



Public Health and Emergency Preparedness in New Jersey: Part II

Background Information for ...

The New Jersey Policy Forum

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INTRODUCTION

During 2003 and 2004, research organizations and professional associations have focused studies on measuring and assessing the status and impact of federal biodefense funding on the states, as well as state and local levels of preparedness and emergency response. Although the summaries and references included below show some variation in overall assessment, they emerge with a common theme – whether their approach be conservative or progressive – “funds continue to be spent without regard to a broad national strategy for preparedness. . . and the roles of key players – state, local and regional governments – remain undefined” (Kettl, “Unconnected Dots,” *Governing*, April 2004).

SELECTED SUMMARIES

The United States General Accounting Office released several reports during 2003 and 2004:

“Preparedness Varied Across State and Local Jurisdictions.” U.S. GAO Report (GAO-03-373, April 2003). The findings of the GAO visits to seven cities and their respective state governments indicate varying levels of preparedness to respond to a bioterrorism attack as reported by state and local officials.

- Officials reported deficiencies in capacity, communication, and coordination elements essential to preparedness and response.
- In addition, state and local officials reported a lack of adequate guidance from the federal government on what it means to be prepared for bioterrorism.
- States have also expressed a desire for the Department of Health and Human Services to coordinate a program of sharing best practices across states in order to save time and avoid needless duplication of efforts.

“Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism.” U. S. GAO Report (GAO-04-408T, February 3, 2004). GAO was requested to identify and define the desirable characteristics of an effective national strategy and to evaluate whether the national strategies related to terrorism address those characteristics. Based on a review of numerous sources, GAO identified a set of desirable characteristics to aid responsible parties in further developing and implementing the strategies, and to enhance their usefulness in resource and policy decisions and better assure accountability. The characteristics GAO identified are:

- purpose, scope, and methodology;
- problem definition and risk assessment;

- goals, subordinate objectives, activities, and performance measures;
- resources, investments, and risk management;
- organizational roles, responsibilities, and coordination; and,
- integration and implementation.

This list was then applied to the seven national strategies published by the Bush Administration after the 9/11 terrorist attacks. The study concluded that all of the seven national strategies could be improved, while none of them comprise all of the elements of the list, especially in the areas of resources, investments, and risk managements; nor integration and implementation. Overall, the *National Security Strategy* and the *National Strategy to Combat Weapons of Mass Destruction* contain the fewest desired characteristics, while the *National Strategy for Homeland Security* and the *National Strategy for the Physical Protection of Critical Infrastructure and Key Assets* comprise the most.

“HHS Bioterrorism Preparedness Programs: States Reported Progress but Fell Short of Program Goals for 2002.” U.S. GAO Report (GAO-04-360R, February 10, 2004). The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 directs GAO to report on federal programs that support preparedness efforts at the state and local level. The states’ semi-annual progress reports were analyzed and a series of interviews of state officials were conducted. The study found that states reported progress toward the CDC program’s goal of strengthening public health preparedness:

- Four critical benchmarks (out of fourteen) were met by most of the states, including the establishment of a bioterrorism advisory committee and nationwide coverage of 90 percent of the state’s population by the Health Alert Network.
- Two critical benchmarks were met by few of the states: development of a statewide response plan and development of a regional response plan.
- The remaining eight benchmarks were met by half of the states.

The states also reported progress on the HRSA requirements:

- Almost all states met two of the three critical benchmarks for the HRSA program goals: designation of a coordinator for hospital preparedness planning and establishment of a hospital preparedness planning committee.
- No state reported meeting the third benchmark: development of a plan for the hospitals in the state to respond to an epidemic involving at least 500 patients.
- States had not met the priority issues that HRSA required them to address.

- State officials expressed concern that HRSA funding was insufficient for states to meet the requirements of the 2002 program.

The main factors hindering completion of all CDC and HRSA requirements included:

- redirection of funds and resources to the National Smallpox Vaccination Program;
- state and local budget deficits; and,
- delays caused by state and local management practices, such as contracting and hiring procedures.

