

STATEMENT OF RICHARD G. MUTH
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Before the:

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON HOMELAND SECURITY

Hearing On:

BEYOND READINESS: AN EXAMINATION OF THE
CURRENT STATUS AND FUTURE OUTLOOK OF THE
NATIONAL RESPONSE TO PANDEMIC INFLUENZA

July 29, 2009

INTRODUCTION:

Chairman Thompson, Ranking Member King, and Members of the Committee, my name is Richard Muth and I am the Executive Director of the Maryland Emergency Management Agency. It is an honor to be invited here today to discuss Maryland's current preparedness and response activities for the H1N1 pandemic influenza and the critical issues that remain a challenge for the future.

What is the Maryland Emergency Management Agency?

The Maryland Emergency Management Agency (MEMA) is mandated under state law to ensure that the State is prepared to deal with all emergencies, especially those that exceed the capabilities of the local jurisdictions, and to coordinate the overall state's response in a declared emergency or major disaster. In addition to supporting the local governments, MEMA coordinates assistance with the Federal Emergency Management Agency (FEMA) and other federal partners when the Governor declares a state of emergency and receives a Presidential disaster declaration. While MEMA is part of the Maryland Military Department and under the authority of the Adjutant General, during emergencies the Governor assumes direct authority over the Agency and the Executive Director of MEMA reports directly to the Governor.

A key element within MEMA is the Maryland Joint Operations Center (MJOC). Operated round-the-clock by National Guard and MEMA employees, it is a joint civilian-military watch center. In addition to serving as a communications hub for emergency responders statewide and supporting local emergency management, the MJOC monitors local, state, national and international events, including weather, and advises decision-makers in Maryland when a situation warrants.

MEMA coordinates the States' response to an emergency at the State Emergency Operations Center (SEOC) in Reisterstown, Maryland. When the SEOC is fully activated, each state agency, as well as some federal agencies, private sector and volunteer organizations sends a representative to the SEOC with authority to make decisions and allocate needed resources and funds to response efforts on behalf of their agency.

MEMA also serves as the state administrative agent for all homeland security grants received from the federal government.

Pandemic flu response presents challenges distinguishable from most emergencies:

There are a few aspects to pandemic flu that distinguish it from other emergencies that states and localities are accustomed to handling. The nature of this type of event is new and unfamiliar to almost all Americans because the United States has not experienced nor witnessed a severe flu pandemic since 1918-1919. With little to no past experience to guide us outside of history books, aspects of our response efforts have to be revised and reconsidered. The unknown duration and potentially long-term nature of this novel event also creates enormous resource strains, especially in an environment of budget deficits.

As we approach the fall, states and localities will have to balance competing priorities: meeting the demands of a flu of unknown duration and severity, ensuring the ability to manage the needs

of other emergencies (such as a possible hurricane), and continuing to provide basic and essential government services to the public. The response and implications of pandemic influenza are not simply a public health or individual medical issue. The health response will require an increase in resources, coordination, and support from all levels and sectors of government while at the same time will create a severe reduction in the available government and private workforce. Pandemic influenza has the potential to severely impact every aspect of our economy.

The Committee on Homeland Security Majority Staff Report on “Getting Beyond Getting Ready for Pandemic Influenza” identified four major categories of action items to strengthen response: (1) establish effective management and coordination, (2) addressing and meeting key medical requirements, (3) evaluating and updating plans, and (4) improving early warning and detection. Maryland strongly agrees with these recommendations and is currently taking steps to complete these actions. I will highlight some of our accomplishments, future intentions, and remaining gaps in these four areas.

