Low-Cost Measures to Improve Local Emergency Preparedness and Response in New Jersey

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Executive Summary

Since 2001, the federal government has provided local emergency preparedness partners with dedicated funding to develop emergency response capacity and improve interagency coordination. This money commonly funds exercises based upon severe, relatively infrequent emergency scenarios, such as bioterrorism, nuclear threats, pandemics, or 100-year-floods. However, several studies report that these severe-but-infrequent scenarios are ill-suited to produce sustained improvement in the ability of local partners to manage the emergencies that communities commonly do experience, such as water main breaks, power outages, HAZMAT spills, or food-borne disease outbreaks.[1]

"You go with what you know"

According to the CDC Office of Public Health Preparedness and Response,[2] all emergency response begins at the local level. In addition, behavioral health science demonstrates that "when faced with a threat, organizations, groups, and individuals often react with well-learned behaviors or habitual responses."[3] Thus, during high-stress events such as emergencies, front-line local responders reach out to the partners and organizations with whom they are already familiar, whose strengths and assets they already understand, and whose roles in the emergency scenario are well established and clearly communicated. In short, "you go with what – and whom – you know."

Yet large-scale, relatively infrequent, interagency emergency response exercises align poorly with this basic tenet of human behavior. The infrequency of these actual events reduces the likelihood that participants will incorporate lessons learned from these exercises into their regular emergency preparedness and response activities. In addition, as funding for emergency preparedness efforts

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1 Bartley et al., 2006; Williams et al., 2008; Gebbie et al., 2006.

2 "How Prepared Are We for Public Health Emergencies?" http://www.cdc.gov/phpr/areweprepared.htm

3 Plotnick et al., 2009.

decreases,[4] it will be increasingly difficult to coordinate sufficient large-scale exercises to foster and maintain local emergency preparedness partners' ability to effectively respond to severe but infrequent emergency events.

The ability to "prevent, protect against, respond to, and recover from" emergency incidents of any size "requires better coordination between the health system and the emergency response system."[5] Given that large-scale, infrequent exercises are ill-suited to improving routine coordination between traditional emergency responders and health sector partners with emergency response roles, Rutgers examined how local response partners interact during planning for and response to more common emergency scenarios.

Key Questions and Barriers for Preparedness Coordination

Since more common types of emergencies occur (by definition) more frequently, these events are more likely to foster the development of more effective and coordinated response habits.[6] Rutgers conducted surveys and in-depth interviews with key local informants from New Jersey's traditional and health sector emergency response organizations to answer the following questions:

- How effectively are local emergency response partners currently coordinating their preparedness and response efforts for more common emergency scenarios?
- What are the most significant barriers to effective coordination between local emergency response partners?
- What creative and low-cost solutions have local emergency response partners developed to overcome these identified barriers?
- How can these solutions be adapted by other localities to improve the effectiveness and coordination of emergency response to more common emergency scenarios?

[4] According to the Trust For America's Health 2010 preparedness report "Ready or Not?," federal support for public health preparedness has been cut by 27% since 2005. New Jersey decreased its state funding for public health services in FY 2009-2010 by 5.3% compared to the FY 2008-2009 budget.

[5] US Department of Health and Human Services, 2009.

[6] Plotnick et al., 2009.

Survey respondents identified the following issues as the three most common barriers to an effective and coordinated multi-agency emergency response to common emergencies:

1. One or more of the relevant partners was unclear about their roles and responsibilities in the event;

2. The organization was not notified of the event in a timely manner by partners – OEM, EMS, LHDs, and hospital respondents especially noted this as a barrier to multi-agency response); and

3. The organization did not meet with relevant partners to plan a coordinated response for this type of event.

Many respondents, including local Offices of Emergency Management (OEMs), reported that the lack of an actionable written response plan impeded their responses. Many also noted that a lack of sufficient staff was a barrier. Federally Qualified Health Centers (FQHCs), among others, reported that their response efforts were hindered by difficulty in contacting other partner organizations. Respondents also observed that local partners' communications equipment is frequently not interoperable, which makes coordinating responses much more difficult.

The solutions recommended below are based on the experiences and successes of the key informant interviewees, responses from survey participants, and results of the nationwide research mentioned above.

For most communities, these solutions should be achievable and affordable with existing resources. Implementing these steps is the fundamental difference between jurisdictions that have built and sustained collaborative emergency preparedness and response partnerships, and those that fail to meet that goal.

Achievable, Proven Steps for Improvement

Local emergency preparedness and response partners are encouraged to implement the following low- or no-cost solutions to NJ-specific barriers to the effectiveness and coordination of local response efforts:

1. **MEET MONTHLY WITH LOCAL RESPONSE PARTNERS.** Make interacting with local response partners a habitual, routine occurrence – when response partners are in the habit of communicating with each other, they are more likely to communicate well during an emergency event. These monthly meetings are an ideal venue for the collaboration, discussion, and information sharing ideas that follow.

2. **DRAFT OR UPDATE A ONE TO TWO PAGE LOCAL MULTI-AGENCY RESPONSE PLAN FOR EACH TYPE OF EMERGENCY THAT IS RELATIVELY LIKELY TO OCCUR IN THE JURISDICTION.**[7] These plans should identify all partners who would be involved in responding to the event, the roles and responsibilities of each partner agency, the resources each partner brings to the response effort (e.g., personnel, supplies, equipment), and the framework incident command structure (ICS) for the first 48 hours of the response (i.e., initial response and post-event recovery).

3. **CONDUCT QUICK TABLETOP EXERCISES AROUND LOCAL MULTI-AGENCY RESPONSE PLANS.** Talk through a hypothetical situation relating to the response plan that has just been drafted or updated (see 2, above). Each partner should briefly summarize what their organization's role and actions would be, and what they perceive as their partners' roles and responsibilities. Discuss how organizations' perceptions of their own and their partners' roles can affect communication and efforts to collaborate. Brainstorm about how to coordinate the local response most effectively and then document these ideas and update the multi-agency response plan as necessary.

4. **SHARE UPDATED EMERGENCY CONTACT INFORMATION WITH LOCAL RESPONSE PARTNERS.** Regularly reaching out to partners to share and solicit updated emergency contact information forces each organization to regularly confirm their own internal staff's contacts. This practice also ensures that the organization is able to contact appropriate partners in the event of an emergency, and helps the organization stay abreast of changes to local service contracts.[8] An ideal venue for sharing this emergency contact information is at monthly meetings of local response partners (see 1, above). See *Appendix E* for a multi-agency emergency contact information template.

5. **DEVELOP A LOCAL INTER-AGENCY COMMUNICATION STRATEGY.** Ideally, all response partners' communication equipment and protocols would be interoperable and compatible, but budget constraints frequently prevent the purchase of such equipment. A low-cost work-around is to ensure that all response partners (especially the local emergency dispatch) have copies of the updated multi-agency emergency contact information and the one to two page local response plans for more common types of emergencies (see 4 and 2, above). Provide dispatchers with brief training about how to communicate with each response partner, and about which partners need to be contacted in each type of emergency event. If possible, document this information in a one to two page "How to Handle Local Emergency Communications" summary sheet for

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[7] Refer to the list of more common emergency response scenarios in the Survey Results section of this report, or review the community's Hazard Vulnerability Analysis to identify possible topics for these planning sessions. These meetings are most effective when the planning focuses around an event more likely to occur in the next few months (e.g., at the October meeting, draft or update the local response plan for severe winter weather; in February, draft or update the plan for flooding).

[8] For example, if public health services are contracted out to a nearby local health department following the retirement of the local Health Officer.

dispatchers. An ideal venue to discuss and document communication strategies and barriers is at the monthly meetings of local response partners (see 1, above).

6. **CONDUCT INTER-AGENCY POST-EVENT DEBRIEFING AND AFTER-ACTION REVIEWS.** According to interviewees,[9] post-event "hotwashes" (after-action debriefings) that include all relevant partners generate better and more actionable ideas for improving collaboration and effectiveness of future responses than non-collaborative, agency-specific debriefings. Briefly document what worked – and what didn't – and incorporate these "lessons learned" into the interagency response plan for this type of event. In addition to improving all partners' response plans and processes, brief after-action reports serve as documentation for quality improvement monitoring initiatives, as well as justification for disaster management funding and mutual aid reimbursements. Again, an ideal venue for these multi-agency after-action reviews is the monthly meetings of local response partners (see 1, above).

7. **DRAFT MUTUAL AID AGREEMENTS AMONG LOCAL EMERGENCY RESPONSE PARTNERS.** Monthly interagency meetings are an ideal venue to develop mutual aid agreements (MAAs) among partner agencies. These agreements should spell out which specific resources would be expected to be shared in various emergency scenarios, so that all participating parties are clear on what "interagency cooperation" means in each type of emergency situation. Refer to Appendix D for examples.

[9] For example, local emergency response key informants interviewed in Spring 2011 by Rutgers as part of this project.

PART 1

Approach for the Project

This project was comprised of three complementary approaches:

1. Literature review of current emergency preparedness and response research, including federal guidance documents and peer-reviewed journal articles. Refer to *Part 2: Research Results* for more information.

2. Distribution of an online survey[10] for local emergency preparedness and response partners to: local offices of emergency management, police departments, fire departments, hospitals, emergency medical service organizations, federally qualified health centers, local public health departments, and long-term care facilities. The survey was developed to answer the following questions:

    a. How effectively are local emergency response partners currently coordinating their preparedness and response efforts for more common emergency scenarios? Survey results were also designed to serve as baseline for comparing current levels of coordination against results in future years.

    b. How well aligned are local partners' understanding of each other's roles and responsibilities? Does perception of who would be expected to respond affect emergency preparedness training and response practices?

    c. What are the most significant barriers to effective coordination between local emergency response partners?

    d. What creative and low-cost solutions have local emergency response partners developed to overcome these identified barriers?

