks. What changes have been accomplished in New Jersey and other states regarding public health infrastructure readiness, coordination and collaboration among public safety entities and protecting states' vulnerability to terrorist threats? How can New Jersey public policymakers continue to address implementation challenges related to emergency preparedness and readiness in an environment of budgetary constraints and gaps in public health infrastructure integrity?**

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## INTRODUCTION

*The best-laid plans of mice and men so often go awry.*

—Robert Burns

During the first week of February 2004, the potent toxin ricin was found in a Senate mailroom in Washington D.C., and the country was again confronted with its vulnerability to the threats of bioterrorism. This event highlights the critical importance of public health and emergency response systems on national, state and local levels. Experts in both the public and private sectors recognize the critical need to forge partnerships to develop efficient and rapid systems of monitoring, surveillance and response in order to establish clear lines of jurisdiction, emergency interventions and crisis resolutions.

Appropriate and efficient response requires the work of professionals across many sectors – public health, public safety, police and fire departments, hospitals, emergency medical services (EMS), transportation, hazardous materials (HazMat), military affairs and mental health services. Public health infrastructure – at the state, county and local levels – is the linchpin in preparedness initiatives: “[T]he health of America’s communities hinges on the nation’s public health work force” (Smith and Runyon, 2003). However, it was a well-recognized fact among policy analysts and researchers – underscored by analyses conducted during 2002-2003 – that the capacity of the public health system for monitoring and responding to emerging threats to the public’s health was limited, inadequate, had been historically under-funded and “well behind fire and emergency services organizations” (National Conference of State Legislatures. *State Health Policy Issue Brief*. February 2002.)

In 2003, reports conducted by the Institute of Medicine (IOM) and the U.S. General Accounting Office (GAO) found that the public health infrastructure utilized outdated and non-secure health information systems, had a workforce which was inadequately trained, had antiquated laboratory capacity, suffered from a lack of appropriate surveillance and epidemiological systems, and used communications and emergency response capabilities that were fragmented and incomplete. The GAO report also observed that although some of the problems – such as coordination and communication – were being addressed, others, including workforce issues and overall infrastructure, “are more resource-intensive and thus more difficult to address” (GAO-03-373, 2003).

The primary aims of increased federal funding post 9-11 were to strengthen public health infrastructure at the state and local levels and to improve preparedness in responding to acts of bioterrorism and health emergencies. While the influx of monies from the federal Department of Health and Human Services (HHS) represented the largest amount of new dollars coming into public health for decades, it also arrived at a time when states are undergoing the most severe budget shortfalls since World War II. How are these factors interacting with state preparedness activities?





## NEW JERSEY – ACCOMPLISHMENTS 2001 – 2004

In speaking at the Centers for Disease Control and Prevention (CDC) regional meeting on public health preparedness in mid-2001, New Jersey’s Department of Health and Senior Services Senior Assistant Commissioner Jim Blumenstock offered a profile of the state that captured both its strengths and vulnerabilities to terrorism:

- A population of over 8 million;
- The most densely populated state in the U.S. (1,134 per square mile);
- Situated in the Northeast Corridor;
- Home to Newark International Airport, the busiest in the tri-state area;
- Major shipping yards and points of entry (5000 vessels per year);
- Highly industrialized with 90 of the nation’s 100 largest companies;
- Three nuclear generating stations;
- Active military bases;
- Performing arts and sport venues.

These facts and numbers illustrate the challenges of protecting the public’s health and safety throughout the state. Since the events of 2001, the state of New Jersey has addressed the need to increase preparedness capabilities for potential bioterrorism attacks or naturally occurring public health emergencies using both federal grants and state appropriations and working with the state’s cadre of first responders. Several strategies have been employed to address preparedness responsibilities, including structural changes within the New Jersey Department of Health and Senior Services (NJDHSS), comprehensive planning, improved and integrated communication systems, disbursement of funds to counties, and various training activities.<sup>1</sup>

In response to the increasing demands on and concomitant responsibilities of the NJDHSS, it has created the Office of Health Emergency Preparedness and Response as part of its administrative restructuring. The office allows for an integrated, multidisciplinary team, based in one operational unit, and entirely dedicated to the preparation for, and response to, natural and technological public health emergencies and acts of terrorism.