1. ESTABLISH EFFECTIVE MANAGEMENT AND COORDINATION:

On June 24, 2009, Maryland Governor Martin O’Malley hosted a State after-action meeting to discuss and evaluate Maryland’s initial response to the H1N1 outbreak. As a result of the information gleaned from this meeting, Governor O’Malley immediately established an H1N1 Leadership Task Force. This Task Force is co-chaired by the Secretary of the Department of Health and Mental Hygiene (DHMH) and me and includes executive level personnel from all relevant State agencies. To ensure that Maryland is prepared to respond effectively to H1N1 this fall, the Task Force has been assigned specific action items and a 45 day timeline to report back to the Governor on the ways in which it has corrected gaps and resolved issues. This Task Force has been charged with the following deliverables:

1. Resolve any issues involving implementation of the unified command / incident command system during public health emergencies; the number, location, and staffing of operations centers; and the use and implementation of a Joint Information Center.
2. Ensuring that the States’ Pandemic Flu, Strategic National Stockpile (SNS), and Mass Vaccination plans are completed and have been reviewed and signed by all agencies to ensure they understand and can execute their roles during an emergency.
3. Identifying a date within 60 days to convene meetings among State and local leadership such as local public health officials and emergency managers, school officials, emergency medical service providers, and/or hospital leadership and local elected officials to ensure a two-way dialogue and discussion regarding communications and response to fall H1N1 operations.
4. Determine whether reconsideration of statewide human resource and personnel policies (leave, tele-work, and on-call situations) for public health emergencies is needed, and as appropriate, develop and implement these policies.

5. Pre-identify trigger points and guidance for State agencies to activate their pandemic influenza Continuity of Operations Plans (COOP).
6. Pre-identify optimal procedures, combinations, and sequences for requesting a Stafford act emergency, public health emergency, and authoring emergency powers in conjunction with H1N1.
7. Develop a streamlined system to ensure comprehensive and consistent internal communications across State agencies and externally with local partners which can be applied to all-hazard situations.
8. Conduct an exercise of the State's plan for mass distribution of an H1N1 vaccine, as well as any other aspects of the State's pandemic influenza plan deemed in need of exercise by the taskforce.
9. Provide an assessment of local jurisdictions and private sector partners' readiness.

By identifying and demanding timely action on these issues, Maryland will increase its ability to respond to a potentially more severe wave of H1N1 this fall. Many of these action items will address critical components of effective management and coordination for future response. However, there is additional assistance and clarity that could be provided by the federal government to assist us with our efforts.

All Federal Government Agencies must use the Incident Command System (ICS) and provide a consistent message to the states regarding who is in charge during a public health emergency:

It is the state's policy to coordinate, to the extent possible, all emergency management functions of the state with the comparable functions of the federal government. Despite state mandates to use the incident command system (ICS), it does not appear to the states that all federal agencies have fully adopted or institutionalized its use, particularly within the Department of Health and Human Services (HHS). Traditionally, first responders, fire, police, Emergency Medical Services, etc. understand and use ICS every day. There appears to be confusion with other Agencies as to the use of and fully understanding of this system. One of our first lessons learned from the event last spring was that, in the future, we must use the ICS standard as soon as practical because failure to use it can cause inconsistent commands across government, can delay the coordination of resources and information, and may endanger responders and the safety of the public.

We know that moving forward, it must be clear to all stakeholders that DHMH is the lead response agency in a public health emergency and MEMA is the lead coordinating agency. The roles are analogous to that of an airline pilot and air traffic control tower. An airplane pilot is responsible for the safe takeoff, flight, and landing of an aircraft. To successfully accomplish these tasks, an airplane pilot needs to receive a steady stream of information on weather conditions and other traffic in the area to make appropriate decisions on how to fly the plane.

The air traffic control tower is responsible for maintaining situational awareness, coordinating any needed resources, and providing the pilot with the information required to fly the plane in a skillful manner. These roles are similar to that of DHMH and MEMA in a public health emergency. MEMA will maintain situational awareness of the conditions of the emergency throughout the State and coordinate this information with DHMH so it can use its subject matter expertise to make effective decisions on responding to the emergency. This division of roles must be the same at the federal level between HHS and DHS.

There continue to remain questions and inconsistent messages about whether HHS or DHS is in charge of the response to a public health emergency at the federal level. In July, the DHS Secretary Napolitano and HHS Secretary Sebellius held a H1N1 Summit with the States. Even at this event, it was not clear to participants about the differences in roles and responsibilities between HHS and DHS in pandemic influenza. For example, DHS has a new initiative of H1N1 Field Response Teams and the states would like to know how these will be used in the most effective manner.