“Response Capacity Improving, but Much Remains To Be Accomplished.” U.S. GAO Report (GAO-04-458, February 12, 2004). GAO found that although states have further developed many important aspects of public health preparedness since April 2003, no state is fully prepared to respond to a major public health threat.

- States have improved their disease surveillance systems, laboratory capacity, communication capacity, and workforce needed to respond to public health threats, though gaps in each remain.
- Regional planning between states is lacking.
- Many states lack surge capacity.
- Plans are being developed for receiving and distributing medical supplies and materials for mass vaccinations from the Strategic National Stockpile in the event of a public health emergency.
- HHS has not published the federal influenza pandemic plan, leaving key questions about the federal role in the purchase, distribution and administration of vaccines and antiviral drugs during a pandemic. HHS reports that most states continue to develop their state plans despite the absence of a federal plan.

“Emergency Preparedness: Federal Funds for First Responders.” U.S. GAO Report (GAO-04-788T, May 13, 2004). The Department of Homeland Security, Office of Inspector General (OIG) and the House Select Committee on Homeland Security examined the distribution of funds to states and localities. Both reports found that although there were delays in getting federal first responder funds to local governments and first-responder agencies, the grant management requirements, procedures, and process of the Office for Domestic Preparedness (ODP) were not the principal cause for the delay.

- The delays in allocating grant funds to first responder agencies are frequently due to local legal and procedural requirements, specifically state and local jurisdiction approval and acceptance of the grant funds. In addition, state and local procurement processes were found, in some cases, to have been affected by delays

resulting from specific procurement requirements, for example competitive bidding procedures.

The GAO stresses the need for homeland security grant managers to balance the speedy allocation of funds with the necessary measures to ensure the grants are being appropriately used to maximize their effectiveness.

FEDERAL ACTIVITIES

Association of State and Territorial Health Officials. *Legislative Update*. May 2004. The U. S. Senate recently passed the Project BioShield Act of 2004 by a vote of 99 to 0, which marks the last major hurdle for the bill before it becomes a law. The House is expected to pass the Senate's version of the bill, which will then move to President Bush for his signature.

The Project BioShield program would:

- Fund new vaccines;
- Fund antibiotics;
- Reduce regulatory barriers to the use of experimental drugs during a health emergency; and
- Fund medical countermeasures to terrorism.

The bill allocates \$5.6 billion for the Project BioShield effort, with \$885 million earmarked for 2004. Department of Health and Human Services Secretary Tommy Thompson supports the program and believes "it will allow us to develop and make available modern, effective drugs and vaccines to protect against attack by biological, chemical, nuclear and radiological agents." The federal government has made arrangements to purchase 75 million doses of anthrax vaccine, to be paid for by Project BioShield once the money becomes available.

"HHS Wants to Shift Bioterror Funds: \$55 Million Would be Taken from State Projects to Help Prepare 21 Cities." (Ceci Connolly, *The Washington Post*, May 21, 2004). Health and Human Services Secretary Tommy Thompson announced plans to shift \$55 million from state bioterrorism initiatives to support the "Cities Readiness Initiative," which would assist 21 high-risk cities. The initiative would include training postal workers to distribute antibiotics within 48 hours of any biological attack, the installation of sophisticated disease surveillance equipment and building new quarantine stations at U. S. airports. Thompson's request for plan approval was distributed to federal lawmakers on the appropriations committees.

While some lawmakers supported the plan to shift the funds, several governors, federal and state lawmakers, and public health leaders raised concerns that taking money from one area to give to another is risky:

- Changing the direction of money promised to states is changing the approach to bioterrorism.
- Definition of “preparedness” from the federal government is still not available to states.

Specific regions of the country would feel the impact of the redirection of funds in significant ways: under Thompson’s plan, the states of Washington, Oregon, Idaho and Alaska, for example, would lose more than \$4 million; only Seattle is deemed a priority city in the region and would receive \$830,000. The *Cities Readiness* grants would be spread over 16 states, ranging from \$5.1 million for New York to \$690,000 for Pittsburgh and St. Louis. The District of Columbia would also receive \$830,000.