3. In-depth follow-up interviews with key informant local response partners to document examples of low-cost strategies, processes, and approaches that have improved the effectiveness and coordination of local emergency preparedness and response efforts.

[10] Via the online survey tool SurveyMonkey (www.surveymonkey.com).

These interviews were also used to record the practical effects of the NJ-specific barriers to collaboration and effectiveness that were identified in the survey, as well as examples of successful and unsuccessful methods of coping with these effects. Refer to *Part 4*: *Interview Results and Discussion* for more information.

PART 2

Research Results

Since 2001, the federal government has provided local emergency preparedness partners with dedicated funding to develop emergency response capacity and improve interagency coordination for large-scale, severe, relatively infrequent emergency scenarios. However, several studies report that these severe-but-infrequent scenarios are ill-suited to produce significant long-term positive effect on local emergency preparedness partners' ability to effectively coordinate for and respond to emergency events.[11]

According to the U.S. DHHS 2010 *Draft Biennial Implementation Plan*, the National Health Security Strategy (NHSS) "provides the first comprehensive approach to galvanizing the Nation's many efforts to minimize the health consequences associated with large-scale incidents, including natural disasters, disease outbreaks, hazardous chemical spills, nuclear accidents, and biological and other terrorist attacks." The NHSS states that national health security is achieved "when the Nation and its people are prepared for, protected from, respond effectively to, and are able to recover from incidents with potentially negative health consequences." The two goals of the NHSS are to:

- Build community resilience; and
- Strengthen and sustain health and emergency response systems.

Given the current climate of decreasing financial assistance and diminishing focus on emergency preparedness and large scale demonstration projects, this report suggests that ***improving practice habits and coordinating response with other partners to routine emergencies can be the key components to building community resilience*** within the emergency preparedness and response community. Minimizing gaps in services and knowledge, improving understanding of local vulnerabilities and surge capacity needs, and incorporating all community assets at the local level, across the emergency response spectrum, will result in a more efficient and connected response.

[11] Bartley et al., 2006; Williams et al., 2008; Gebbie et al., 2006.

According to the Centers for Disease Control and Prevention (CDC) Office of Public Health Preparedness and Response,[12] all emergency response begins at the local level. In addition, behavioral health science demonstrates that, "when faced with a threat, organizations, groups, and individuals often react with well-learned behaviors or habitual responses."[13] Thus, during high-stress events, such as emergencies, front-line local responders reach out to the partners and organizations with whom they are already familiar, whose strengths and assets they already understand, and whose roles in the emergency scenario are well established and clearly communicated.

To help improve community resilience – the ability for communities to recover and grow from disasters – emergency planners can incorporate lessons learned from the field of behavioral health. Behavioral science research shows that most actions, especially during an emergency, are habitual. As Crimando and Wainschel (2010) note, "Under stress, we perform as we have practiced." They also state: "*Practice doesn't make perfect. Perfect practice makes perfect.* Flaws that are repeated in drills and exercises may surface in a real-time response and perhaps with dire consequences." Yet, many emergency plans underestimate the very "human" behavior of emergency responders, including the tendency to "react with well-learned behaviors or habitual responses," as the CDC notes. Those habitual responses include people's tendency to stay connected with colleagues within their discipline, unit, or "silo."

Silos in the workforce are a reality that emergency planning must address. Silos may be found within and between organizations and disciplines, and their 'stovepipe' structure restricts vital horizontal communication and coordination among and across local partners. In addition, silos impede an efficient response and block perspective of the full picture of an event response. Rendin, Welch and Kaplowitz (2005) explored the application of bioterrorism funding and the incident command structure principles to improving organizational response to a routine public health emergency. More specifically, they studied the surveillance, screening, and prevention of the spread of active tuberculosis among healthcare workers. Their report documented that by developing an integrated approach and adapting concepts from another discipline, the healthcare workers were able to move beyond the silos and improve their organizational emergency response capacity.

In the health and healthcare community, adding the title "emergency responder" to job descriptions has become increasingly common in the years following 9/11. Yet, some public health and health care workers have struggled to adjust to the new expectations, roles, and demands associated with this role, including 24-hour, on-call response and working within more traditional emergency response cultures. VanDevanter et al. (2010) conducted a qualitative study that involved interviewing three local health departments that responded to Hurricane Katrina in 2005. The interviewees defined role identification and the overburdening of local health departments as major barriers to assuming jobs that needed to be done, but went beyond the employees' job descriptions or qualifications:

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[12] "How Prepared Are We for Public Health Emergencies?" http://www.cdc.gov/phpr/areweprepared.htm

[13] Plotnick et al., 2009.

> *Although some emergency response functions are similar to routine core public health activities – such as surveillance, vector control, and environmental quality assurance and regulation – many functions represent either new responsibilities or new roles for public health, particularly when the conventional providers of those services are either overwhelmed by the disaster or absent. These new responsibilities include either assurance or direct provision of medical equipment and supplies, victim identification and mortuary services, veterinary services, patient evacuation, worker health safety, and the direct provision of clinical and mental health care.*[14]

In a study examining the relationship of local health departments and what the researchers termed "community health centers" (CHCs), which include community, migrant and homeless health centers, Ablah et al. (2010) found there was willingness to partner and work together. However, nearly one quarter (21% of CHC and 23% of LHD) of respondents reported not knowing whether there was a documented role for the CHC in the LHD's emergency response plan. Within the health community, there continues to be a gap in communication and discussion of expectations in emergency response coordination and planning, which can lead to "endangering the needs of low-income and vulnerable populations in an emergency."

Perception of one's role and ability is important. In a study by Barnett et al. (2009) about attitudes and beliefs toward emergency response among local public health communities in three states, the researchers found that 16% of the workers were not willing to "respond to a pandemic flu emergency regardless of its severity." However, those employees within local health departments who perceived themselves as 'concerned and confident' in their awareness of the situation and in their abilities were most likely to respond. They recommended public health agencies design, implement, and evaluate training programs focused on emergency response attitudes in health departments.

Finally, the CDC's 2011 *Public Health Preparedness Capabilities: National Standards for State and Local Planning* should be used to improve overall response and role identification. This document provides metrics in 15 expected capabilities to guide priorities and implementation activities around public health's role in emergency preparedness and response planning. It notes that:

> *While demonstrations of capabilities can be achieved through different means (e.g., exercises, planned events, and real incidents), jurisdictions are encouraged to use routine public health activities to demonstrate and evaluate their public health preparedness capabilities.*

There has been little research exploring the extent to which efforts to prepare local jurisdictions for large scale emergencies have a trickledown effect on improving local response to more common emergencies. There is also a lack of instruction for local officials, and a lack of imperative within federal grant requirements, on partnership and coordination around specific emergency scenarios that have more frequent relevancy to local communities and jurisdictions.

[14] VanDevanter et al., 2010.

As noted above, the large-scale, relatively infrequent interagency emergency response exercises favored by federal and state funding are poorly aligned with the natural human tendency to repeat habitual behaviors. The fact that these exercises bring emergency response partners together only around the least likely, most infrequent emergency scenarios reduces the likelihood that participants will incorporate lessons learned from these exercises into their regular emergency preparedness and response activities. And while these large-scale exercises have always been few and far between, as funding for emergency preparedness efforts decreases,[15] it will be increasingly difficult to coordinate sufficient large-scale exercises to foster and maintain local emergency preparedness partners' ability to effectively respond to these events.

The ability to "prevent, protect against, respond to, and recover from" emergency incidents of any size "requires better coordination between the health system and the emergency response system."[16] Since the large-scale, infrequent exercises mentioned above are ill-suited at improving routine coordination between traditional emergency responders and health sector partners with emergency response roles, this report examines how local response partners interact during planning for and response to more common emergency scenarios.

[15] According to the Trust For America's Health 2010 preparedness report "Ready or Not?," federal support for public health preparedness has been cut by 27% since 2005. New Jersey decreased its state funding for public health services in FY 2009-2010 by 5.3% compared to the FY 2008-2009 budget.

[16] US Department of Health and Human Services, 2009.

PART 3

Survey Results and Discussion

As set out in Part 1, in support of this project, Rutgers developed an online survey aimed at answering the following questions:

- Which local emergency response partners have responded to each of the “more common” emergency scenarios in the survey?
- Are local emergency response partners currently coordinating their preparedness and response efforts for these “more common” emergency scenarios?
- What are the most significant barriers to effective coordination between these local emergency response partners?
- Have these local emergency response partners identified creative, low-cost solutions to these barriers?

The list of “more common” emergency response scenarios used in the survey was not exhaustive, and was intended to represent only *examples* of scenarios more likely to occur with relative frequency. This list included:

1. Gas leak at an elementary school during the school day.
2. Major fire at an apartment building.
3. Flood affecting a mixed residential/commercial area.
4. Greater than usual number of people suffering severe diarrhea, nausea and vomiting (possible suspected foodborne disease outbreak or intentional bioterrorist event).
5. Inspection and evacuation/closure of unacceptable living conditions.
6. Isolation and quarantine of a non-compliant tuberculosis patient.
7. Moderately severe hurricane.
8. Multiple families without heat during extreme cold weather.

9. Providing flu vaccine to the community via clinics.
10. Severe ice storm that brings down power lines.
11. Traffic accident that results in a hazardous chemical spill (HAZMAT event).
12. Water-main break affecting potable drinking water services.

The survey was distributed via email to NJ local emergency preparedness and response partners: local police departments; local fire departments; local Offices of Emergency Management (OEM); Emergency Medical Services organizations (EMS); local health departments (LHD); hospitals; federally qualified health centers (FQHC); and long-term care facilities (LTC).

