EMERGING BIOLOGICAL THREATS AND PUBLIC HEALTH PREPAREDNESS: GETTING BEYOND GETTING READY

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON EMERGING THREATS, CYBERSECURITY, AND SCIENCE AND TECHNOLOGY

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EMERGING BIOLOGICAL THREATS AND PUBLIC HEALTH PREPAREDNESS: GETTING BEYOND GETTING READY

July 22, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON EMERGING THREATS, CYBERSECURITY, AND SCIENCE AND TECHNOLOGY,
Providence, RI.

The subcommittee met, pursuant to notice, at 10:30 a.m., at Rhode Island State House, Smith Street, Room 313, Providence Rhode Island, Hon. James Langevin [Chairman of the subcommittee] presiding.

Present: Representatives Langevin and Pascrell.

Also present: Representative Christensen.

Mr. LANGEVIN. The Committee on Homeland Security will come to order. The committee is meeting today to receive testimony on "Emerging Biological Threats and Public Health Preparedness: Getting Beyond Getting Ready."

Well, good morning. I'd like to thank my colleagues, Congressman Bill Pascrell from New Jersey and Congresswoman Donna Christensen from the Virgin Islands joining us here today. Welcome to Rhode Island. You've traveled all this way to be with us.

I'd also like to thank our witnesses on the Federal panel for traveling here today, as well as welcoming and thanking our Rhode Island witnesses and guests. It's certainly an honor for me to be able to tackle such an important issue here in my own State and also to highlight the practical efforts and best practices of the State of Rhode Island and to have your expertise and your guidance in these efforts.

Today, we will discuss the challenges States and localities face in preparing for and responding to emerging biological threats such as pandemic influenza or weaponized anthrax, among other things, that could affect every sector of society and every person potentially on a global scale.

Efforts to address biological threats are among the most difficult. In fact, they are so challenging that for decades planning for situations involving biological terrorism using diseases such as smallpox, emerging infectious diseases such as ebola, or re-emerging infectious diseases such as pandemic influenza took a back seat to planning for other situations where response would be more straight forward, such as terrorism or accidents involving chemicals.

Now this, obviously, has changed. Our Government no longer considers planning and preparedness for biological threats to be too hard, nor do we think that they are unlikely events. We've effectively determined what we need to do save lives, but clearly, more needs to be done.

Now we all remember the anthrax events of 2001. Before and since then, there have been other biological incidents that have made equally vivid impressions. The outbreak of SARS, West Nile fever, extensively drug-resistant and multi-drug resistant tuberculosis; outbreaks of meningitis and mumps on college campuses; super bugs such as MRSA and VRSA; and the recent cases of salmonella and E. coli that have tainted our Nation's food supply are only a few that have occurred here in the United States.

Time and again, public and private sectors have responded to these threats, but not without difficulty. Our Nation prides itself on confronting the tough issues and not shying away from a fight.

The citizens of Rhode Island exemplify this and it's because of them and others like them throughout our great Nation that we're here today.

It comes down to saving lives. In the case of pandemic influenza and diseases caused by some agents of bioterrorism, in the best case scenario we expect hundreds of thousands of people to become sick across the Nation. In the worst case scenario, hundreds of thousands could be sick just in one State or territory with death resulting.

Now in the case of a biological weapons attack, I'm mindful of the findings of the Hart-Rudman Commission on U.S. National Security in the 21st Century which stated and I quote: "Terrorists and other disaffected groups will acquire weapons of mass destruction and mass disruption and some will use them. Americans will likely die on American soil, possibly in large numbers."

It's a sobering finding. The price we have to pay in terms of lives, the economy, and society is too great to make preparedness for these events a low priority. Now we've increased our readiness for any number of biological threats and it is clear to me, and my colleagues on the subcommittee that our resources and efforts have gone into ensuring that we're more prepared. I know that those we have invited to provide testimony today would agree that clearly still more needs to be done and we have to also work to get beyond getting ready and we have to actually be ready.

