Testimony of John Thomasian
Director, National Governors Association
Center for Best Practices

Submitted to the Senate Ad Hoc Subcommittee on State, Local & Private Sector Preparedness & Integration

"Pandemic Influenza: Closing the Gaps"

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Chairman Pryor, Ranking Member Ensign, members of the subcommittee, my name is John Thomasian and I am the director of the National Governors Association Center for Best Practices (NGA Center). I appreciate the opportunity to testify before you today on pandemic influenza preparedness and what remains to be done to close potential gaps in the nation's capacity to respond. My comments today are based on our previous work with states on pandemic planning as well as our recent experience helping states on issues concerning the H1N1 influenza virus.

The NGA Center develops innovative solutions to today's most pressing public policy challenges and is the only research and consulting entity that directly serves all of the nation's governors. The NGA Center's policy experts provide governors information, technical assistance, and best practices on a full spectrum of policy issues, including education, health care, the environment, homeland security, public safety, and economic development.

Background

The NGA Center has been at the forefront of state pandemic preparedness planning for several years, starting in 2006 with the publication of a primer for governors and senior state officials on the need for robust, cross-sector planning. We followed the publication of that primer with a series of regional workshops throughout 2007 and early 2008 (NGA Center materials on pandemic influenza may be found on our web site, www.nga.org). These workshops emphasized the institutional, governance, and public safety aspects of pandemic preparedness that were designed to ensure that society, government, and the economy continued to function. Issues we explored included:

- Interagency coordination;
- How to manage workforce reductions;

- How to maintain essential services such as law enforcement and fire fighting;
- Arrangements with the private sector to ensure the availability of food and other necessities; and
- Public education and communication.

The workshops, held in partnership with the Association of State and Territorial Health Officials and with funding from the Department of Health and Human Services, involved every state, the District of Columbia, and four of the five U.S. territories. Participants in the workshops consisted of 3- to 7-member teams from each state, selected by their governor. Team members represented diverse backgrounds and responsibilities, including emergency management, public safety, public health, education, local government, and the private sector.

The workshops challenged states to identify gaps in their own plans and used as a planning scenario a "worst case" event built around the example of the 1918 pandemic. Thus, we asked states to consider an infection rate of 30 percent of the U.S. population (approximately 90 million people), with 1.5 million people needing intensive hospital care and 742,000 requiring ventilators. This scenario also included an estimated 1.9 million deaths, with up to 40 percent of the workforce unavailable during each of three expected pandemic waves. Economic costs to the nation were estimated in the range of $500 billion in 2004 dollars—a reduction in GDP of approximately 5 percent. This scenario was consistent with federal guidance issued to assist states in developing their pandemic preparedness strategies.

I mention this because our workshops asked states to envision a far more catastrophic event than we have as yet encountered with the new H1N1 virus. In contrast to a 1918-type scenario, the H1N1 virus so far has proved to be relatively mild, with 8,975 cases and 15 deaths in the United States and, as of June 1, 17,410 cases and 115 deaths worldwide.

My comments today are based on our observations of state preparedness from our workshops as well as our more recent work assisting governors, state homeland security advisors, and other state agencies in managing the response to the H1N1 situation during this spring. I will focus on five key areas:

- Information sharing between states and the federal government;
- Interagency coordination within states and between states and the federal agencies;
- School closing decisions;

- Continuity of government and coordination with the private sector on critical services; and
- Communication with the public.

I will attempt to describe the preparedness status of each issue as we encountered it in our workshops and during the recent outbreak.

Information Sharing

Awareness of the presence or absence of disease at the local, state, and national levels is essential to implementing mitigation strategies that deliver optimum public health benefits while minimizing negative side effects. At the time of our workshops, we concluded that no system then existed to provide state officials with a clear picture of the situation in their states, in neighboring states, or in other parts of the country.

The recent experience with the H1N1 virus illustrates the improvement in information sharing since our 2007-2008 workshops. The flow of information from the federal government to the states, and from the states to federal agencies, was near-constant during the initial weeks of the outbreak. Case counts were updated daily, morbidity and mortality figures were readily available, and federal agencies—in particular the CDC but also the Department of Homeland Security—were proactive in their efforts to push information and guidance to state and local government officials. Similarly, interagency communications at all levels of government appeared to be robust: Health agencies were talking to the public safety and education sectors at the federal, state, and local levels, and federal agencies' plans and strategies appeared to be well-coordinated. States, overall, were very pleased with the quality and quantity of information they received from the federal government.