The survey was also sent to individual organizations by relevant State-level liaisons for each organization type. In addition, Rutgers shared the survey with the NJ Health Officers Association, the NJ County Office of Emergency Management Coordinators Association, the NJ Hospital Association, the NJ Primary Care Association, the NJ Association of Homes and Services for the Aging, and the NJ Health Care Association for dissemination to each organization's respective membership. The survey was also sent directly to active health officers by Rutgers staff. Rutgers then sent follow-up survey reminders directly to local health departments, and distributed survey reminder notices to the above-mentioned state liaisons and professional organization contacts.[17] During the two weeks that the survey was open, more than 150 completed responses were received. A summary and analysis of these responses follows:[18]

- 155 individuals responded to at least one question on the survey (n = 155).
- Most respondents (82%, n = 123/150) self-identified as holding managerial and/or coordinator responsibilities at their respective organizations.
- Most (61%, n = 92/152) respondents' organizations are located in Morris, Somerset, Camden, Warren, and Ocean counties (respectively, n = 27, 21, 18, 14, 12). No more than eight responses were received from any other single county, so the results of this survey best represent the five listed counties.
- Most (80%, n = 125/155) respondents work for OEMs, LHDs, and Police Departments (respectively, n = 57, 42, 26); therefore, the results of this survey are most representative of these organization types. Responses were also received from EMS providers (n = 9), Hospitals (n = 8), FQHCs (n = 6), Fire Departments (n = 4), and Other (n = 3). No responses were received from LTC facilities.

[17] Because of the manner in which the survey was distributed (i.e., indirectly, via organizational listserves and liaisons), the authors were unable to determine a response rate for this survey.

[18] *Legend:* "n = 5" means that five respondents selected the referenced answer choice(s); "n = 5/10" means that five respondents selected the referenced answer choice(s), out of the 10 total responses to the referenced question; Health Sector = pooled EMS, Hospital, LHD, and FQHC responses related to a question; Involvement in emergency scenarios: 80–100% = very involved; 50–79% = moderately involved; 25–49% = minimally involved; 0–24% = not involved.

- Most (95%, n = 147/154) respondents considered “emergency response” to be one of their organizations’ responsibilities. Interestingly, 7% (n = 4/52) of Local OEM respondents said “emergency response” was NOT an OEM responsibility, even though “emergency management” is a core responsibility of OEMs.

- Overall, 90% or more respondents reported having up-to-date emergency contact information for their local OEM (n = 146), Police (n = 143), Fire (n = 142), and EMS Providers (n = 138). Less than 50% of respondents reported having up-to-date contact information for LTC Facilities (49%, n = 75/154) and FQHCs (23%, n = 35/154). About 75% of respondents report having contact information for LHDs and Hospitals.

    - 96% of OEM respondents (n = 54/56) report having contact info for Police, Fire, and other OEM. Yet only 75% of OEMs (n = 42/56) have Health Department contact info, and only 20% (n = 11/56) have FQHC contact info.

    - In comparison to other respondent groups, EMS Providers are least likely to have contact information for LTC Facilities (33%, n = 3/9), FQHCs (0%, n = 0/9), and Public Health Departments (44%, n = 4/9).

    - Compared to other respondent groups, Hospitals and LHDs are much more likely to have contact information for LTC Facilities (respectively, 62% and 67%) and FQHCs (respectively, 50% and 36%).

    - Interestingly, only 75% of Hospitals and 33% of FQHCs have contact information for other organizations of their own type (e.g., one in four hospitals and two in three FQHCs do not have contact information for their peers).

- Whenever a Respondent Group indicated it would be very involved in response to a scenario, other Respondent Groups agreed that the Respondent Group would be very involved or moderately involved in that scenario, EXCEPT:

    - FQHC and Police reported they would be very involved in “suspected food-borne illness outbreak,” while other respondents said they believed these two groups would be minimally or not involved in response to this scenario.

    - FQHC reported they would be very involved in “providing flu vaccine to the community via clinics,” while other respondents said they believe FQHCs would not be involved in this type of response. In general, FQHCs perceived they would be at least minimally involved in most of these emergency scenarios, while other organization types did not believe FQHCs would be involved in any of the routine emergency scenarios.

- EMS Providers think they would be very involved in an "ice storm that causes downed power lines," but other respondents think EMS Providers would only be minimally involved in this scenario.

- Overall, Health sector (LHD, EMS, FQHC, and Hospital) respondents consistently reported their own involvement in these response scenarios at a higher level compared to other response partners' perception of Health sector involvement. This suggests that partners are unclear about the role of health sector partners in emergency response. However, Health sector perceptions about the level of LHD involvement in these scenarios conformed to LHD perceptions about LHD involvement. Essentially, the Health sector is most aware of LHDs' roles in emergency response, but less aware of other Health partners' roles in these same scenarios.

- Perceptions of Police and OEM involvement were relatively uniform across respondent groups, which suggests that all parties agree on the role of Police and OEM in most emergency scenarios.

- Hospital respondents understated their involvement in "isolation and quarantine" scenarios (38%) compared to other respondents' perception of Hospital involvement (54%).

- With only a few exceptions, respondents reported that their organizations coordinated with one or more partners when responding to most routine emergency situations. The rate at which an organization type reported responding to a given scenario was approximately equal to the rate at which it reported coordinating the response with one or more emergency response partners. However, based on comments provided by survey respondents and interviewees, not all relevant partners are included in these collaborative responses, and not all collaborative responses are effectively coordinated.

- Police and OEM respondents practiced for emergency scenarios at approximately the same rate as they responded to the same scenarios, while LHDs responded to scenarios even when they had not prepared for them.

- While 100% of FQHC respondents reported practicing and responding to the recent flu season by distributing flu vaccine via community clinics, less than 30% of survey respondents from other organizations were aware of FQHCs' role in this scenario (and FQHCs' role in the recent H1N1 response). FQHCs prepared for seven of the scenarios included in the survey, but reported responding to only two of them.

- All respondent groups other than Fire believed their organization type would be moderately to very involved in providing flu vaccine to the community. FQHCs, LHDs, and Hospitals reported a high rate of actually providing this service in the last three years. This high level of perceived involvement across sectors and high rate of health

entity response is likely due to the national and international attention on, and funding for response to, the H1N1 pandemic of 2009-2010.

For more detailed survey results, refer to Appendix A: Practice vs. Actual Response by Discipline and Perception of Roles and Responsibilities, by Discipline.

Based on the results of the nationwide research and literature review, the survey also included 13 potential barriers to the coordination and effectiveness of local emergency preparedness and response efforts. Multiple survey respondents identified each of these potential barriers as an actual barrier in their respective jurisdictions, which confirms that the barriers identified through nationwide research are applicable to local New Jersey jurisdictions.

Only half of respondents said they "coordinated effectively with all relevant response partners." More than 60% of Police and EMS respondents believe their organizations coordinated effectively with all relevant response partners in all routine emergency events in their jurisdictions, but even within these respondent groups, many individuals reported that one or more barriers to effective and coordinated response still exist.

Overall, survey respondents identified the following three most common barriers to effective and coordinated multi-agency emergency response to common types of emergencies:

1. One or more of the relevant partners was unclear about their role and responsibilities in the event (27%);

2. The organization was not notified of the event in a timely manner by partners (OEM, EMS, LHDs, and Hospitals respondents especially noted this as a barrier to multi-agency response) (24%); and

3. The organization did not meet with relevant partners to plan a coordinated response for this type of event (20%).

Many respondents, including local Offices of Emergency Management (OEMs), found that the lack of an actionable written response plan impeded their responses. Many also noted that a lack of sufficient staff was a barrier. Federally Qualified Health Centers (FQHCs), among others, reported that their response efforts were hindered by their inability to contact other response partner organizations. Respondents also observed that local partners' communications equipment is frequently not interoperable, which makes coordinating responses much more difficult.

In addition to the potential barriers included in the survey, respondents noted two additional barriers that interfere with effective and coordinated preparedness and response efforts:

- The volume of requests for help overwhelmed response capacity (lack of sufficient surge capacity); and

- Communications equipment was not interoperable between response partners, so coordinating responses is much more difficult.

For more information, refer to Appendix B: Barriers to Routine Emergency Response Collaboration.

PART 4

Lessons Learned: Recommendations from Interviews and Creative Solutions

Rutgers conducted in-depth interviews with eleven (11) local emergency preparedness and response professionals. Interviewees were selected based upon the following criteria:

1. the individual completed the electronic survey distributed as part of this project;
2. the individual volunteered to be interviewed (47 survey respondents indicated willingness to be interviewed);
3. the individual indicated that he or she had one or more creative solutions or promising practices to share;
4. the individual represented one of the targeted emergency preparedness and response sectors (i.e., a local police department, local fire department, local Office of Emergency management, EMS organization, local health department, hospital, or federally qualified health center); and
5. the individual was available to be interviewed during the project period.

The primary purpose of these interviews was to document in detail examples of low-cost strategies, processes, and approaches that have improved the effectiveness and coordination of local emergency preparedness and response efforts. Interviewees also discussed the practical effects of the NJ-specific barriers to collaboration and effectiveness that were identified in the survey and shared examples of successful and unsuccessful methods of coping with these effects.

The creative solutions and recommended strategies identified by interviewees, survey respondents, and national experts (summarized at the beginning of this report), are organized into three categories: Process Improvements; Definition of Roles and Responsibilities; and Content Suggestions for Monthly Emergency Preparedness Meetings.

Process Improvements

- **Steady incremental progress can produce marked long-term improvement in response capabilities.** Interviewees noted that in the ten years since 9/11, individuals and organizations that have made efforts to "change habits" reported strong improvements in building and sustaining team cohesion with other emergency response partners. These responders stated unanimously that incremental changes to how organizations practice, respond and behave are necessary to make noticeable improvements in coordinating response to any local emergency.

- **ICS structure and terminology remains underused among public health and health care partners.** Many interviewees recognized the benefits of using the Incident Command Structure (ICS) as a common framework and language for organizing multi-agency preparedness and response efforts. However, they reported that ICS is not effectively and consistently integrated into preparedness and response efforts for more common types of emergencies, even among traditional emergency first responders (e.g., police, fire, EMS). Some interviewees reported that collaboration during event response was hindered by partners' use of different – and unfamiliar – terminology or operational structure. For example, while many health and healthcare professionals have received ICS training, they do not use it on a regular basis. A lack of familiarity with one's role within an ICS/ NIMS structure reduces productivity and collaboration during emergencies.