NJDHSS is tasked with stewardship of the state and federal funds earmarked for capacity building for bioterrorism preparedness, approximately \$41.65 million. In state fiscal year 2003, \$16.8 million in financial and direct assistance was provided to local and county public health and emergency management agencies. In addition, \$2.3 million was distributed to hospitals and health centers for acquisition of goods and services, employee training and emergency planning. An addition-

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### *Selected Administrative And Programmatic Terms And Definitions Used in This Brief*

#### **Federal/National**

CDC	Centers for Disease Control and Prevention
DHS	Department of Homeland Security
GAO	U.S. General Accounting Office
HHS	Department of Health and Human Services
IOM	Institute of Medicine
SNS	Strategic National Stockpile

#### **New Jersey**

LINCS	Local Information Network and Communications System
MEDPREP	Medical Emergency and Disaster Prevention and Response Expert Panel
NJDHSS	New Jersey Department of Health and Senior Services
	New Jersey Domestic Security Preparedness Task Force
	New Jersey Department of Military and Veterans Affairs
OCT	New Jersey Office of Counter-Terrorism (Department of Law and Public Safety)
OEM	New Jersey Office of Emergency Management (New Jersey State Police)
OHEPP	Office of Health Emergency Preparedness and Response (NJDHSS)





al \$60 million will be received in the coming year to sustain and continue preparedness efforts.

In November 2001, then Governor-elect McGreevey convened a multidisciplinary panel of experts in medicine, nursing, pharmacy, emergency medical services, and health care – the Medical Emergency and Disaster Prevention and Response Expert Panel (MEDPREP). In September 2002, MEDPREP was merged with the bioterrorism advisory committee to form the MEDPREP Terrorism Advisory Committee. This committee is comprised of 150 of the state’s leading experts in medicine, public health, law enforcement and emergency management to provide advice, counsel, and subject matter expertise as well as to serve as a liaison to critical partners to foster more effective planning and response coordination.

In order to prepare for any type of bioterrorism event, or naturally occurring public health emergency, New Jersey has developed the following operational plans:

- The *Terrorism and Public Health Emergency Preparedness and Response Plan* is a synthesis of the findings and recommendations of MEDPREP and the identified priority activities and associated work plans of NJDHSS to achieve a desired state of readiness. The Plan provides the blueprint for strategic planning, tactical operations, and existing protocols and operating procedures governing the public health response to acts of terrorism and other public health emergencies. This plan was submitted to the New Jersey Domestic Security Preparedness Task Force in October 2002.
- A detailed plan has been developed to qualify New Jersey to receive and manage assets from the Strategic National Stockpile (SNS). This plan, which will be an appendix to the State’s Emergency Operations Plan, details the procedures for requesting, accepting, securing, delivering and accounting for the use of the drugs and ancillary medical supplies provided through the SNS Program. The plan has been accepted by the CDC and the Department of Homeland Security.<sup>2</sup>
- The smallpox vaccination plan has been developed in coordination with the national smallpox preparedness plan. Educational sessions were held as well as vaccination of volunteers.
- New Jersey has also addressed the potential for acts of terrorism through the theft or diversion of pathogen containing materials normally used for research and for medical purposes. A working group was convened by the Commissioner of Health and Senior Services to conduct a gap analysis of storage, transport and handling of pathogenic biological agents. On June 5, 2003, their report of findings and recommendations was submitted to the New Jersey Domestic Security Preparedness Task Force.

The improvements to the New Jersey response infrastructure include<sup>3</sup>:

- New Jersey has worked to implement state-of-the-art information dissemination capabilities statewide. Among the accomplishments, New Jersey has been the first state to implement a radio communications network which connects the 84 acute care hospitals, three level one trauma communication centers, six Mobile Intensive Care Unit dispatch centers, the State Police Emergency Operations Center, the Department of Military and Veterans Affairs, the two Veterans’ Administration hospitals and the key DHSS operations center. The system is currently being updated from analog to digital and once the upgrade is complete, the system will be expanded to include the 22 Local Information Network and Communications System (LINCS) public health agencies, neighboring states of New York, Pennsylvania and Delaware, and possibly the cities of New York and Philadelphia.