There were some early "glitches," however, that should be easy to correct. We did hear complaints that the briefings used to deliver information to the states were not well-coordinated and resulted in too much time spent hearing redundant information. Both CDC and DHS established daily conference calls to brief relevant state officials on new or updated information, and confusion existed as to whether each briefing contained new information or simply repeated an earlier briefing for a different audience. Early in the outbreak, the calls sometimes ran concurrently, which resulted in some federal officials being unavailable for one call because they were briefing state officials on another call. Later, the calls were scheduled to run consecutively. This, however, resulted in state officials spending several hours each day

monitoring conference calls to ensure they were up to speed on the latest information and guidance.

Moving forward, we would suggest that DHS and CDC coordinate a single or twice-daily briefing with states on flu developments. States, for their part, would urge all of their key agency officials to join that daily briefing. The purpose of the briefing would be to provide essential situation updates and suggested response actions. This daily briefing would not preclude other conversations, but would offer some assurance that all essential information could be obtained in one call and, thus, free up more time for in-state activities.

Another issue that arose was the need to support more information exchange *among* states. In our work to support the state homeland security directors, they stressed a desire for more information on what other states were doing. To help address this issue, we began issuing weekly updates to the governors homeland security directors on various state actions. Two examples of these updates are attached. We would plan on continuing this work if another outbreak occurred and would welcome working with DHS and other federal agencies to examine how to improve this type of cross-state information exchange.

Interagency Coordination

Interagency coordination within states and between states and the federal government is crucial for an effective pandemic response. At our workshops, we found that many of the state interagency teams were meeting for the first time and were not fully aware of what each team member's responsibilities were in a pandemic. Although state plans define the responsibilities of each agency, many states had not had the opportunity to practice their roles in an interagency exercise. In addition, many state teams were unsure what roles each of the federal agencies were to play in a pandemic.

Based on the response to the recent outbreak, we can report the situation today is much improved. For one, the key federal agencies—CDC and DHS—appeared to be working together and did a good job articulating their scope of responsibilities to the states.

At the state level, preparedness exercises, including our workshops, had given state agencies the opportunity to learn and practice their roles and establish relationships among agency officials. At the early stages of the outbreak, states quickly "stood up" their public health emergency response teams but, more importantly, state homeland security advisors were quickly engaged to begin coordinating an overall state response. Many states soon began to go beyond the walls of their health departments and lay the groundwork to mobilize broader state

resources through emergency declarations and other actions. Examples of these actions can be found in our weekly updates (attached).

As we look ahead, we must recognize that good interagency coordination can be ephemeral. It needs to be exercised regularly to work properly. To ensure that it not become a gap or challenge, states must have the opportunity to work through response actions periodically with other agencies and the federal government. A truism in state emergency preparedness is that states are most ready for a disaster right after experiencing the last one. States and the federal government are more prepared to address a pandemic event today because they responded to an actual outbreak in April and May. This type of readiness deteriorates quickly, however, and at this moment there are no designated resources available to all states to conduct multiagency preparedness exercises.

School Closure

The issue of school closure presents perhaps the most complicated pandemic-related challenge for officials at all levels of government. The issue was a topic of intense discussion at each of our regional workshops, and state officials obviously were struggling with the implications of a long-term closure early in their efforts to plan for a pandemic. The issue is multi-faceted:

- The disease-mitigation benefits of closure or class dismissal must be weighed against the impact on the availability of workers throughout the local economy, as some workers will need to care for school-aged children.

- School closures disrupt the school year and the educational continuity for affected children. They affect testing schedules and district budgets. They also disrupt school-based nutrition and counseling programs.

- Colleges and universities have particular challenges that also must be addressed, including dormitory-style living quarters that could facilitate the spread of disease and the presence of international students who may not be able to return home easily, particularly if limits on international travel are in place.

During the H1N1 event earlier this spring, the issue of school closure received significant attention from the national media and from government officials who were attempting to react swiftly to stop the virus from spreading. To their credit, officials at the federal and state levels began considering school closure almost immediately as a non-pharmaceutical intervention that promised to at least slow the spread of the virus until better information became available

about the nature of the threat. This was an entirely appropriate response given the information available at the time.

Inconsistencies soon arose when attempting to implement school closure policies. One issue was that CDC's written guidance directed state and local officials to consider closing schools based on laboratory-confirmed cases, while public comments by some federal officials indicated closure decisions should be made based on suspected or probable cases. This created confusion among state officials and resulted in divergent approaches, with schools in one state closing only when cases had been confirmed and schools in a neighboring state closing based on probable cases. How long to close also was an issue. Many used a two-week timeframe or even longer, but that may prove unnecessary if no further cases were discovered in the student body after five days.