Now we've established and added to Federal and State stockpiles of drugs and equipment, but we're not ready yet. We've engaged in planning efforts, but we're not ready yet. We've done a great deal of research on developing methods to get us new drugs and better treatments faster, but we're not ready yet. We've increased communications between public and private sectors, but we're not ready yet.

Although we recognize that difficult decisions will need to be made regarding the delivery of medical care, when resources are short, and patients number in the millions, we're not ready yet to make those decisions.

There are many issues that need to be addressed, but among them the most important are encouraging different sectors to partner with each other to counter these threats; integrating efforts to

increasing efficiencies in public health and emergency response to biological events and helping our health care professionals save as many lives as possible when resources are strained by biological disaster.

Now when it comes to large-scale issues like diseases for which we have few or no treatments and which could sweep across the country and the world, it's clear that no one sector or entity is solely responsible for prevention, deterrence, preparedness, detection, response, recovery, or mitigation. Different sectors must partner with each other and the kinds of partnerships that we need to see between the Department of Homeland Security and the Department of Health and Human Services or the State Emergency Management Agency and the State Department of Health are critical.

There are hundreds, if not thousands of efforts going on right now to address Federal requirements for getting ready for a variety of different situations that would affect the health of the public. Now we've talked about coordinating those efforts before, but we need to go from coordinating to integration.

Public health and public health care resources are limited, so the efforts of these sectors need to be as efficient as possible. This efficiency must be inherent in what the Federal Government is asking the non-Federal, public, and private sectors to do, the way shelf life is extended for various medications and the way grants and planning guidance go out to the States and the territories—in a way that truly means to hold the States and territories accountable to the Executive branch, and the Executive branch accountable to the Congress and ultimately to the American people.

Decisionmaking when lives are at stake is difficult at best especially when large number numbers of people could be affected. I realize that there are certain decisions that no leader wants to make. But emergencies, disasters, and catastrophes demand this of us. To the greatest extent possible, we need to decide now what we're going to do when the number of people ill with a disease far exceeds the number of resources available to treat them.

The Federal Government has issued some guidance in these and other areas, but we have not made enough headway. Everyone needs to roll up their sleeves, work their way through these challenges and develop decisionmaking criteria for those that will have to make the tough calls in the midst of a crisis. We must not back down from the fight against biological threats of any type whether naturally occurring or intentionally produced by a terrorist. We cannot let artificial situations like boundaries between States and countries or change of administrations keep us from continuing that fight.

I certainly appreciate the efforts of the public and the private sector witnesses here today. Together, we will address a number of issues including partnering across sectors and creating greater efficiency in public health and other preparedness efforts and making the most difficult decisions of all, those that affect the lives of our families, our friends and our citizenry.

Again, I want to thank everyone for being here this morning and also I want to point out something. It has certainly taken a tremendous amount of work to put this hearing together and I appreciate the interest that is shown by the number of people who have

turned out for the hearing today. We also have an overflow room down in the House Finances Committee room down in the basement. However, if the room gets too crowded and people get uncomfortable and want to go down there—I thank everyone for attending.

Because this is an official congressional hearing, it was also mentioned that we have to abide by certain rules of the committee and of the U.S. House of Representatives, so I would kindly ask that there be no applause of any kind or any kind of demonstration with regards to testimony. I would also ask that cell phones be turned off and put on vibrate mode. It's important to respect the decorum of the rules of the committee and again, I want to thank everyone for being here.

With that, I would just ask if any Members have opening statements they would like to make?

I'm reminded of the committee rules that opening statements may also be submitted for the record.

Well, let me begin by welcoming our Federal panel here today. I want to begin by welcoming our first panel of witnesses. Our first witness is Dr. Jeff Runge. He is the Assistant Secretary for Health Affairs and the Chief Medical Office of the Department of Homeland Security. This will be his last appearance before this or I believe any committee of the Congress as he's set to depart from his current post and we thank you for your service, Dr. Runge. We thank you for being here.