- A rapid response on-call team of leading infectious disease physicians has been created to enable the rapid diagnosis of certain illnesses associated with terrorism or naturally occurring events.
- To systematically upgrade regional public health preparedness and response capabilities the Local Public Health Core Capacity and Infrastructure Grant Program provided approximately \$12 million in financial and direct assistance to the 22 (LINCS) lead public health agencies. As a direct result, the local public health work force has been expanded by approximately 110 FTEs statewide, including epidemiologists, health educators, risk communicators, informatics specialists, and for the first time, state-employed Emergency Planners/Coordinators who will be detailed to each of the 22 LINCS agencies. This is a strategic approach to improved and standardized emergency planning and response coordination through integrating regional and county public health teams.
- Additional grants have been issued to county health departments to procure decontamination equipment to improve the response capability, competency and capacity of responding to hazardous material emergencies. Each county has tailored the equipment to their specific requirements.
- Potassium Iodide (KI) has been made available and distributed to persons who live, work or go to school within 10 miles of the nuclear generating stations in New Jersey. Stockpiles are maintained at all schools in the areas.

## **NEW JERSEY: RELATED PREPAREDNESS AND DOMESTIC SECURITY ACTIVITIES**

The New Jersey Domestic Security Preparedness Act (P.L. 2001, c. 246; signed into law on October 4, 2001) created and appropriated funds for the New Jersey Domestic Security Preparedness Task Force. The Task Force has a focus of strengthening public safety partnerships, increasing training and standards for intelligence and security personnel and providing the necessary workforce to protect the state's health, safety and economic infrastructure.

At present New Jersey's domestic security efforts are coordinated among the New Jersey Office of Counter-Terrorism (the Department of Law and Public Safety); the New Jersey Office of Emergency Management (the New Jersey State Police); the New Jersey Department of Health and Senior Services (which has authority of the public health components of preparedness in its Office of Health Emergency Preparedness and Response) and the afore-mentioned New Jersey Domestic Security Task Force. The Office of Counter-Terrorism is the state's primary agency responsible for combating terrorism. It works closely and collaboratively with law enforcement agencies at the federal, state, county and municipal levels, including the State Police, the 21 county prosecutor offices and the state's 566 municipal police departments. Since 2001, the Center for BioDefense at the state's University of Medicine and Dentistry has expanded into areas of emergency planning and response, clinical preparedness and public health. Its Incident Support and Operational Planning (ISOP) unit develops training programs, assists with emergency preparedness planning and exercises and provides on-scene assistance.

Eighty-five to ninety percent of New Jersey's critical infrastructure is privately owned, included its utility, chemical and pharmaceutical industries (*State of the State Address*, Governor James E. McGreevey, 2003). One of the efforts of the state's Domestic Security Preparedness Task Force is to focus on and identify vulnerable targets and the means to protect them. In planning with private industry, the state's Domestic Security Preparedness Task Force formed an "Infrastructure Advisory Committee Sector Group" in order to develop "best practices" security plans applicable to 24 key industries that could be affected by terrorism in New Jersey.





## FEDERAL PUBLIC HEALTH FUNDING TO STATES – A GENERAL OVERVIEW

Although some states received years of federal bioterrorism funding prior to 2001, the amount of funding was quite small by comparison to monies disbursed in mid-2002. For example, the Public Health Threats and Emergencies Act of 2000 allocated \$540 million to federal and state biodefense and public health capacity-building activities; approximately \$300 million of that amount was made available to state and local public health agencies in 2000 (Gursky, 2003; Turnock, 2003). This funding was to support the process of “defining and assessing the status of state and local capacities that would be necessary to respond effectively to a significant public health threat” (ibid).

Under the Public Health Security and Bioterrorism Preparedness Act of 2002 (as a result of the 2001 anthrax attacks), close to \$1 billion was allocated to improve state and local level public health capabilities and hospital preparedness. In Fiscal Year 2002, the CDC received \$940 million to support state and local public health preparedness and HRSA received \$124.5 million to enhance the preparedness of hospitals. Under the terms of the funding, each state entered into a “Cooperative Agreement” with the Department of Health and Human Services (HHS), the CDC and the Health Resources and Services Administration (HRSA) in being awarded its funds for public health preparedness and response for bioterrorism. Grantees received an initial 20 percent of their grant, and the disbursement of the remaining 80 percent of the funds was contingent upon approval by HHS. Each state was required to submit its plan related to six focus areas:

- Preparedness planning and readiness assessment
- Surveillance and epidemiology capacity
- Laboratory capacity for biological agents
- Communications and information technology
- Risk communications and health information
- Education and training

From this federal funding in Fiscal Year 2002, the state of New Jersey received a bioterrorism allocation of \$23,732,611 from the CDC, which was targeted to support bioterrorism, infectious disease and public health emergency preparedness activities statewide and an allocation of \$3,509,769 through HRSA to be used to create regional hospital plans to respond in the event of a terrorist attack. In Fiscal Year 2003, New Jersey received a total of \$36,127,468 in CDC and HRSA funds, comprised of \$22,248,528 from the CDC and \$13,878,940 from HRSA. Table I breaks out CDC and HRSA funding for New Jersey, New York and Pennsylvania, representing that a total of close to \$131.5 million in federal public health emergency preparedness funding was allocated to New Jersey and its closest neighbors.

**Table I**  
**Public Health Emergency Preparedness Grants (CDC)**  
**and Hospital Preparedness Grants (HRSA) Fiscal Year**  
**2003, for New Jersey and its Neighbors**

State	CDC	HRSA	Total
New Jersey	\$22,248,528	\$13,878,940	\$36,127,468
New York	\$27,794,404	\$18,019,873	\$45,814,277
Pennsylvania	\$29,933,326	\$19,616,940	\$49,550,266

*Source: U.S. Department of Health and Human Services; Governing magazine, February 2004*

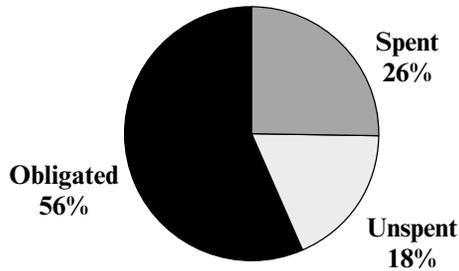




FY 2003 CDC and HRSA funds for states, territories and localities totaled over \$1.3 billion, with \$870 million disbursed through the CDC and \$498 million through HRSA (<http://www.hhs.gov>). The charts below show findings from the Association of State and Territorial Health Officials (ASTHO) survey of states regarding funds spent, obligated and unspent as of August 31, 2003, in New Jersey:

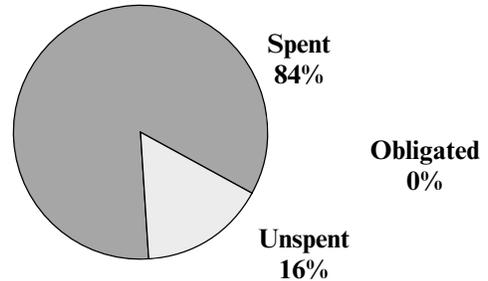
**State Preparedness Funding Allocations**

**CDC Funding for NEW JERSEY**



**The Centers for Disease Control and Prevention Cooperative Agreement/Public Health Preparedness and Response for Bioterrorism**

**HRSA Funding for NEW JERSEY**



**The Health Resources and Services Administration Cooperative Agreement for Bioterrorism Hospital Preparedness**

**HOW ARE STATES DOING? – RECENT REPORTS AND STUDIES:  
A SPECTRUM OF PREPAREDNESS**

During 2003 several research organizations and professional associations have focused studies on measuring and assessing the status and effects of federal biodefense funding on the states. In an effort to assess and evaluate states' public health emergency preparedness, the Trust for America's Health (TFAH) – a nonpartisan organization whose focus is on promoting and protecting the public's health – worked with an advisory committee of state and local officials and public health experts to select 10 indicators which reflect core capabilities that each state should have:

1. Spent or obligated at least 90 percent of FY 2002 federal funds
2. Passed on at least 50 percent of federal funds to local health departments
3. State spending on public health increased or was maintained
4. Sufficient workers to distribute Strategic National Stockpile supplies
5. Has at least one bioterrorism (BT) lab (Biosafety Level-3 Lab)
6. Has enough BT labs to handle a public health emergency
7. No more than 3 counties are without emergency alert capability
8. Has initial BT plan
9. Has pandemic flu plan
10. State-specific information about SARS was available during crisis