Also missing from the equation was a public explanation of the potential costs, possible benefits, and expected limitations of school closure. Parents in some communities accused government officials of acting too precipitously and complained of lost wages and unscheduled absences. In other communities, parents complained that schools did not close quickly enough, or that they opened too soon after initial closing, resulting in further spread of the virus. Meanwhile, national media lost no time in heading to local shopping malls to photograph and interview high school students who simply swapped school hallways for mall food courts as a venue in which to share viruses.

A serious public discussion must take place around the issue of school closure to clarify its ultimate purpose: not to cure disease, but rather to slow the spread of the virus in a community, to "flatten the curve" of peak illness and, essentially, to buy time until a vaccine can be produced. School closure is not a "silver bullet," and the public must be made aware of both its benefits and its limitations.

More detailed advice from CDC would be welcomed by states so they could implement a more consistent approach to school closure. Such guidance could be flexible, and designed to adapt as more information is known. For example, in the early stages of a new outbreak, a higher infection rate (i.e., ratio of infection, or R0) might be assumed, thus suggesting aggressive closure policies. As more is learned and research suggests lower infection rates, guidance can shift to suggest closure only after a certain number of cases are confirmed. In any case, more work is needed in this area to craft good guidance.

Continuity of Government and Coordination with the Private Sector on Critical Services

Two issues emerged in our 2007 and 2008 workshops that were directly related to the expected high degree of absenteeism resulting from a pandemic: the need for improved continuity of government planning and the need for states to coordinate more closely with the private sector to ensure the availability of critical goods and services.

All states have continuity of government or continuity of operations plans for general emergencies, and in many cases states included annexes to agency continuity of operations plans to address the unique workforce shortages likely during a pandemic. In some cases, however, we found that states were relying solely on their traditional continuity plans, which do not reflect the specific challenges of maintaining government operations and protecting workers during a pandemic. We have recommended that states examine and, where necessary, develop or improve policies to increase the willingness and ability of personnel to perform their duties. States should consider expanded policies on telecommuting as well as condensed or amended schedules or operating hours for some agencies. Policies also must be developed to address the need of some workers to care for sick family members, or for children affected by school closures, for extended periods of time, and to balance those needs against government continuity requirements.

States also must work more closely with the private sector to ensure the availability of essential goods and services during a pandemic. The public sector relies heavily on the private sector for a range of products and services, including critical infrastructure such as water, electricity, food and telecommunications services. Similarly, the private sector's ability to weather a pandemic will require close collaboration with the public sector on policies that could affect worker availability, supply chain reliability, and the provision of public safety services. As a result, efforts to control the spread of disease at the community level—including closing schools, limiting public gatherings, and restricting public transportation services—must be implemented with recognition of their effect on the ability of the private sector to deliver critical services.

Because the H1N1 outbreak has so far been relatively mild, continuity planning and public-private coordination strategies were not tested and remain among the "unknowns" of our preparedness for a more serious event. We do know that some states had reviewed their continuity plans and were considering strategies for implementing those plans, at least in the early days of the outbreak, but the strategies were never tested in a real-world environment. Similarly, we still do not know whether states are engaging sufficiently with their private sector

employers to ensure their respective continuity efforts adequately reflect their interdependencies. Nor do we have a clear sense of whether the private sector in general is amply prepared. This is an area that requires attention as we move forward.

Communication with the Public

The key to any effective pandemic response is a fully engaged and educated public. During our workshops in 2007 and 2008, there was concern that the public was not engaged in the discussions about pandemic preparedness. The public seemed aware of the potential threat from a human-to-human transmittable version of avian flu, but confused about what they should do about it. In the two years since the last workshops, states and the federal government made strides informing the public and the media about the ramifications of a pandemic. Both levels of government have stressed general preparedness and focused on self-reliance strategies such as stockpiling food, water, medicines and other necessities. However, the public still is not sufficiently educated on the type of actions that might be undertaken to stop the spread of the flu, and this creates a great deal of confusion around such issues as school closings, quarantine, public distancing, and travel restrictions.