Dr. RUNGE. Mr. Chairman, thank you.

Mr. LANGEVIN. Our second witness is Rear Admiral Craig Vanderwagen, Assistant Secretary for Preparedness and Response at the Department of Health and Human Services. Dr. Vanderwagen was the senior Federal health official in response to Hurricane Katrina and Rita. Welcome to you, Dr. Vanderwagen.

Our third witness is Dr. Michael Kurilla, Director of the Office of Biodefense Research Affairs for the Institute of Allergy and Infectious Diseases at the National Institutes of Health; and also Dr. Daniel M. Sosin, Director of the Biosurveillance Coordination Unit at the Centers for Disease Control and Prevention for being here to answer questions in regard to the Agency's efforts specifically and also Captain Peter Boynton is here to answer questions as the Deputy Regional PFO.

With that, without objection the witnesses' full statements will be submitted for the record and I now ask each witness to summarize their testimony for 5 minutes, beginning with Dr. Runge, who as a courtesy will actually be given a couple extra minutes since he's departing.

Welcome, Dr. Runge.

STATEMENT OF JEFFREY W. RUNGE, MD, ASSISTANT SECRETARY FOR HEALTH AFFAIRS AND CHIEF MEDICAL OFFICER, DEPARTMENT OF HOMELAND SECURITY

Dr. RUNGE. Mr. Chairman, thank you for the going-away present. I want to thank you for the chance to be here with the subcommittee, and I also want to thank Congressman Pascrell and Dr. Christensen for making the trip. I'm a veteran of these field hearings. I know it's not the easiest thing to be here and you all

have consistently demonstrated your interest and passion on this issue and I want to thank you for being here.

Mr. Chairman, I also wanted to thank you publicly for all that you have done to ensure the success of our new Office of Health Affairs. You have sat through the classified briefings. You have been a great partner with you and your staff and I really appreciate your helping us accomplish what we have been able to do.

As you and I have discussed, our efforts toward readying our Nation for widespread disease outbreaks are not centered solely around pandemic influenza, but on the broader threat. Fortunately today on the panel are the Nation's preeminent experts on pandemic management, so I'm not going to dwell on that topic. We'll take a slightly different tack on emerging infectious diseases by discussing the intentional use of biological agents against our Nation.

The multi-use biological preparedness planning that we've been doing in preparation for a pandemic will pay off regardless of whether an attack is naturally occurring or a terrorist attack. But it's the intentional use of biological agents by a terrorist or terrorist group that keeps me up at night. I'd ask the subcommittee to consider first the current biological threat environment and the effect that a biological attack might have in a mid-size city like Providence, Rhode Island; second, the need for effective biosurveillance and environmental detection; and third, the roles and responsibilities of Federal, State, and local governments and the private sector and the public down to the family level in responding to and recovering from a biological attack.

Now this discussion is not to cause fear and we're not fearmongering here. Rather, making the public aware of and prepared for such an event creates, in our view, a more resilient community. By reducing the elements of surprise and creating a culture of readiness, we can eliminate the terror associated with such a horrific event and make the public's reaction a key part of the solution to a successful response, rather than part of the problem.

So what is the risk? We believe that a large-scale, biological attack on the Nation is significant. We know that terrorists have sought to use biological agents as instruments of warfare and we are searching for better assessments of their capability. Our intelligence sources have determined that in the late 1990's, al Qaeda began developing a biological weapons program for anthrax production. Fortunately, this facility was disrupted by our military during Operating Enduring Freedom, but the intent to use biological agents as a weapon of mass destruction has not gone away.