During the spring incident, guidance and information from the Centers for Disease Control (CDC) was disparate, sometimes confusing, and constantly changing, especially as it applied to recommendations on school closings. When guidance from the federal government changes frequently, it affects the public's perception of the government's control of the event and impacts the likelihood that the public will comply with government's decisions and recommended advice. While the constantly changing decisions were only somewhat understood this past spring due to the new and unknown nature of H1N1, it is critical this fall that states receive timely, definitive guidance from the federal government, especially on recommendations for school closings. The authority to close schools within Maryland depends on the nature of the emergency. To avoid delay and confusion during times of emergency, the Maryland State Department of Education (MSDE) and DHMH recently signed a Memorandum of Understanding to clarify their respective roles when an emergency requires the closing of public and non-public schools.

It is extremely important that the public perceive that governments are relying on the same credible information before making decisions. This is of particular importance in Maryland, due to its proximity to the District of Columbia and the Commonwealth of Virginia. It would be very difficult for a parent who lives in the DC, works in Virginia, and possibly has a child attending school in Maryland to understand why each jurisdiction has different policies on social distancing measures such as school closings or tele-work policies. The local governments in the National Capital Region are meeting to find ways to coordinate school closing decisions so that each government is informed of the decisions and justifications before they are announced to the public.

2. ADDRESSING AND MEETING KEY MEDICAL REQUIREMENTS AND RESOURCES:

States and Localities Need Flexibility with the Use of Grant Funding for H1N1:

As noted in the February 2009 GAO report on pandemic influenza, the usual emergency management approaches to increasing resource capacity during disasters, such as requesting

assistance from other states through the Emergency Management Assistance Compact (EMAC), may not be viable options during a pandemic because other states may want to hold onto resources in order to meet their own needs or may not wish to expose their staff to the disease. EMAC still will play a role in flu response but the amount of resources available from other states will depend on the extent of cases and the severity of illness in other states.

Workforce protection is an issue of key concern for states and localities. While some funding for EMS protection is included in the recent supplemental HHS Healthcare Preparedness Program grant, the level is not sufficient to cover Personal Protective Equipment for all EMS responders and does not offer any protection for law enforcement and other public safety responders who may be at risk during a pandemic in the line of duty. Public safety agencies have not been included in these grants but will need to provide support to the health and medical response. They will need the resources to protect their workforce and also to ensure the ability to continue providing services with a reduced workforce. Recent Congressional appropriations for pandemic influenza only appear to provide funds to states and localities through grant awards to public health departments and hospitals.

I ask that Congress and the Administration introduce new funding for PPE. In the absence of new funding, flexibility in the usage of current grants would address these issues. Each state and locality will have different needs that will not fit into “a one size fits all” box.

As for medical resources, Maryland knows it has gaps in surge capacity that will require tough policy decisions this fall. The State has insufficient knowledge of private antiviral inventories and needs to encourage partnerships and communications with the private medical sector. CDC has indicated it will assist states with a better understanding of the commercial pipeline for critical pharmaceuticals and medical supplies by developing a “supply chain dashboard” using aggregated proprietary data from the manufacturers and distributors. States look forward to access to such a dashboard to support resource allocation and SNS decisions. While we cannot address everything this fall, Maryland is in the process of developing forward thinking approaches to potential resource shortages through the use of volunteers and by using health care workers in non-traditional roles to assist with response. These efforts are described in detail below:

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP):

ESAR-VHP is a federal program that establishes and implements guidelines and standards for registering, credentialing, and deploying medical professionals in the event of a large scale national emergency. Maryland purchased a web-based, fully compliant ESAR-VHP system in June 2009 from Collaborative Fusion, Inc., called CORES. After multiple phases of testing, it is anticipated that the system will go "live" August 24, 2009 and will be available for volunteers to register the following month. This system will allow Maryland to register volunteers through a website, with volunteers able to log into the system with a password at any time to update their information. The CORES system will directly access state licensing and national credentialing agencies to ensure volunteers are practicing professionals in good standing. The system has a messaging and notification component that will send messages through a variety of methods (e-

mail, pager, cell phone, etc). It also has a mission manager component that will allow volunteers to view a detailed description of missions as they arise.