- **Continually Engage and Inform Policy Makers.** Keeping local policy makers engaged and informed about local emergency partners' progress and activities helps sustain momentum and support. Notification of how money is being used, integration of emergency response and brand recognition at local events, and soliciting constructive feedback from other agencies and partners in the community can strengthen the case for multi-agency collaboration and justify the required resources.

- **Incorporate Behavioral/ Mental Health Training into Emergency Preparedness Planning and Response.** One interviewee stated, "The plan should follow people then the people will follow the plan." The 2008 Disaster Mental Health Subcommittee of the National Biodefense Science Board makes this recommendation more directly: "Integrate mental and behavioral health into all public health and medical preparedness and response activities." Integrating mental and behavioral health training into drills and exercise scenarios can help emergency responders gain an understanding of how various groups react and respond to emergencies. As a result, they will be able to anticipate the behaviors of the public and work together with other responders in a more cohesive manner.

- **Monitor the Change in Organizational Perception and Training Activities Among Emergency Response Partners at Two Levels.** First, partners should note the incremental

changes (retirements, reassignments, reorganizations, staff growth or decline) that inevitably occur in organizations and leadership. These changes may require modifications in local response plans in order to ensure that all partners remain aligned to maximize use of collective resources, skills and strengths. Second, because personality conflicts and 'egos' were routinely identified as barriers to effective coordination, local partners should monitor individual perceptions and expectations. The roles and responsibilities questions in the 'Rutgers Routine Emergency Preparedness and Response Survey' provides an annual opportunity to impartially measure – and discuss – perceptions and expectations of each partner's capabilities and roles. Following the completion of the survey, those perceptions and expectations should be compared to actual responses to routine emergencies.

Clarifying Roles and Responsibilities

- **Strong Relationships and Clearly Defined Roles And Responsibilities Drive Successful Local Coordination.** Effective local emergency management coordination depends critically upon (1) the interpersonal relationships that people have built and continue to build with local partners, and (2) understanding organizations' roles and how they relate to local partner organizations during a local routine emergency.

  - **Broadening the definition of "organization" and "team" improves local preparedness and response.** Successful emergency response communities noted that organizational change to perceptions and mindset are crucial to emergency preparedness and response. As one interviewee stated, "You are not your organization but something greater." Yet, several interviews identified two common barriers: individual 'egos' and organizational 'cultures' that devalue or dismiss the need to work collaboratively. Developing an inclusive team mindset may require cultural and organizational shifts, but lives can literally depend on making these changes.

    For example, an EMS professional noted that lack of team orientation causes needless response delays during snowstorms in his municipality. Because contract EMS personnel are not considered municipal employees during snow emergencies, they must secure -- and wait for -- multiple levels of authorization for a roadway clearing to drive through the streets to provide emergency paramedic care. Furthermore, because EMS units are not included in emergency planning meetings, local emergency managers lack clear expectations of the types of EMS services that can be provided during a mass casualty or regional event.

    Start a new habit of 'early notification' of other partners for routine emergencies. While certain partners may not be part of the initial response, they would benefit from the early notification to prepare necessary supplies/ equipment and provide the best response/ treatment possible. However this requires communication and discussion to understand what roles organizations play and when they would be involved. Efforts made toward this

recommendation address a National Health Security Strategy Objective: 'Incorporate Post-Incident Health Recovery Into Planning and Response.'

- **Strengthen the Relationship and Coordination Efforts between Partners in the Health/ Healthcare Sector.** As evidenced in the survey, health and health care organizations seemed to overestimate their involvement in responding to routine emergencies, beyond what other response partners thought. While hospitals and FQHCs had a better idea of the role of local health departments within the health/healthcare arena, there were still gaps in understanding the role that they play in emergency preparedness at the local level, in general. Health and healthcare organizations need to clarify their contributions, value, and assets in order to assist more effectively in routine emergencies. This may mean that these entities need to build a stronger health/healthcare alliance to justify their cumulative worth to the traditional emergency responder family. Acting on this recommendation works toward achieving an objective of the National Health Security Strategy: 'Foster Integrated, Scalable Health Care Delivery Systems.'

- **Clarify the Roles of Organizational Leaders with Two Job Titles/ Multiple Functions.** Organizational leaders stated that one of the barriers to emergency preparedness and response was how to handle multiple job functions/ job titles. Several times, a local Office of Emergency Management Coordinator is also the local police or fire chief. In a local health department, a Health Officer can also perform the activities of a Registered Environmental Health Specialist on a routine basis. While having multiple perspectives and a diversified training background is beneficial, clearly defining when a role starts and what 'new' responsibilities are required based on the emergency is critical. This ensures that there is someone able to man that post and provide direction to subordinate staff. Conducting drills and exercises to become more familiar with 'switching hats' is important not only for the individual, but also for other response partners so that they have an opportunity to see and accept that person in their emergency role/ capacity.

- **Develop Mutual Aid Agreements Among Local Emergency Response Partners.** Formal and regularly updated Mutual Aid Agreements (MAAs) should spell out the specific resources (people, equipment) that would be expected to be shared in various emergency scenarios. In this way, all participating parties will be clear on what "interagency cooperation" means in each type of emergency situation. The monthly interagency meeting would be an ideal venue to identify necessary updates to MAAs and response plans. In addition, it is important to revise these plans annually. One interviewee noted that "planning should be top-down but pragmatic solutions are bottom-up." From this perspective, it makes sense to look at routine emergencies at the local level as the focal point for developing relationships and cross-agency protocol for emergency response.

One interviewee stated that standardization can lead to efficiency and aid in leveling expectations. Another said that Continuity of Operations Plans should also be 'Consistent,' and the framework should be standardized to the best extent possible. Templates of documents that spell out expected services can assist a deputy or second in command who needs to step into a leadership role during an emergency and move the process quickly. Several interviewees hoped that that state departments would demonstrate collaboration and develop those templates to be used by local entities. For examples of what has been developed by neighboring local communities, see Appendix D.

- **Hire professionals with a cross-discipline background.** Several interviewees cited that invaluable insight was gained from hiring someone who previously worked in another sector. Such professionals provide a perspective into their organization's needs and the assets, resources and processes of the previous organization or discipline. For example: A local OEM agency hired a professional who was a previous hospital employee. This employee's understanding of the hospital community and its players was integral to coordinating exercises and developing new cross-discipline grant projects.

Content Suggestions for Monthly Emergency Preparedness Meetings

- **Review and Improve Emergency Response Plans (with ICS) Among All Partners.** Developing and writing insightful, relevant and actionable plans is a challenge for many partners. Monthly meetings offer an ideal venue to draw upon the collective wisdom and experience of local partners, and it actively engages and educates them about perceived roles, responsibilities and resources that each partner brings in emergency scenarios. Multi-agency coordination of emergency response plans brings partners to the table as stakeholders in the response process, and reviewing an actual written plan promotes better accountability of actions during an event.

- **Staff Turnover Presents an Opportunity to Ensure Sustainability of Emergency Response Resources.** Several interviews highlighted the need for sustainability of emergency preparedness and response activities. Despite the decrease in federal and state funding for emergency preparedness, interviewees noted that people and leadership -- not money -- are the most valuable assets of local emergency preparedness and response. They also noted that turnover of personnel in key positions presents an opportunity for, rather than a barrier to, sustainability. By providing "new blood," staff turnover can provide renewed energy and insights into group coordination, and seasoned leaders can continually use the orientation and assimilation of new staff as opportunities to promote team dynamics.

- **Build Multi-Agency Recovery Capacity into Planning and Response.** Drill or conduct exercises that take into account the subsequent health related incidents and needs that can stem from a routine emergency event. This may require developing plans that outline an immediate response structure and a secondary, health-centric response framework. In addition, include non-traditional emergency response partners in these plans, such as building zone inspectors, power utility companies, outpatient facilities, United Way and other non-profit/ non-governmental organizations, and faith based organizations.

- **Coordinate Federal and State Funding Streams.** In times of declining resources, monthly meetings create a unique opportunity to identify and coordinate efforts to secure and manage federal and state grants. This allows for more cross sector collaboration and synchronizes overlap in grant requirements. In this way, organizations can work together to accomplish stated objectives, address gaps, improve response, and reduce the "silos mentality," which fosters redundancy and lack of communication.

- **Synchronize Training Requirements and offer Programs that Satisfy Multiple Certification Requirements**. Cross-over training courses that meet the requirements of multiple organizations (e.g. American Red Cross, CERT, MRC) help emergency responders to avoid the frustration of arriving at a scene and being unable to assist because of a lack of proper certification. Local preparedness and response organizations should provide these types of trainings to their employees and volunteers who may be called upon to assist during an emergency.

PART 5

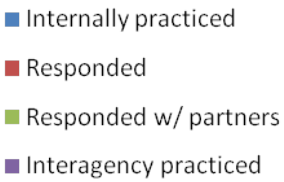
Conclusion

As a final note, interviews revealed that the 2009-2010 H1N1 Influenza Pandemic provided an excellent opportunity for local emergency preparedness and response partners to conduct real-world plan-do-study-act performance improvement cycles for an emergency scenario that requires the involvement of many key local emergency response partners (i.e., mass vaccination). Interviewees reported that, as local agencies practiced-by-responding for this type of event, they observed marked improvement in the coordination and effectiveness of response efforts (within local funding and staffing constraints). Jurisdictions that adjusted their response efforts and strategies after each round of local vaccination clinics were able to clarify roles and expectations for all response partners in a timely way, leading to more streamlined clinic operations by the end of the pandemic response effort. [19]

In conclusion, the authors strongly encourage communities to look upon the limited funding for emergency preparedness as an opportunity to develop new habits and implement the creative solutions and practices from successful local emergency response communities and national research. The findings of this report provide low-cost and realistic steps toward achievable, demonstrable, and positive results. When residents can see that emergency responders are working together to address local emergencies that affect and matter to them, it sends a very important and reassuring message and can bolster a community's perception of its own preparedness and resilience.