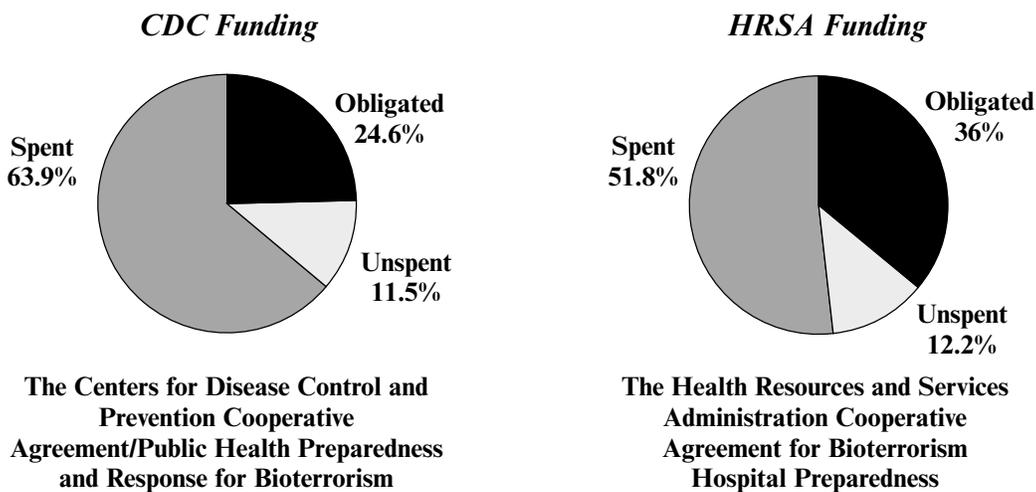
Appendix 1, *State Preparedness Scores*, includes a table showing the ranking and “grade” of each state. Study findings indicate that 75 percent of states failed to meet at least half of the criteria. Trust for America’s Health Executive Director Dr. Shelley Hearne attributes the challenges to meeting preparedness criteria – even after close to \$2 billion of federal bioterrorism funding to states since 2001 – to recent state budget cuts for public health programs, state hiring freezes and related workforce issues, as well as a history of inadequate attention and funding to public health emergency response programs (Patton, 2003).<sup>5</sup> The report found that progress has been made in most states to expand the health emergency communications network, upgrade public health laboratories and develop initial BT response plans. Major concerns raised by the report include:

- Public health program cuts in almost two-thirds of the states;
- Critical shortages of trained professionals in the public health workforce;<sup>6</sup>
- Resource allocation disagreements among state and local health agencies; and
- Challenges of bureaucratic obstacles related to disbursement and assignment of the federal funds.

The Association of State and Territorial Health Officials (ASTHO) conducted a survey of the country’s state and territorial health agencies in early October 2003 to “obtain information regarding the extent to which their CDC and HRSA preparedness cooperative agreement funds had been “spent,” were contractually “obligated,” or remained “unspent,” with an assumption that requests would be submitted to carryover unspent funds for use in FY 2004” ([www.astho.org](http://www.astho.org)). Responses to the surveys were received from 47 of the 50 states and several important findings emerged:

- Collectively, the states report that they will be requesting an average 10.8 percent carryover of current preparedness funds to FY 2004 (10.8 percent of CDC funds and 10.2 percent of HRSA funds);
- Almost a third of all reporting states indicate that they have spent or obligated 98 percent or more of their CDC funds; and
- More than 50 percent of all reporting states indicate that they have spent or obligated 98 percent or more of their HRSA funds.

***State Preparedness Funding Allocations as of August 31, 2003  
(Based on Reports from 50 States)***





The ASTHO survey report identified several future considerations regarding how to move towards the next phase of development of effective public health preparedness systems. Specific challenges were identified through the survey, which included the need for a long-term commitment to the funding of public health infrastructure; an awareness that preparedness not be funded at the expense of other critical public health programs and priority areas; the importance of addressing workforce training and shortage issues; the importance of balancing the needs of hospitals, outpatient clinics, emergency medical services and mental health systems, especially in an environment of limited resources; and the building-in of flexibility in areas of human resources, spending authority and program development.