Maryland Civic Guard:

Maryland's Civic Guard, launched July 16, 2009 by Governor O'Malley, is a coordinated effort between MEMA and the University of Maryland's Center for Health and Homeland Security (CHHS) that will engage local governments, private groups, businesses, corporations, and nonprofit organizations to enhance the system of cooperative volunteering during emergencies. The Civic Guard seeks to build on the strength of current partnerships between local governments, volunteer organizations, private businesses, and Maryland State government. Under the first phase of the initiative, supported in part by a FEMA Regional Catastrophic Preparedness Grant, MEMA and CHHS will work with local government, the private sector, and non-profit entities to identify resource needs and potential opportunities for private sector and non-profit entities to create or expand partnerships. The Civic Guard initiative will seek to share information on needs and resources and, where possible, create agreements and memoranda of understanding - before disaster strikes - with business and non-profit partners.

Broadening scope of practice and use of non-traditional professionals to assist with mass vaccination:

The state is developing procedures that would have the Governor modify state regulations on a temporary basis under a declared state of emergency to broaden scope of practice standards among various trained health care providers and also use trained health care providers in non-traditional roles to assist with a mass vaccination this fall. Under this plan, the state would consider using veterinarians, pharmacists, dentists, emergency medical technicians, and other auxiliary providers to meet the personnel requirements associated with a state-wide vaccination campaign.

3. EVALUATING AND UPDATING PLANS:

Continuity of Operations Plans (COOP):

The recent H1N1 influenza situation highlighted the need for up-to-date and comprehensive COOP plans within state government to ensure the ability to maintain vital operations and services for our citizens, especially in the face of possible reduced workforce availability due to illness.

By request of the Governor, MEMA and DHMH are leading an initiative to ensure that all executive agencies have viable, operational, and up-to-date Pandemic COOP plans by September 1, 2009 and full COOP plans by October 1, 2009. As part of this initiative, MEMA, in coordination with DHMH, provided a series of free training sessions on developing a COOP plan to state employees, locals, and non-profit agencies in July. In addition, the Governor is requiring executive level personnel from all state agencies and departments to participate in a one day COOP tabletop exercise and is scheduling a statewide COOP drill for late summer / early fall. MEMA will begin a peer review process of all COOP plans submitted October 1, 2009 or before.

Even with free training for local governments, it will be difficult for some local agencies to complete or update their COOP plans because of budget and staff shortages. The state is aware,

but cannot currently assist, in addressing known gaps in COOP planning within many private businesses.

Coordinating Emergency Management and Public Health Planning:

On July 27th, Maryland initiated a meeting among each localities public health officers and emergency managers to share their experiences from H1N1 and address communication gaps. This was an important first step in bringing together two disciplines that, in the past, have not had a great deal of experience working together and not always understood the others roles and responsibilities. In the future, it will be critical to have these disciplines integrate and coordinate their planning efforts, especially for the myriad of issues in an influenza pandemic that implicate both disciplines, such as mass fatality and special needs populations planning. One way to assist with this task is to ensure that public health and emergency management planning guidance at all levels of government must be consistent. Unfortunately, the federal government has created barriers to accomplishing this task because public health planning guidance released by HHS is often inconsistent with established emergency management planning guidance that is released by FEMA. The states would like to see emergency planning guidance come from DHS in coordination and conjunction with appropriate subject matter experts, to ensure that all planning guidance provided to the states is consistent.

CDC Pandemic Influenza Planning Guidance:

One area of public health planning guidance in need of serious revision is the Centers for Disease Control's (CDC) guidance to states on pandemic influenza planning. In addition to being inconsistent with established emergency management planning guidance, it does not sufficiently allow for necessary flexibility or scalability to the specific needs of a state. Maryland's pandemic influenza plan closely corresponds to the template provided by the CDC, which ended up not being easily understood in an operational context this past spring. DHMH is currently reviewing and revising the State plan to address these issues in time for fall.