[19] Although the effectiveness of some local response continued to be limited by local funding and staffing constraints, interviewees reported that planning and responding together with their local partners improved the coordination and effectiveness of response. For example, one jurisdiction failed to include the finance department in their initial planning. When expense reports were submitted following the first round of clinics, the finance department informed the response agency that there was not sufficient budget to pay for the level of response staff involvement that had been planned. Given this constraint, the following rounds of clinics were staffed at a lower level than the first round (a decrease in capacity), but key partners (e.g., the finance department) were included in planning for all additional clinics (an improvement in coordination and realistic planning).

APPENDIX A: Survey Results
Practice vs. Actual Response by Discipline



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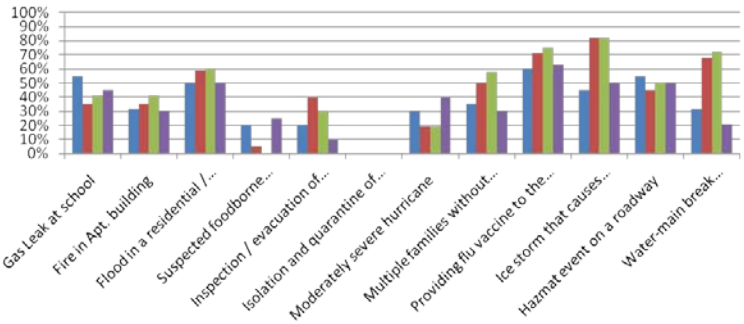

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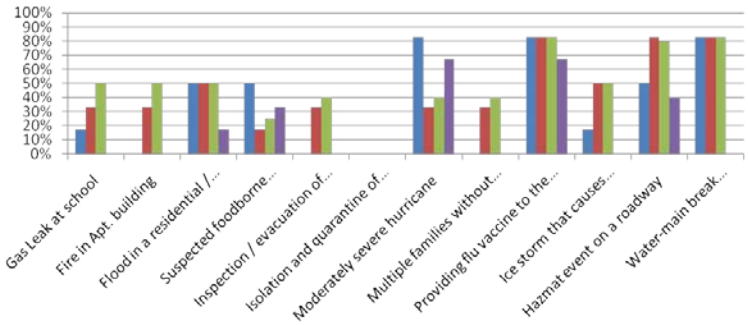

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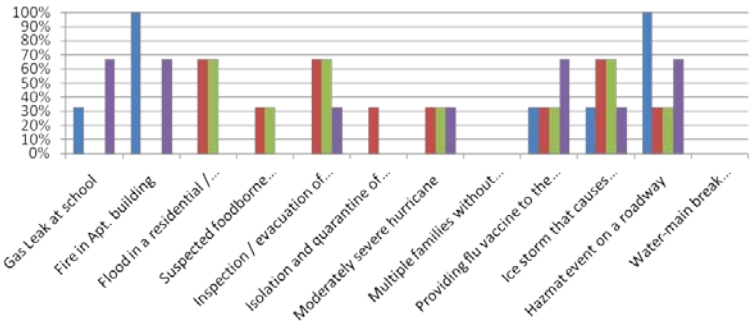

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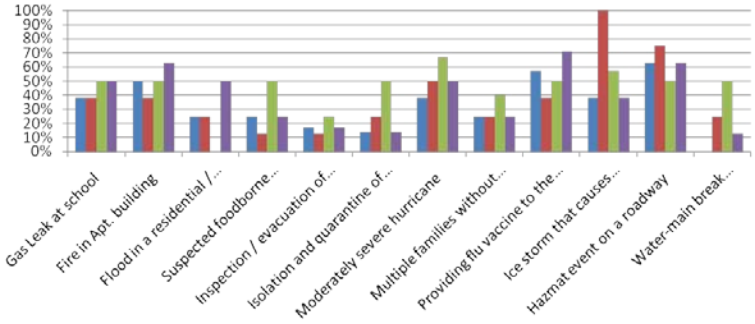

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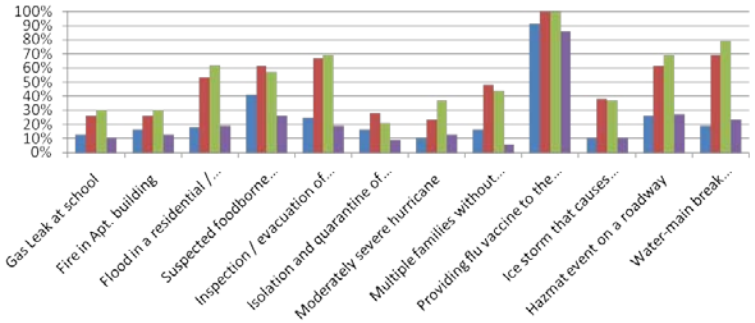

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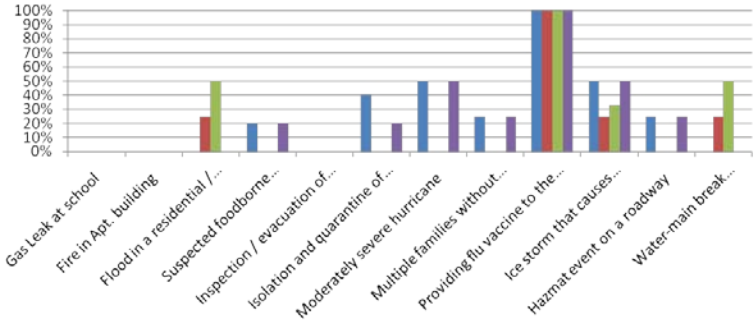

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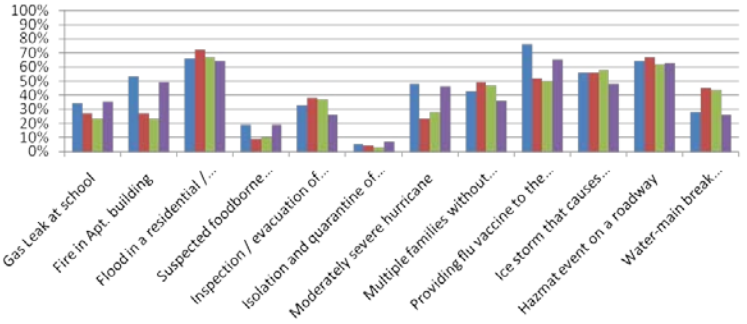
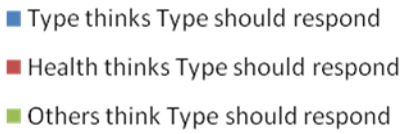


Survey Results: Perception of Roles and Responsibilities, by Discipline



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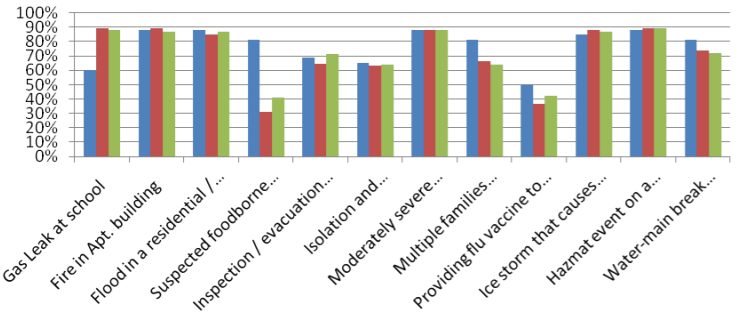

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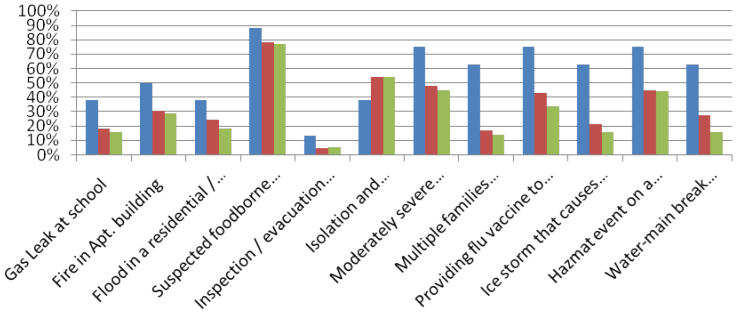
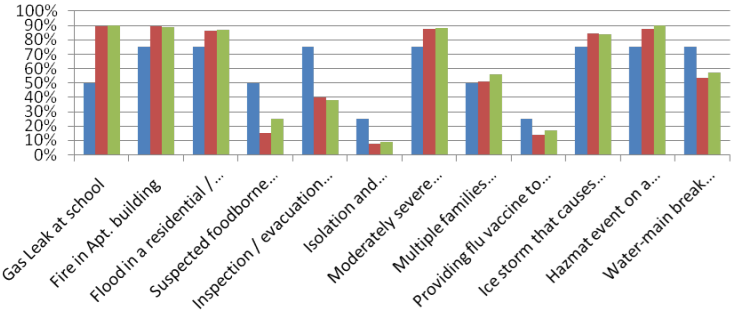


FIRE



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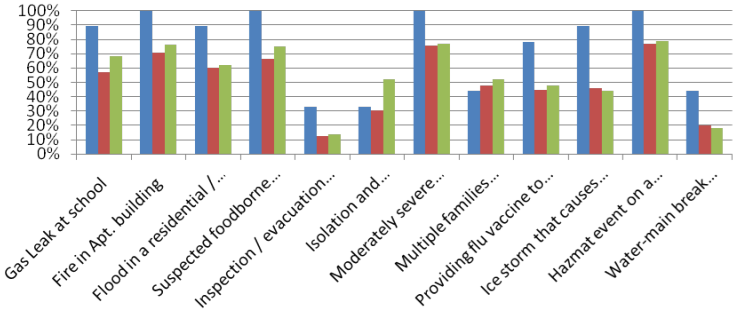