**The National Conference of State Legislatures (NCSL)** has published a series of reports about state responses to public health threats. Its most recent report in the series – July 2003 – focuses on state actions related to terrorism preparedness and response (Smith and Runyon, 2003). States have responded by enacting more than 50 pieces of legislation ranging from how to allocate terrorism funding from the CDC to enhancing surveillance capabilities (ibid). Several other issues were addressed through legislation including the creation of biological agent registries, preparation and readiness and emergency health powers. Key areas of need for states identified by NCSL include the need to coordinate with volunteer organizations, such as the Red Cross and Salvation Army; the development of sophisticated surveillance systems, such as those which can detect the release of a biological weapon or other pathogens; and the interoperability of communications devices. For example, several organizations have examined how to upgrade the ability of public safety personnel to communicate by radio across agency lines, a system known as public safety wireless interoperability. It is estimated that it could take up to 20 years to create a secure, nationwide emergency communications network – with an estimated cost of more than \$18 billion (Peterson, 2003).

**The Century Foundation** recently released two reports focusing on state and local public health preparedness: “Progress and Peril: Bioterrorism Dollars and Public Health,” by Elin Gursky and “Illinois: Preparedness at a Price,” by Bernard Turnock. Overall, both studies found that although gaps remain, public health officials report improving relationships with first responders, hiring needed epidemiologists and lab technicians and building better systems of communication with hospitals and the public. Both reports stress the importance of a long-term commitment on the part of the federal government to support public health emergency preparedness. Findings in the Illinois state-level analysis indicated that “political, economic and bureaucratic tendencies promote supplanting of state and local resources” (Turnock, 2003). Researcher Turnock further commented: “Preparedness should be viewed as an important attribute of an effective public health system rather than a categorical end in itself.”

In September 2003, the National Health Policy Forum conducted a site visit to Pittsburgh, Pennsylvania, in order to assess the region’s experience regarding its medical response for terrorism and public health threats. Working with a team of public health, bioterrorism and medical experts, the Forum’s Pittsburgh site visit was part of a series of activities that included earlier visits to Baltimore (1999) and Atlanta (2002). The Pittsburgh region includes the Region 13 Working Group, an alliance of 13 southwest Pennsylvania counties committed to maintaining linkages to support regional emergency management. Overall impressions from the site visit included:

- States and localities are seeking that federal decision-makers offer clear, strategic guidance to them in their planning efforts
- In the absence of a comprehensive national strategy to guide preparedness efforts, preparedness goals are developing from localities and individual organizations in a “bottom-up” nature, lacking standardization and creating duplication of efforts
- Planning efforts and preparedness needs appear primarily a function of population density and identifiable targets and do not appear to be guided by threat assessments
- While individual hospitals and hospital systems have engaged in preparedness needs assessments and plans, they are doing so in isolation from regional planning efforts and priorities





- The current status of state budgets and concomitant budgetary restraints pose a threat to the viability and consistency of preparedness efforts
- Preparedness improvement initiatives involve a long “ramp-up” phase

With a specific focus on hospital systems, the **U.S. General Accounting Office (GAO)** conducted a study during 2002 in response to federal, state and local officials’ concerns that hospitals may not have the capacity to accept and treat a sudden, large influx of patients in the event of a large-scale infectious disease outbreak, as could be seen with a bioterrorist attack. GAO surveyed over 2,000 urban hospitals and received an approximate 73 percent response rate; the survey collected information on hospital preparedness for bioterrorism, staff training and capacity for response. Findings from the study, released in August 2003, indicated that although most urban hospitals across the country participated in and have emergency plans for bioterrorism response, they did not have the medical equipment to handle the number of patients that would be likely to result from a bioterrorist incident. For example, if a large number of patients with respiratory complications related to anthrax entered hospital emergency rooms, there would be a critical need for respirators. Study data found that less than half of the urban hospitals surveyed reported fewer than six ventilators per 100 staffed beds, a number significantly lower than required to care for the surge of patients.

## POLICY IMPLICATIONS

### *Funding and Sustainability*

A common theme in recent reports focusing on the assessment and evaluation of preparedness is the need for a sustained commitment through funding and resource allocation for federal and state sources. The Fiscal Year 2005 budget as proposed by the Bush Administration is raising concerns regarding the public health community’s effort to continue its commitment to preparedness activities. ASTHO reports that the budget includes proposed cuts to states of \$144 million in terrorism preparedness funding. ASTHO President Mary C. Selecky, Secretary of the Washington State Department of Health, observed: “State public health agencies have made great strides in improving laboratory capacities, communication and information networks and emergency response capabilities since 2001. Previous budgets have supported the efforts of public health departments to respond to new preparedness needs and rebuild 20 years of neglect, but there is a long way to go. Sustained federal funding is essential to continuing the progress we’ve made (February 3, 2004).” At the same time, state governments are facing another fiscal year of budgetary constraints. **How do national, state and local policymakers create a sustainable source of funding support for preparedness in order to ensure the public’s health and safety?**