State Strategic National Stockpile Plan:

Maryland's SNS plan was developed and exercised with the assumption that all of the available resources would be deployed to the State, rather than the 25% that was distributed in May. This demonstrates a flaw in the CDC's planning requirements established for state plans. State SNS plans are rigidly reviewed annually using a tool developed by the CDC. Under federal requirements, a state SNS plan is required to be written under the assumption of receiving a 100% deployment of SNS assets. The CDC has already recognized this gap and is actively working to develop the scalable concept at the federal level to provide to the states.

The Federal planning assumption was that a state's SNS shipment would follow a request from the Governor, an assumption which proved to be inaccurate in May 2009. Upon announcement that the State was to receive 25% of its antiviral allocation, DHMH made arrangements for receipt at the designated RSS site, and upon arrival, the shipment was immediately inventoried by type, lot number and expiration dates. A long term lease for secure, temperature controlled storage was obtained through an emergency procurement and the assets transported and secured. Since then, the CDC and FDA have successfully worked out a protocol for the extension of the shelf life of those antiviral medications and soon to expire dates.

This effort to safely maximize the shelf life and therefore the economic utility of these anti-virals should be replicated for the FDA for other medication caches purchased by the states with federal funding.

4. IMPROVING EARLY WARNING AND DETECTION OF INFLUENZA:

Maryland uses the Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE). This is a web-based syndromic surveillance system designed for the early detection of disease outbreaks, suspicious patterns of illness, and public health emergencies. It automatically categorizes data such as chief complaints from 46 acute care hospitals, over the counter medication sales from two large pharmacy chains (approximately 300 total stores), and call data from two state poison control centers into syndromes to detect aberrations in the expected level of disease. ESSENCE runs automated statistical algorithms on each syndrome and generates alerts when the observed counts are higher than expected. To our knowledge, Maryland is the only state with 100% connectivity to all acute hospitals, reflecting achievement of a priority goal of Governor O'Malley.

DHMH epidemiologists review ESSENCE alerts daily and determine if follow up is necessary. Follow up investigation of alerts includes contacting local health departments and the hospital infection control staff to obtain more information. In addition, DHMH epidemiologists notify the DHMH Physician On-Call and State Epidemiologist for alerts determined to have public health significance and initiate an active investigation.

ESSENCE provides situational awareness on the health of Maryland residents, detects disease clusters and exposures to allow for a more rapid response to disease prevention and mitigation, and provides early indication of increased influenza activity before cases are confirmed. This analysis provides a critical tool for planning and resource allocation. Maryland will continue sustained year round flu surveillance and is currently working with the State Superintendent of Schools to assess what is needed to add school absenteeism data to the system.

CHALLENGES IN APPLYING THE STAFFORD ACT TO PANDEMIC FLU:

Recent events, such as the 2009 Presidential Inauguration, have demonstrated the need for Congress to review the Stafford Act declaration process and regulations, particularly to ensure relevancy to post 9/11 threats and emergencies. The Stafford Act was designed to deal with disasters like tornados and hurricanes. The time has come for Congress and the Administration to revisit the Stafford Act, particularly as it might apply to pandemic influenza and other public health threats.

Under 42 U.S.C. § 5121 (b), the purpose of the Stafford Act is to provide an orderly and continuing means of assistance by the federal government to states and localities in carrying out their responsibilities to alleviate the suffering and damage from disasters.

There are two major types of declarations:

1. **Emergencies** – any assistance for which, in the determination of the President, federal assistance is needed to supplement state and local efforts and capabilities to save lives

and to protect property and public health and safety, or to lessen or avert the threat of catastrophe in any part of the United States. 42 U.S.C. §5122(1)

2. **Major Disasters** – include any natural catastrophe, which in the determination of the President cause damage of sufficient severity and magnitude to warrant major disaster assistance under the Act to supplement the efforts and available resources of states, local governments, and disaster relief organizations. 42 U.S.C. §5122 (2)

There are two main types of assistance that correspond with these declarations: major disaster assistance and emergency declaration assistance. Significantly less assistance is available under an emergency declaration than under a major disaster declaration. Expenditures made under an emergency declaration, unlike under a major disaster declaration, are limited to \$5 million per declaration, unless the President determines that there is a continuing need for immediate emergency assistance.