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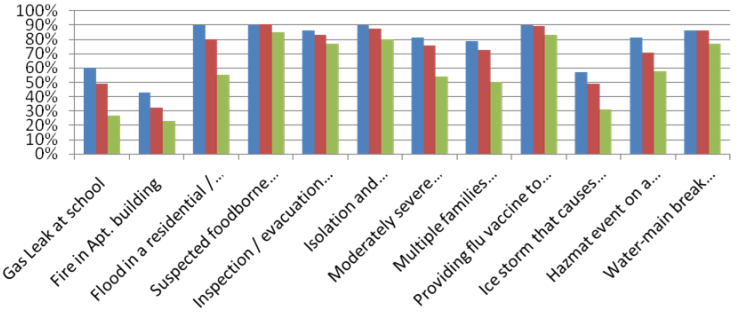

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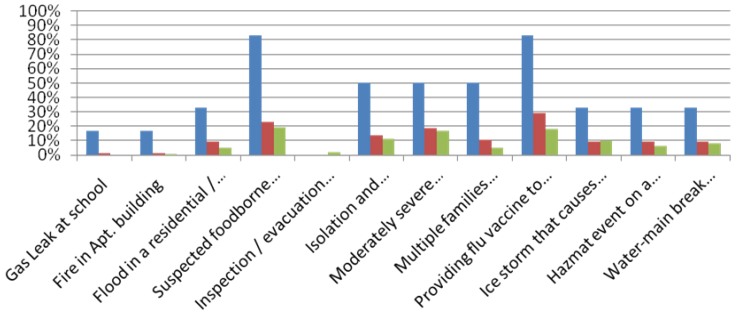

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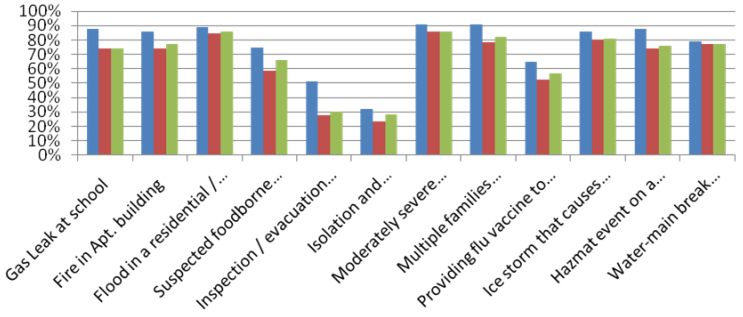
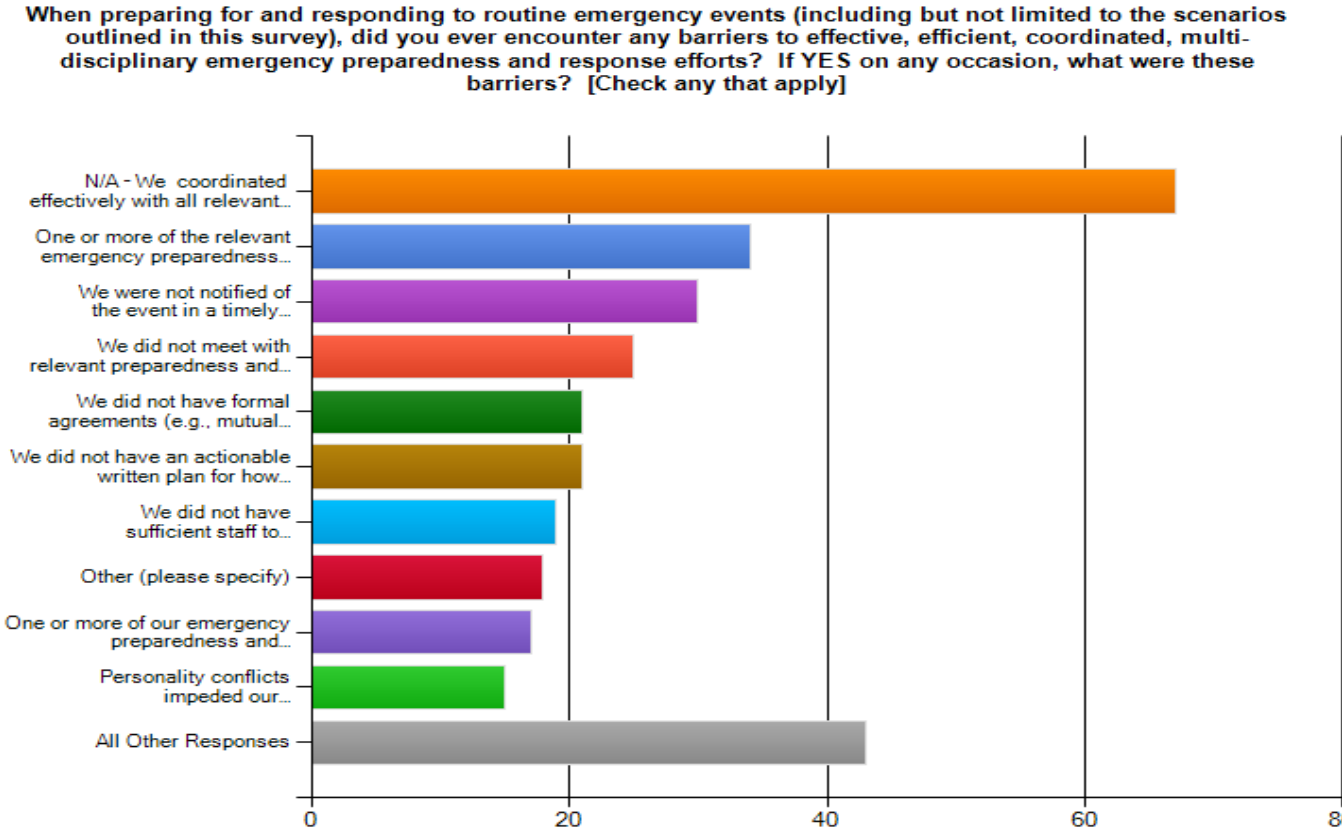


APPENDIX B

Survey Results: Barriers to Routine Emergency Response Collaboration



List of Barriers

1. N/A – We coordinated effectively with all relevant response organizations in all routine emergency events.

2. One or more of our relevant emergency preparedness and response partners was unclear about their role and responsibilities in the event.

3. We were not notified of the event in a timely manner by our emergency preparedness and response partners.

4. We did not meet with relevant preparedness and response partners to plan a coordinated response for this type of event.

5. We did not have formal agreements (e.g., mutual aid agreements) with relevant preparedness and response partners for the event.

6. We did not have an actionable written plan for how to respond to the event.

7. We did not have sufficient staff to respond to the event.

8. One or more of our emergency preparedness and response partners lacked appropriate training or credentials to assist with the event.

9. Personality conflicts impeded our response to the event.

* "All Other Responses" represents the cumulative responses to other barrier options, each of which had less than or equal to 11% of respondents:

- We were unable to reach key staff from a relevant preparedness and response partner during the event.

- We were unaware that we had a role in the event.

- We were unclear of our role and responsibilities in the event.

- We did not see the need to contact additional emergency preparedness and response partners for the event.

- We were unable to reach key staff from our organization during the event.

* 'Other' pertains to open-ended responses from 18 respondents. General themes of barriers mentioned include lack of staff (due to layoffs), lack of training (specifically in the Incident Command System or CERT volunteers unable to assist shelter residents because they lacked American Red Cross certification) or personnel trained in a particular function (lack of interpreters), and poor communication and communication equipment interoperability.

APPENDIX C

Public Health Emergency Preparedness and Response Routine Emergency Project: Follow- Up Interview Questions

Format for follow-up interview questions with workforce professionals:

1. Provide your name, job title and organization:
2. Are we responding to routine emergencies more collaboratively? Are we practicing more collaboration through responding to routine emergencies? Is this beneficial?
3. Are we more prepared to deal with routine emergencies?
4. Please describe the routine emergency event in which you encountered barriers to effective response and coordination with your preparedness and response partners (local OEM, health department, hospitals, FQHCs, LTCFs, EMS).
5. Please describe some of the barriers that made the response less effective, or increased the difficulty of the response.
6. Were there potential barriers that you dealt with effectively? If yes, which barriers and how did you overcome them?
7. Did you use ICS to respond to the event? Y/N, Why or why not?
8. Did it help to use ICS? Y/N, Why or why not?
9. Did you implement strategies to deal with a problem(s)? If so, when (during the scenario, after the scenario, before the scenario), and how did you come to that solution?

10. Did you use templates or base your changes on lessons learned or evidence-based programs? If so, what did you use? OR did you find you had to build your own templates?

11. What are some lessons learned on collaboration that you have identified?

12. Since that time, have you been able to test out your creative solutions? Have these changes improved relationships or improved response?

13. Do you think that regular interaction or monthly meetings with partners is beneficial or necessary for building collaboration? If so, why? What are barriers?

14. As funding and grant requirements decrease and we get farther away from 9/11/01, how do you think communities can sustain emergency preparedness planning and the cohesion that is required for collaboration?