### *Funding Allocation and Disbursement Issues*

Appropriate and adequate distribution of funding continues to be a significant policy issue. The Trust for America’s Health report offered recommendations which included that the Centers for Disease Control should track expenditures and institute measurable preparedness standards for state and local health departments to ensure accountability and efficient distribution of funding. **What current mechanisms need to be employed or new mechanisms to be developed in order to meet this recommendation?**

Widespread criticism continues among stakeholders regarding how the federal anti-terrorism funding is being distributed to states. The current distribution formula – created through Congress – requires that each state receive at least 0.75 percent of the total anti-terrorism funding and additional funds based on population. Critics argue that the funding allocation fails to take into account the heightened needs of some areas of the country, while it provides funds to other states, cities and localities that have a low-level of need for such funding. Homeland Security director Tom Ridge – in agreement that the current formula for fund distribution is inappropriate – established a high-threat fund to direct preparedness dollars to high-threat cities such as New York and Washington; the fund has distributed over \$600 million to 37 of the country’s largest cities (Hall, 2003). **What impact would changes to the distribution formula have on New Jersey?**





***Research, Data and Measurement***

Much debate has centered on the selection and measurement of preparedness criteria and the research methodology used to assess and evaluate levels of preparedness. **If policymakers must make funding and policy decisions based on such data, how can best practices regarding the collection and analysis of data be determined? Should there be a single public-private entity to do so in order to ensure standardization, timeliness, reliability and validity of the research?**

***Emergency Responders – Coordination and Collaboration***

Coordination and collaboration with all levels of state and local first responders are critical elements of an efficient and effective preparedness plan. A February 15, 2004 *New York Times* profile of the New York Police Department described how the Department has brought together government agencies in a broad effort of working together on preparedness activities in a program “that some national security and law enforcement officials describe as unrivaled among American cities” (Rashbaum and Miller, 2004). Yet, department officials acknowledge that some measures – such as implementing a quarantine of all or part of the city – may be unworkable based on their scope and coordination. Other issues involve obstacles created by the traditional rivalry between the police and other departments; for example, the police and fire departments have not yet completed a set of formal rules for how they should respond to disasters. Even in the best of cases, there remains broad variation in the level and degree of preparedness at the local levels. **How are internal and jurisdictional challenges remedied in order to create a seamless system of response?**

***Hospitals and Emergency Rooms***

The National Health Policy Forum’s Pittsburgh regional site visit found that hospitals and hospital systems were engaged in emergency preparedness efforts but there was a lack of coordination with regional planning activities. In their expert discussion on regional surge capacity, the questions were raised: **“To what extent do credentialing standards and liability concerns undermine hospitals’ willingness to reach personnel-sharing agreements in the event of a disaster? What strategies have been pursued to minimize these concerns?”** Do such concerns extend to New Jersey’s regional planning among hospitals and first responders and if so, how are they being addressed?





## ENDNOTES

- <sup>1</sup> Acknowledgment is made for the generous assistance of Kevin Hayden (Director, Office of Health Emergency Preparedness and Response) who provided the information for this section, which was included in the August 26, 2003, "Domestic Security Preparedness Annual Report to the Legislature" compiled by the New Jersey Department of Health and Senior Services.
- <sup>2</sup> The creation of the federal Department of Homeland Security ([www.dhs.gov](http://www.dhs.gov)) coordinated 22 previously discrete domestic agencies into one department with three primary missions: to prevent terrorist attacks within the U.S.; to reduce America's vulnerability to terrorism; and to minimize the damage from potential attacks and natural disasters. There are five major divisions within DHS: (1) Border and Transportation Security; (2) Emergency Preparedness and Response; (3) Science and Technology; (4) Information Analysis and Infrastructure Protection; and (5) Management, which is responsible for budget, personnel and management issues within DHS.
- <sup>3</sup> The public health infrastructure includes labs, hospitals, computer systems, pharmaceuticals, doctors, nurses and first responders. The CDC has identified seven priority capacities of the public health infrastructure: (1) well-trained workforce; (2) effective program and policy evaluation; (3) sufficient epidemiology and surveillance capability to detect outbreaks and monitor incidence of diseases; (4) appropriate response capacity for public health emergencies; (5) effective laboratories; (6) secure information systems; and (7) advanced communications systems (Centers for disease Control, 2002).
- <sup>4</sup> Reference is made to the two earlier reports cited which were conducted by the Institute of Medicine and the U.S. General Accounting Office in 2003 (see "References" section for specific citations).
- <sup>5</sup> The TFAH study focused on the FY 2002 funds distributed to states through the CDC cooperative agreements; in FY 2002, Congress provided the CDC with \$870 million to support state and local public health preparedness.
- <sup>6</sup> At present, approximately 500,000 people work in the public health system workforce; estimates are that the workforce needs between 10,000 and 30,000 more employees in order to meet current system demands (*Governing magazine*, 2004).