RESEARCH STUDIES

“How Prepared Are Americans for Public Health Emergencies? Twelve Communities Weigh In.” Megan McHugh, Andrea B. Staiti, and Laurie E. Felland. *Health Affairs*, May/June 2004.

A community level analysis of the state of preparedness in twelve nationally representative metropolitan areas in late 2002 and early 2003 was conducted as part of the Center for Studying Health System Change’s Community Tracking Study funded by The Robert Wood Johnson Foundation. The Community Tracking Study (CTS) site visits were conducted in Phoenix, Little Rock, Orange County, Miami, Indianapolis, Boston, Lansing, Northern New Jersey, Syracuse, Cleveland, Greenville and Seattle. The basic findings include:

- Hospitals in most of the CTS communities had not yet received any of the HRSA funding allocated for hospital preparedness (approximately \$100 million) even though in many cases the states had received their distribution.
- In the three communities that have made major strides, the key factors to improvement are strong leadership, early attention to and funding for emergency preparedness, previous experience with public health threats and successful collaborative efforts.
- The major challenges to improving public health preparedness include lack of funding, budget deficits and the shortage of local public health staff.
- The perceived deficiencies are reported significantly in the areas of communication, information technology (IT) and workforce education and training.

“Local Variation in Public Health Preparedness: Lessons from California.” Nicole Lurie, Jeffrey Wasserman, Michael Stoto, Sarah Myers, Poki Namking, Jonathan Fielding and Robert Burciaga Valdez. *Health Affairs. Web Exclusive.* June 2004.

Since September 2001, Congress has allocated approximately \$3 billion to strengthen the public health infrastructure, largely through programs that are administered by the CDC that are focused on public health agencies. The companion program funded by HRSA focuses on hospitals' preparedness. Prior to this influx of federal funding the CDC found in its 2001 report – *Public Health's Infrastructure: A Status Report* – that the American public health system remains “structurally weak in nearly every area.” In response to the absence of evidence-based measures to assess public health preparedness, Lurie and her team of researchers developed and conducted tabletop exercises in California to evaluate preparedness to detect and respond to a hypothetical smallpox outbreak. The study included seven jurisdictions, which contained 39 percent of the state population. The researchers found wide variation of readiness in California, one of the best-prepared states.

- Monitoring health status in a community – there was a general lack of recent community health assessment and incomplete information about the distribution and demographics of potentially vulnerable or underserved populations
- Rapid alert systems – there was wide variation in the ability of health departments to rapidly alert the physician and hospital community to a potential outbreak.
- Communication and education – jurisdictions were split regarding when they would first communicate with the public about a potential outbreak. Some would notify the public as soon as they began investigating a suspicious case; others would wait until a diagnosis was confirmed (days later) to hold a press conference.
- Public health legal authority – there was wide variation in the understanding of public health legal authority, especially with regard to quarantine and its enforcement.
- The study finding that two jurisdictions seemed highly prepared by most measures suggests that there may be exemplary practices that could be shared with other jurisdictions and other states.

“Bioterrorism and State Public Health Laws: New Challenges.” National Governors Association, Homeland Security and Technology Division, May 2004. www.nga.org.

As states prepare for terrorism, governors must be sure they have legal power to authorize any actions emergency responders need to take. Many public health laws relating to quarantine authority, compelled vaccinations, and the commandeering of resources have not changed since the early and middle decades of the twentieth century. As a result, many states have had to reassess their public health laws. The areas that deserve close review include:

- quarantining;
- stockpiling equipment, medicine, and personnel;
- first responder liability; and,
- compelled treatment and vaccinations.

Many states have taken ideas from or fully adopted Georgetown's Center for Law and the Public's Health sponsored Model State Health Emergency Powers Act (MSHEPA). This outline helps states ensure they have sufficient legal protections for responding to a bioterrorism attack. The well-being of the public must be a priority; however, any laws regarding this protection must also strike a balance with individuals' civil liberties. To ensure these liberties are not compromised, several states, such as New Mexico have solicited the opinions of their citizens in this critical decision-making process.

“Unconnected Dots.” Donald F. Kettl, *Governing Magazine*, April 2004.
www.governing.com.