APPENDIX D

Templates for Standard Operating Procedures, Resolutions and Memorandums of Agreement for Shared Services During an Emergency

Acknowledgements to Tabernacle Township Office of Emergency Management and the East Hanover Township Health Department:

- COUNTY/MUNICIPAL Resolution to Adopt Shared Service Agreement for Emergency Response
- Mutual Aid And Assistance Agreement Between Participating Units
- Authorizing Membership in a Mutual Aid and Assistance Agreement with Participating Units
- COUNTY/MUNICIPAL Resolution to Implement the National Incident Management System

COUNTY/MUNICIPAL Resolution to Adopt Shared Service Agreement for Emergency Response

[JURISDICTION NAME]
[COUNTY NAME] COUNTY, NEW JERSEY
RESOLUTION NO. _____

A RESOLUTION AUTHORIZING [JURISDICTION NAME] TO ENTER INTO A SHARED SERVICES AGREEMENT WITH THE COUNTY OF [COUNTY NAME]

WHEREAS, the [GOVERNING BODY] recognizes the need to provide residents of the County and its various townships with appropriate cost savings measures and opportunities for the benefit of all residents of the County; and

WHEREAS, [JURISDICTION NAME] has requested that [COUNTY NAME] County allow routing of [JURISDICTION NAME] Central Communications and “911” calls through the existing [COUNTY NAME] County Office of Emergency Management dispatch services that are paid for and administered by [COUNTY NAME] County; and

WHEREAS, the County and [JURISDICTION NAME] would maintain the mutual responsibilities as detailed in the attached Shared Services Agreement between the parties for the period of July 1, 2010 through June 30,2013; and

WHEREAS, [JURISDICTION NAME] evidences its desire to enter into such Agreement through passage of this resolution; and

WHEREAS, the County and [JURISDICTION NAME] are authorized by the “Shared Services Act”, N.J.S.A. 40A:65-4, et seq. to enter into any contract with joint provision of any service which any party to the agreement is authorized to render within its own jurisdiction; and

WHEREAS, the parties have agreed to participate as documented in the Shared Services Agreement between the County of [COUNTY NAME] and [JURISDICTION NAME] establishing the respective rights and obligations of the parties regarding this Shared Services Agreement;

NOW, THEREFORE, BE IT RESOLVED by [JURISDICTION NAME] that:

1. The attached Shared Services Agreement between [COUNTY NAME] County [DEPARTMENT/DIVISION NAME] and [JURISDICTION NAME] for utilization of the [COUNTY NAME] County [DEPARTMENT/DIVISION NAME] 911 call service shall be effective for the period of July I, 2010 through June 30,2013.
2. The [EXECUTIVE BRANCH LEADER, i.e., MAYOR] of [JURISDICTION NAME] is hereby authorized to sign, seal, execute and witness/attest the Agreement.
3. The [EXECUTIVE BRANCH LEADER, i.e., MAYOR] and [JURISDICTION] clerk are authorized to take any action necessary to implement the terms of the Shared Services Agreement.
4. The term of this Agreement shall be for a period of three (3) years commencing [START DATE] and terminating [END DATE].
5. All terms, conditions, and responsibilities between the parties as detailed in the attached Shared Services Agreement shall remain in full force and effect.

DATE [MONTH DAY, YEAR]: _____

[JURISDICTION] CLERK: _____

[EXECUTIVE BRANCH LEADER, i.e., MAYOR]: _____

Mutual Aid And Assistance Agreement Between Participating Units

[JURISDICTION NAME]

[COUNTY NAME] COUNTY, NEW JERSEY

MUTUAL AID AND ASSISTANCE AGREEMENT BETWEEN PARTICIPATING UNITS

THIS AGREEMENT (having a term which expires [DATE]) is made between the parties set forth on Schedule A (attached hereto) all of which are either: the County of [COUNTY NAME] and all of its departments; municipalities including but not limited to municipal police and public works, Emergency Medical Service, and fire departments; volunteer fire companies, EMS organizations, and Fire Districts; or other jurisdictions defined as "local governments" in the Homeland Security Act of 2002.[20] Hereinafter the parties may be referred to as "Participating Units," "Requesting Units," or "Responding Units."

WHEREAS, the President, in Homeland Security Directive (HSPD – 5), directed the Secretary of the Department of Homeland Security to develop and administer a National Incident Management System (NIMS) to provide a consistent nationwide framework for Federal, State, local, and tribal governments to work together more effectively and efficiently to prevent, prepare for, respond to and recover from domestic incidents, regardless of cause, size or complexity; and

WHEREAS, "The New Jersey Civilian Defense and Disaster Control Act," N.J.S.A. App.A9-33 et. seq., provides for the health, safety, and welfare of the people of the State of New Jersey during any emergency by centralizing control of all civilian activities having to do with such emergency, giving the Governor control over the resources of each and every political subdivision to cope with any condition that shall arise out of such emergency, and

WHEREAS, the State of New Jersey adopted the "Fire Service Resource Emergency Deployment Act," N.J.S.A. 52:14E-11 et. seq., to establish a mechanism for the coordination of fire service resources throughout the State that facilitates a quick and efficient response to any emergency incident or situation that requires the immediate deployment of those resources in order to protect life and property from the danger or destruction of fire, explosion, or other disaster, and

WHEREAS, the Director of the Division of Fire Safety in the Department of Community Affairs promulgated rules commonly referred to as the "Fire Service Resource Emergency Deployment Regulations" N.J.A.C. 5:75A et. seq., wherein N.J.A.C. 5:75 A-2.2 specifically requires each municipality or fire district to adopt a local fire mutual aid plan, and

WHEREAS, an emergency responder is defined as anyone employed by, contracted to provide services to, or otherwise affiliated with the Participating Units and possessing special skills, qualifications, training, knowledge, and experience beneficial to the mitigation of disaster situations. An emergency responder includes but is in no way limited to the following: law enforcement officers; fire fighters; emergency medical services personnel;

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[20] As defined in the Homeland Security Act of 2002, Section 2(10), the term "local government" means: a "county, municipality, city, town, township, local public authority, school district, intrastate district, council of governments… regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or in Alaska a Native village or Alaska Regional Native Corporation; and a rural community, unincorporated town or village, or other public entity." 6 U.S.C. 101(10)

physicians; nurses; other public health personnel; emergency management personnel; public works personnel; those persons with specialized equipment operations skills and training or any other skills needed to provide aid in a declared emergency, and

WHEREAS, the Participating Units recognize that entering into an agreement for mutual aid and assistance with each other to protect against loss, damage or destruction by fire, catastrophe, civil unrest, major emergency or other extraordinary devastation and to address those situations when additional aid and assistance is needed to protect the best interests of the persons and property in each individual jurisdiction.

NOW, THEREFORE, THE PARTIES HERETO AGREE AS FOLLOWS:

In consideration of the mutual benefits and covenants contained in this agreement, the Participating Units respectively agree as follows:

1. **Mutual Aid and Assistance.** Upon the request as provided herein, the Participating Units shall provide mutual aid and assistance to each other. Mutual Aid and Assistance shall include the following:

    a. Rendering of aid and assistance, including pre-established immediate response by one or more Participating Units to an emergency scene under the control and/or jurisdiction of another Participating Unit. Said emergency may include but not to be limited to fire, civil unrest, major criminal or emergency events, natural and man-made disaster, or catastrophe affecting the environment.

    b. Rendering of aid and assistance by one or more Participating Units to another Participating Unit to serve as supplemental reserve protection in the Requesting Unit's jurisdiction while the Requesting Unit is on an emergency call and/or otherwise currently unable to address emergency service needs in its jurisdiction.

    c. Participating in training exercises with other participating units, where the purpose of such training exercises is to coordinate and prepare for fire, civil unrest, major emergency, natural disaster, environmental disaster, and/or other emergency situations that are a threat to life or property.

2. **Requests for Mutual Aid and Assistance.** All requests for mutual aid and assistance shall be initiated through the [NAME OF COORDINATING AGENCY, i.e., COUNTY NAME, DEPARTMENT, DIVISION NAME] or its designee, in accordance with all procedures in effect at the time of the request. [COORDINATING AGENCY OR DESIGNEE] shall immediately summon Participating Units to the scene of an emergency in accordance with the pre-established policies and procedures in effect at the time of the request.

    a. Each local jurisdiction shall develop a Municipal Mutual Aid Plan to include mutual aid assistance to the levels they deem acceptable when measured against potential risks. Said information shall be submitted annually to the [COORDINATING AGENCY] for review by the appropriate coordinator prior to the first day of March each year.

        i. All Local Fire Mutual Aid Plans shall be in compliance with the New Jersey Fire Service Emergency Deployment Rules N.J.A.C. 5:75A et seq, specifically N.J.A.C. 5:75A-2.2.

        ii. The County Fire Coordinator, the County EMS Coordinator, or the County Prosecutor, where appropriate, will implement the Mutual Aid Plan for jurisdictions/agencies failing to submit plans as required in Section 2.a. above.

3. **Tactical Command and Authority at Emergency Scene.** The Incident Commander of the Requesting Unit shall have overall command authority of all Participating Units at the scene of the emergency. Participating Units of the fire service shall operate in compliance with the State Incident Management System N.J.A.C. 5:73-1.6(b).

4. **No Charge for Use of Personnel or Equipment.**

    a. No Participating Unit shall bill a Requesting Unit for wages, salaries, or use of equipment in making mutual aid and assistance responses, except as is provided for by a pre-existing separate agreement and/or as permitted within the regulations of the Stafford Disaster and Emergency Assistance Act, 42 U.S.C. 5121-5206 and the implementing regulations of 44 CFR 204 and 206, in which case reimbursements as permitted therein shall be recoverable as provided within said regulations.

    b. If fuel, chemical substances, crowd control gases, water additives, sterilized medical equipment, or other disposable goods are used for mitigation of the incident by a Responding Unit at a mutual aid and assistance response which will cause the Responding Unit to incur an expenditure to replace the same, and/or portable equipment requires repair or is lost, the Requesting Unit shall replace or, upon receipt of an appropriate voucher, reimburse the Responding Unit for the expenditure involved. Said reimbursement or replacement shall not be construed as payment or consideration for making the mutual aid and assistance response but only as an effort to compensate a Responding Unit for its actual cost outlay in replacing these expendable materials.

    c. This agreement does not supersede any agreement either formal or informal between jurisdictions (e.g. state or federal governments) or between Responding Units (e.g. fire departments of different municipalities).

    d. Participating Units, when possible, will be reimbursed in accordance with the Spill Compensation Control Act (N.J.A.C. 7:1E-5.3/N.J.S.A. 58:10-23.11e).

    e. This agreement recognizes the provisions as required by New Jersey Civilian Defense & Control Act App.9-33 et seq. and specifically Emergency Medical Services NJ.S.A.26:2K-60.