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**APPENDIX**

STATE PREPAREDNESS SCORES											
States	Funding			Preparedness					Double Duty		Total / Score
	1 Spent or obligated at least 90% of FY 2002 federal funds	2 Passed on at least 50% of federal funds to local health departments	3 State spending on public health increased or was maintained	4 Sufficient workers to distribute Strategic National Stockpile supplies	5 Has at least one BT Lab (Biosafety Level-3 Lab)	6 Has enough BT Labs to handle a public health emergency	7 No more than 3 counties without emergency alert capability	8 Has initial BT Plan	9 Has pandemic flu plan	10 State-specific information about SARS was available during crisis	
Alabama	✓		✓		✓	✓	✓	✓			6
Alaska	✓				✓			✓			3
Arizona		✓			✓		✓	✓	✓		5
Arkansas							✓	✓			2
California	✓	✓	✓		✓			✓	✓	✓	7
Colorado	✓	✓	✓		✓			✓			5
Connecticut					✓		✓	✓		✓	4
Delaware	✓	✓			✓		✓	✓			5
District of Columbia		✓					✓	✓			3
Florida	✓	✓		✓	✓		✓	✓	✓		7
Georgia					✓		✓	✓			3
Hawaii			✓				✓	✓		✓	4
Idaho					✓		✓	✓			3
Illinois	✓	✓		✓	✓			✓			5
Indiana			✓		✓			✓	✓		4
Iowa	✓				✓			✓			3
Kansas	✓				✓			✓			3
Kentucky							✓	✓			2
Louisiana	✓		✓		✓		✓	✓			5
Maine	✓				✓			✓			3
Maryland	✓		✓		✓		✓	✓	✓	✓	7
Massachusetts		✓			✓			✓	✓	✓	5
Michigan	✓				✓			✓			3
Minnesota					✓	✓	✓	✓	✓		5
Mississippi					✓			✓			2
Missouri	✓						✓	✓	✓		4
Montana					✓	✓		✓			3
Nebraska	✓	✓	✓		✓			✓		✓	6
Nevada		✓	✓		✓		✓	✓			5
New Hampshire			✓		✓			✓	✓	✓	5
New Jersey		✓	✓				✓	✓	✓		5
New Mexico							✓	✓			2
New York	✓	✓	✓		✓		✓	✓			6
North Carolina	✓				✓		✓	✓		✓	5
North Dakota	✓				✓		✓	✓		✓	5
Ohio			✓		✓	✓		✓			4
Oklahoma	✓				✓			✓			3
Oregon		✓					✓	✓			3
Pennsylvania					✓		✓	✓			3
Rhode Island	✓	✓	✓		✓		✓	✓			6
South Carolina					✓		✓	✓	✓		4
South Dakota	✓	✓			✓			✓			4
Tennessee	✓		✓		✓		✓	✓	✓	✓	7
Texas		✓	✓		✓			✓			4
Utah	✓				✓	✓		✓			4
Vermont					✓		✓	✓			3
Virginia					✓	✓	✓	✓	✓		5
Washington	✓	✓			✓		✓	✓		✓	6
West Virginia		✓	✓		✓			✓			4
Wisconsin					✓			✓			2
Wyoming			✓		✓		✓	✓			4
	24	18	18	2	43	6	30	51	13	11	

Source: Trust for America's Health, December 2003.