In the recent outbreak, the federal government did a good job keeping the public and media informed. In addition, the mainstream media provided good reporting to the public about the spread of the disease and what individuals could do to avoid infections. However, because clear explanations were not provided about the value (or lack of value) of such actions as school closures and travel restrictions, there was confusion in the early stages. Moreover, the lack of clarity from the World Health Organization on the definition of pandemic and the different levels it uses to identify a pandemic threat only added more confusion and anxiety.

At the state level, almost every state created or updated their pandemic Websites. The sites informed the public about the situation in the state and nation and provided steps that citizens could take to avoid infection or limit its spread. However, a full explanation on the type of actions states and the federal government might take to prevent further spread of the disease generally was lacking. CDC and DHS did an excellent job early in the outbreak describing the nature of the health threat and providing information on the status of the disease, but they did not explain well what type of actions might be used to stop the flu's spread. In these early stages, the federal government and states need to better explain what actions are being considered and why (e.g., school closings, voluntary isolation when sick, and cancellation of public events) and which actions likely will be avoided and why (e.g., quarantine and travel restrictions).

To address this gap, we recommend that the public be engaged in substantive discussions about issues with difficult ethical dimensions, including:

- The need for self-enforcement of community mitigation efforts, in particular to ensure that children dismissed from school do not simply re-congregate in other settings that are equally conducive to virus transmission;
- Triage and rationing of health care, including the prioritization of medicines and scarce medical equipment such as ventilators;
- Voluntary quarantine and isolation as disease-mitigation strategies; and
- The value, risks, costs, and limits of more aggressive actions, such as enforced quarantine and travel and trade bans.

The window for effective engagement is now open, as the public again appears to understand the threat posed by emerging diseases and the reality of influenza pandemics. However, the relative mildness of the H1N1 outbreak thus far may be causing some complacency among the public and may have reinforced the skepticism in some quarters that the pandemic threat is not as real or as significant as public health and other officials have warned.

Conclusion

In conclusion, states have made strides in the last three years to improve their ability to respond to the full range of issues they are likely to encounter during a severe pandemic. But significant work remains.

The H1N1 outbreak this spring was not a test of a worst-case or even moderate pandemic scenario, but it did serve as a strong wake-up call to officials and agencies at all levels of government—and hopefully to the public as well—that the threat of a pandemic is real, even if the severity of the disease is unpredictable. We should take advantage of this renewed attention to close the gaps still remaining and maintain a high level of readiness.

We are presented with a unique opportunity: we have several months before the onset of the next influenza season. Scientists warn that the H1N1 could return at that time in a more-potent form. We should use the intervening months to address the weaknesses the initial outbreak exposed:

- Federal agencies should clarify the guidance on school closures to ensure consistency and, to the extent possible, include a discussion of the impacts school closures could have on state and local economies.
- Information exchange mechanisms should be improved so that state and local officials are not required to monitor phone calls for several hours each day.
- The public absolutely must be engaged over the next several months in a concerted outreach effort to explain the benefits and costs of school closures and other mitigation strategies and to solicit their participation and cooperation so that maximum benefits accrue from any decision requiring a change in public behavior.
- The federal government should encourage and support state efforts to hold periodic pandemic exercises that practice response coordination with federal agencies, local governments, and the private sector, review communication strategies with the public, and engage multiple agencies in the state, including public safety and health.

Thank you for the opportunity to appear before you today. I am pleased to answer any questions you might have.

Attachments

Summary of State Actions and Selected Federal Actions to Address H1N1 Swine Influenza Outbreak

May 1, 2009

State Web Sites/ Pages

52 states and territories have set up web sites or pages on their state portals dedicated to the H1N1 influenza outbreak.

Public Health Emergency Declarations

New York Governor Paterson, Wisconsin Governor Jim Doyle and the Virginia State Health Commissioner have declared a Public Health Emergency in their respective states. In addition, Iowa Governor Chet Culver has prepared a declaration for a Public Health Emergency.

State of Emergency and Other Gubernatorial Declarations

Four states have issued various gubernatorial declarations:

- California Governor Arnold Schwarzenegger has declared a *state of emergency* to hasten government services by suspending non-competitive contract bids for services needed to combat the outbreak and by waiving certification requirements to expand lab capabilities in the state and to pursue federal assistance;
- Illinois Governor Pat Quinn has issued a *gubernatorial proclamation* to mobilization state assets and aid in the distribution of medical supplies;
- Maine Governor John Baldacci has proclaimed a *civil emergency* to activate the Maine Pandemic Influenza Plan, activate elements of the national guard and expedite funds; and
- Texas Governor Rick Perry has issued a disaster *declaration* to allow the state to implement emergency protective measures and seek reimbursement under the federal Stafford Act.