5. **Limitation of Providing Mutual Aid and Assistance.** Nothing contained in this Agreement shall be construed to require a Participating Unit to make a mutual aid and assistance response if the response will leave the Participating Unit's jurisdiction without sufficient police, fire, ambulance, and/or emergency protection.

6. **Death or Disability.** If any member of a Participating Unit suffers injury or death at the scene of a mutual aid and assistance emergency or training exercise, the member or the member's designee or legal representative shall be entitled to all salary, pension rights, worker's compensation and other benefits to which the member would be entitled if injury or death occurred in the performance of duties within the jurisdiction of the Participating Unit in accordance to N.J.S.A.40A: 14-26. Said rights, benefits, and compensation shall be paid by the Participating Unit and not by the Requesting Unit. Each Participating Unit shall be individually responsible for providing adequate benefits, coverage, and compensation for its members.

7. **Members Authority.** The members of each Participating Unit making a mutual aid and assistance response shall have the same powers and authority as the members of a Requesting Unit at the scene of the emergency in accordance with N.J.S.A. 40A: 14-156.2. Said members of a Participating Unit shall also have, while so acting, such rights and immunities as they would otherwise enjoy in the performance of their normal duties within their own jurisdiction.

8. **Liability Insurance.** Each Participating Unit shall maintain adequate liability insurance, the minimum limits of which shall be $1 million. Additionally, the Requesting Unit agrees to hold harmless a Participating Unit in the event of any lawsuit arising out of such assistance.

9. **Term; Withdrawal.** This Agreement shall commence upon signing by each of the Participating Units and shall continue in full force and effect through [MONTH DAY, YEAR]. Any Participating Unit may withdrawal from this Agreement by providing all other Participating Units and the [COORDINATING AGENCY] or its designee with sixty (60) days advanced written notice of withdrawal, clearly specifying the applicable date of withdrawal. In the event of withdrawal by any Participating Unit, this Agreement will continue in full force and effect for all remaining Participating Units.

10. **Legal Authority.** This Agreement for mutual aid and assistance is expressly made in accordance with N.J.S.A. 40A: 14-26 and 156.1 et seq.

11. **Entire Agreement.** This agreement constitutes the entire understanding between the Participating Units. This Agreement supersedes all communications, representations, and prior agreements, oral or written, between Participating Units with respect to the subject matter hereof.

IN WITNESS WHEREOF, [COORDINATING AGENCY] and each Municipality, Volunteer Corporation, or Fire District representing each Participating Unit has executed this Agreement and affixed its corporate seal on the date indicated. By executing this agreement, each Participating Unit acknowledges that said execution has been duly authorized by proper Resolution, a copy of which is annexed to this agreement.

The [PARTICIPATING UNIT NAME] has executed this agreement on the [DATE AGREEMENT WAS EXECUTED].

Authorized Signature: _____ Official Title: _____

Authorized Signature: _____ Official Title: _____

[PARTICIPATING UNIT]

RESOLUTION NO. _____

Authorizing Membership in a Mutual Aid and Assistance Agreement with Participating Units

WHEREAS, mutual aid and assistance agreements between municipalities, counties, law enforcement agencies, police, Emergency Medical Service, fire departments, fire companies or EMS organizations, and fire departments situated in fire districts operated by a Board of Fire Commissioners are permitted pursuant to N.J.S.A. 40A: 14-26 and 40A: 14-156.1; and

WHEREAS, the President, in Homeland Security Directive (HSPD–5), directed the Secretary of the Department of Homeland Security to develop and administer a National Incident Management System (NIMS) to provide a consistent nationwide framework for Federal, State, local, and tribal governments to work together more effectively and efficiently to prevent, prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity; and

WHEREAS, "The New Jersey Civilian Defense and Disaster Control Act" App.A9-33 et. seq, provides for the health, safety, and welfare of the people of the State of New Jersey during any emergency by centralizing control of all civilian activities having to do with such emergency, giving the Governor control over the resources of each and every political subdivision to cope with any condition that shall arise out of such emergency, and

WHEREAS, The Director of the Division of Fire Safety in the Department of Community Affairs promulgated rules in accordance with the "Fire Service Resource Emergency Deployment Act," N.J.A.C. 52:14E-ll et. seq., commonly referred to as the "Fire Service Resource Emergency Deployment Regulations" NJ.A.C. 5:75A et. seq., and

WHEREAS, it is deemed to be in the best interests of the residents of this municipality and/or fire district to enter into a mutual aid and assistance agreement with the [COORDINATING AGENCY] and other Participating Units, including but not limited to municipal police, Emergency Medical Service or fire departments, volunteer fire companies or EMS organizations, and fire districts, to provide additional protection against loss, damage, or destruction by fire, catastrophe, civil unrest, major emergency, or other extraordinary devastation damage or destruction to person and property in those situations when outside aid and assistance is needed.

NOW, THEREFORE, BE IT RESOLVED, by the [GOVERNING BODY] of the [PARTICIPATING UNIT], County of [COUNTY IN WHICH PARTICIPATING UNIT IS LOCATED] and State of New Jersey as follows:

A. That the [GOVERNING BODY EXECUTIVE] is hereby authorized and directed to enter into the [COORDINATING AGENCY] Mutual Aid and Assistance Agreement Between Participating Units, a copy of which is attached hereto and made part hereof, on the terms and conditions contained herein.

B. That the [GOVERNING BODY EXECUTIVE] and [PARTICIPATING UNIT] Clerk are hereby authorized and directed to execute said Mutual Aid and Assistance Agreement on behalf of the [PARTICIPATING UNIT].

C. That the [PARTICIPATING UNIT] Clerk is hereby authorized and directed to forthwith file a certified copy of this Resolution and an executed copy of the Agreement with the [COORDINATING AGENCY]. Said [COORDINATING AGENCY] shall serve as the central repository and shall maintain a master listing of all Participating Units to the Mutual Aid and Assistance Agreement.

DATE [MONTH DAY, YEAR]: _____

[PARTICIPATING UNIT] CLERK: _____

[GOVERNING BODY EXECUTIVE, i.e., MAYOR]: _____

COUNTY/MUNICIPAL Resolution to Implement the National Incident Management System

[JURISDICTION NAME]

[COUNTY NAME] COUNTY, NEW JERSEY

RESOLUTION NO. _____

A RESOLUTION IMPLEMENTING THE NATIONAL INCIDENT MANAGEMENT SYSTEM

WHEREAS, in Homeland Security Directive (HSPD)-5, the President directed the Secretary of the Department of Homeland Security to develop and administer a National Incident Management System (NIMS), and the Governor issued Directive Number 50 to provide that consistent nationwide approach for federal, state, county and municipal governments to work together more effectively and efficiently to prevent, prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity; and

WHEREAS, the collective input and guidance from all state, local, and county homeland security (Emergency Management) partners has been, and will continue to be, vital to the development, effective implementation, and utilization of a comprehensive NIMS; and

WHEREAS, it is necessary that all state, county, and municipal emergency management agencies and personnel coordinate their efforts to effectively and efficiently provide the highest levels of incident management; and

WHEREAS, to facilitate the most efficient and effective incident management, it is critical that state, county, and municipal organizations utilize standardized terminology, standardized organizational structures, uniform personnel qualification standards, uniform standards for planning, training, and exercising, comprehensive resource management, and designated incident facilities during emergencies or disasters; and

WHEREAS, the NIMS standardized procedures for managing personnel, communications, facilities, and resources will improve the ability of the [JURISDICTION] to utilize federal funding to enhance local agency readiness, maintain first responder safety, and streamline incident management processes; and

WHEREAS, the Incident Command System components of NIMS are already an integral part of various incident management activities throughout the state and county, including all public safety and emergency response organizations training programs;

NOW, THEREFORE, BE IT RESOLVED, that, pursuant to the authority vested in [JURISDICTION GOVERNING BODY] and by the Emergency Management Act, N.J.S.A, Appendix A; 9-30 et seq. (Chapter 251, P.L. 1942, as amended by Chapter 438, P.L. 1953; Chapter 405, P.L. 1985; and Chapter 222, P.L. 1989), the [JURISDICTION GOVERNING BODY] does hereby mandate that the National Incident Management System be utilized for all incident management in [JURISDICTION NAME] and wherever mutual aid and assistance may be rendered.

BE IT FURTHER RESOLVED, this is to take effect immediately.

DATE [MONTH DAY, YEAR]: _____

[JURISDICTION] CLERK: _____

[EXECUTIVE BRANCH LEADER, i.e., MAYOR]: _____

APPENDIX E

TEMPLATE CONTACT LIST FOR COMMUNITY EMERGENCY RESPONSE PARTNERS

Fill in all that apply. Add fields as needed.

Organization Name	**Population Served**	**Primary Contact**	**Primary's Phone #**	**Primary's email**	**Backup Contact**	**Backup's Phone #**	**Backup's email**
County Office of Emergency Management							
Local Office of Emergency Management							
County Health Department							
Local Health Department							
[Name of] Hospital(s)*							
NJDHSS Medical Coordination Center (MCC)							
Federally Qualified Health Center (FQHC)							
Emergency Medical Services Provider							
Local Police Department							
Local Fire Department (s)							
Department of Public Works							

American Red Cross Chapter							
Superintendent of Schools							
Building Code Inspectors							
Power Utility Company							
Long Term Care Facility							
Other							

*A community may have multiple hospitals. We encourage you to list all of the hospitals and healthcare facilities (both inpatient and outpatient) where you will expect your residents to be taken in the event of an emergency. As for points of contact at the hospital, there could be multiple appropriate contacts (Infectious Disease Control Practitioner, Safety and Environmental Control Coordinator, Security/ Facilities Manager, Emergency Preparedness Coordinator, Emergency Department phone number, etc.)

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