To qualify for federal assistance, the Governor must:

- (1) certify that the situation or disaster is of such severity and magnitude that effective response is beyond the capabilities of the state and local governments;
- (2) direct execution of the state's emergency plan;
- (3) describe the state and local efforts and resources which have been or will be used to alleviate the emergency;
- (4) for emergencies, define the type and extent of federal aid required; and
- (5) for major disasters, certify that state and local government obligations and expenditures will comply will all applicable cost-sharing requirements of the Act. See 42 U.S.C. §5170, §5191.

There are at least two challenges with applying the Stafford Act to pandemic influenza. First, the Stafford Act requires that a state describe the nature of the emergency or disaster and certify that it is beyond the capacity of the state to respond. While this process is relatively straightforward in the context of a storm or flood, it is more difficult in a lengthy event of unknown duration without a well-defined start and end date / time attached it, such as pandemic influenza. FEMA has noted that a pandemic influenza will last longer than other public health emergencies and may include waves of activity separated by months. See FEMA Disaster Assistance Policy, DAP9523.17 (March 17, 2007). Unlike a request to rebuild a bridge, human service needs are more difficult to quantify, especially with regard to a state's capacity to handle the issue.

Given the unique characteristics of pandemic influenza, states need specific guidance from the federal government on when this event would be considered of such severity and magnitude that effective response is beyond the capabilities of the state and local governments. In addition, states need guidance on the level of specificity that would be required in the declaration request with regard to available state and local resources and the type and extent of federal aid required.

Second, there is ambiguity in the law concerning whether the Stafford Act would cover an influenza pandemic under a major disaster declaration or just under a declaration of emergency. This legal uncertainty has been noted in several recent congressional reports. See e.g., CRS Report RL34724, *Would an Influenza Pandemic Qualify as a Major Disaster under the Stafford Act?*, by Edward C. Liu, at 6-10 (Oct. 20, 2008.)

This ambiguity is significant for a number of reasons. Assistance for declared emergencies is generally capped at \$5 million while major disaster assistance does not have this cap. A declaration of a major disaster also expands the types of aid that are available to states, localities, and individuals. For example, a major disaster declaration permits the distribution of aid directly to individuals and households to meet disaster-related medical and other expenses. 42 U.S.C. § 5174.

States need guidance from the federal government on whether and what type of major disaster assistance is potentially available for responding to pandemic flu outbreaks and what thresholds would have to be met for pandemic flu to be considered a major disaster, as opposed to an emergency. Maryland is not the only state looking for this advice. We are aware of the states of California and Oregon also raising this issue.

Effective response to a pandemic flu requires a closely coordinated effort among federal, state, and local partners. Disaster assistance should be clearly defined. States should not be left to guess and debate what might or might not qualify for assistance. In light of recent and emerging threats, it is time not only to provide guidance on these issues, but to revisit the Stafford Act to make sure it is relevant to 21st century threats and disasters.

CONCLUSION:

The State requests the following actions by the federal government to help close gaps in preparedness and response for pandemic influenza:

1. We request guidance from FEMA on whether and what type of major disaster assistance will potentially be available for responding to pandemic influenza and what thresholds would have to be met for pandemic influenza to be considered a major disaster, as opposed to an emergency. We also ask that the Stafford Act be revisited for its relevance and applicability to post-9/11 threats and incidents like pandemic influenza.
2. We are concerned about leadership, coordination, and communication at the federal level. States need to understand who is in charge at the federal level and the difference in roles and responsibilities between DHS / HHS. We need assurance that all federal agencies are using the incident command system. We need to ensure we have timely, credible, definitive guidance from HHS on issues such as school closings.
3. We ask for expansion and or flexibility on use of grant funds for H1N1 and also ask that you consider providing funds to other public safety disciplines outside of public health and hospitals.
4. We ask that the federal government revise pandemic flu planning guidance for the states and ensure that all public health planning guidance is consistent with established emergency management planning guidance.