In this overview of inter-governmental roles and responsibilities, Kettl identifies a fundamental disconnect that exists between the federal homeland security efforts and those of state and local governments. The original intention of Congress and the president to restructure the federal government to improve coordination, put more muscle into policy, “connect the dots” and direct money where it is most needed has not been realized at the local level. There have been modest improvements in local planning and preparedness after 9/11, however, it has not been possible to link state and local efforts to the federal strategy because, so far, there is no coherent federal strategy.

Moreover, the roles of the key players – state, local and regional governments – remain undefined. These issues raise the question of whether the urgency of homeland security can break down the barriers of intergovernmental relations that have historically frustrated policy coordination and implementation.

National Conference of State Legislatures. *Legisbrief – Briefing Papers on the Important Issues of the Day*. June/July 2004.

Energy security is a critical component of emergency preparedness and domestic security at the state level. One of the actions designated most critical to states is to obtain information about energy systems and security and to work with the private sector to identify vulnerabilities. Delivery of energy should be an issue of concern for policymakers because of the problems that can result in any disruption. Most systems rely on each other to function. There are certain points which are specifically “vulnerabilities” within the energy system as a whole:

- **Electricity:**
 - Power plants, nuclear fuel, electric transmission lines, electric substations.
 - Much has been invested in the security issues before and after September 11, 2001.
 - Nuclear fuel safety remains largely in the hands of the federal government.

- **Natural Gas:**
 - Storage terminals, pipelines.
 - The system is most vulnerable after compression for storage and transportation.
 - Any disruption could cause public safety issues to arise, as well as affecting natural gas markets and the economy in general.

- **Petroleum:**
 - Oil refineries, storage and transport facilities, pipelines, offshore stations.
 - Any disruption to the system would cause problems in the transportation system, public health and the environment.
 - Larger and more concentrated refineries are an increased risk because they are interconnected.

Threats to the system include natural disasters, technological issues, and terrorism, whether it be a human attack, or through technology. Lawmakers have several options in terms of improving energy security as state policy options on energy security fall into two broad categories: (1) prevention and planning and (2) emergency response:

- State law should provide a framework for communication and cooperation.
- Share information among government agencies and the energy industry.
- Review statutes that affect the utility commission and state energy office.
- Examine security implications of state siting laws.
- Determine the diversity and redundancy of the energy system.

SUMMARY: MARCH 9, 2004 NEW JERSEY POLICY FORUM

The Issue Brief prepared for the March 9, 2004 New Jersey Policy Forum on public health and emergency preparedness featured information from the following reports and research studies, which are again referenced as forum background materials.

Trust for America's Health. "Ready or Not? Protecting the Public's Health in the Age of Bioterrorism." December 2003. 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:

- spent or obligated at least 90 percent of FY 2002 federal funds;

- passed on at least 50 percent of federal funds to local health departments;
- state spending on public health increased or was maintained;
- sufficient workers to distribute Strategic National Stockpile supplies;
- has at least one bioterrorism (BT) lab (Biosafety Level-3 Lab);
- has enough BT labs to handle a public health emergency;
- in more than 3 counties are without emergency alert capability;
- has initial BT plan;
- has pandemic flu plan; and,
- state-specific information about SARS was available during crisis.

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). 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;
- 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). 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.

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. (Public Health Preparedness. A Progress Report – The First Six Months. Association of State and Territorial Health Officials. July 2003.)

The National Conference of State Legislatures (NCSL) has published a series of reports about state responses to public health threats. It's 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). (Smith, J. A. D. and C. Runyon. “Terrorism Preparedness and Response. States Take Action.” *NCSL Special Report*, July 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.” (Gursky, E. “Progress and Peril: Bioterrorism Preparedness Dollars and Public Health.” 2003; Turnock, B. “Illinois: Preparedness at a Price.” 2003. www.tcf.org.)

National Health Policy Forum. “Medical Response for Terrorism and Public Health Threats: One Region’s Experience.” *Site Visit Report*. Pittsburgh, PA. September 22-23, 2003.

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.