Activation or Partial-Activation of State Emergency Operation Centers (EOCs):

Eight states and territories have activated or partially activated their state EOCs or state public health EOCs. California, Delaware, Illinois, Indiana and Rhode Island have activated their state EOCs. Guam and Michigan have partially activated their EOCs. In addition, North Dakota activated the state's public health EOC.

Engagement with the National Guard

Four states—Illinois, Nevada, Vermont and Wisconsin--have activated their National Guard or requested their help in dispensing antiviral medication.

School Closures

According to the U.S. Department of Homeland Security, as of Friday, May 1, 2009 approximately 11 states have closed at least one school.

Other State Actions

- Maryland has opened the Maryland Swine Flu Command Center.

- Vermont Governor James Douglas ordered the Vermont National Guard to ship nearly 30,000 courses of antiviral medicine to hospitals around the state on Wednesday. Also, Vermont has issued guidance that migrant workers pose no significant flu threat, as migrant workers are already well-established in the United States.

- Indiana halted visits to prison inmates and at least two schools canceled classes Thursday in the state's latest steps to prevent the spread of the swine flu virus.

- Delaware Governor Jack Markell requested a CDC advisory team to assist the state in response to the H1N1 virus.

Selected Federal Actions

- Per CDC, 25 states have received their initial SNS allotment, 24 other states have received partial shipment, 7 shipments are en route and 6 shipments are moving from the SNS warehouses today. The first push of SNS to the states is to be completed by May 8th. (DHS Intergovernmental Affairs Call, May 1st, 2009)

- FEMA is developing guidance on how to use current UASI and SHSGP funds for response to the H1N1 virus. (DHS Intergovernmental Affairs Call, May 1st, 2009)

- CDC will release guidance to the states via their website at http://www.cdc.gov/h1n1flu/

- CDC is preparing interim direction for use of existing CDC Preparedness Grant funds for emergency response (CDC Daily Conference Call, Thursday, April 30th).

- Per HHS Secretary Sebelius, CDC will have updated interim guidance on K-12 school closings, higher education school closings and day care facilities. Guidance is current as of May 1st, 2009.

H1N1 Influenza: Summary of State Actions

For the week ending May 8, 2009

The following is a brief summary of state actions concerning the H1N1 influenza outbreak. NGA's research is based on state press releases and open source media, and this summary is by no means comprehensive. If you would like to add your state actions to this summary, submit corrections and updates, or would prefer NGA track additional information, please contact dhenry@nga.org.

State Web Sites/ Pages

52 states and territories have set up web sites or pages on their state portals dedicated to the H1N1 influenza outbreak.

Community Mitigation Strategies

States have instituted social distancing measures in state prisons. South Carolina has suspended person-to-person visits. In addition to prison visits, Louisiana Governor Bobby Jindal has suspended tours of prison facilities.

Mutual Aide Activations:

Tennessee has begun assisting Texas in lab testing of suspected H1N1 cases. Tennessee's outbreak and lab workloads have been light compared to a 3,500 case backlog in Texas. Tennessee received 400 samples this week to begin lab testing.

SNS Deployment

Colorado utilized a public/private partnership to distribute SNS medical supplies to 13 dispensing sites in the state. Additionally, Hawaii and Ohio National Guard units are tasked in their state pandemic plans to assist in SNS deployment[i]. The Michigan Volunteer Defense Force—an element of the State Militia under the command and control of the Michigan National Guard—was deployed to assist the Michigan Department of Community Health with antiviral logistics and distribution[ii].

State EOC Activations Update:

Utah made a partial activation of the state EOC on Monday April 27th, using WebEOC as a primary monitoring tool. The Utah Department of Health has an active departmental operations center and a Joint Information Center (JIC) that is coordinating public media and information to the state EOC[iii]. Ohio has followed a similar structure, and is issuing daily situation reports from the state EOC. As of May 4th, South Carolina's Health and Environmental Control Departmental Operations Center is open[iv].

School Closures

CDC issued updated interim guidance on school closings for K-12 this week. Additionally, CDC has issued updated interim guidance for higher education.

[i] Per MG Robert Lee, Hawaii HSA; Ohio Emergency Operations Center
[ii] Per BG Mike McDaniel, Michigan HSA
[iii] Per Keith Squires, UT HSA.
[iv] Per Blair Goodrich, SC Governor Sanford's Washington Representative.