You may recall that in 2002 al Qaeda stated that they had the right to kill 4 million Americans, 2 million of them children. An advisor to bin Laden later increased that number to 10 million. There are not many weapons that can kill millions of people, but it can come close if one considers a coordinated attack on multiple cities. This should not be confused with the type of anthrax attack that occurred through the mail in 2001 which killed five people and injured three times that many. Even though it cost disruption to the Postal Service's building in Washington and elsewhere, it had an economic impact in the billions.

The magnitude in both lives and economic effects is very, very small when compared to the scenario of an aerosolized anthrax attack envisioned by our enemies. It is that threat which we vigorously plan on, invest in, and intend to defeat. We cannot depend strictly on receiving action or specific warning of an imminent biological attack which is why it is imperative that we continue to enhance our Nation's efforts to provide the earliest possible detection and warning immediately after an attack, to strengthen our preparedness and response efforts and to increase our capacity to recovery, physically, psychologically, and environmentally.

While it may be easy to assume that terrorists are only interested in striking major cities like Washington, DC or New York City, we cannot ignore the attractiveness of softer targets to our enemies. No one can forget that Oklahoma City experienced the horrors of terrorism when a truck bomb was detonated in the Murrah Federal Building killing 168 people including 19 children, and injuring hundreds more. Who would have thought that Oklahoma City would have been a target for terrorism? Is it therefore imperative that every State and every local jurisdiction be adequately prepared to handle catastrophic events across the threat spectrum.

The city of Providence, Mr. Chairman, like many mid-sized cities has a number of characteristics that make it and many cities like it a potentially attractive target, proximity to military assets, concentrated population, and a vital transportation route along the East Coast. Without an environmental detection system in place, an aerosolized anthrax would not necessarily be detected in time for HHS and local health providers to provide prophylactic antibiotics. Clinical symptoms of inhalational anthrax would appear after 2 to 6 days following the release. But the earliest clinical cases would be harbingers of tens of thousands or more, nearly all requiring intensive care in medical facilities including ventilatory support and whatever anthrax countermeasures we have in the national stockpile. But by then the die is cast. We predict that if an attack of a plausible magnitude were directed at Providence, the number around 180,000 people would be exposed to a sufficient dose of anthrax spores to make them ill and we would expect about 90 percent of those to die without aggressive treatment which in those numbers may simply not be available.

We can reduce the numbers of people who would die only by ensuring that affected people receive treatment before they show symptoms. This requires an environmental warning system. Moreover, without detection devices to characterize the area of exposure, I'm very concerned about managing the immediate aftermath with respect to giving valid information to the public about the extent of the release and the maintenance of public confidence.

Mr. Chairman, the response to such an attack would be a monumental effort requiring seamless cooperation and coordination at all levels of government. That's why Congress created DHS. We do not provide the health care or the medical countermeasures. HHS does that. We do not catch the bad guys. FBI and local law enforcement does that. We don't clean the environment. EPA does that. We do not manage the international ramifications of such an attack. The Department of State does that.

We do, however, Mr. Chairman, have the responsibility for coordination of all of those efforts and for several programs that are multi-agency and are under your oversight jurisdiction. They are crucial and in need of the support of the subcommittee.

While we're continuing to make significant strikes in our BioWatch Program which provides that early and necessary detection of biological attack, we are quickly moving toward the next generation of detectors that will significantly reduce that time to allow our health providers to get countermeasures into the hands of the affected populations within the time window to save lives. However, we need the funding to continue this vital progress.

We are also developing the National Biosurveillance Integration Center known as NBIC, authorized in the 9/11 Act, which brings together data from other Federal departments, the public domain and eventually the private sector in State and local governments to understand and characterize biological events and incidents across the areas of human health, animal health, food, water, and the environment.

Mr. Chairman, I have a number of recommendations for the subcommittee to consider which I put into my written testimony and I will enumerate here.

Again, I sincerely appreciate your personal dedication toward the security of the Nation. It has been a real pleasure working with you, with Dr. George, with Chris Beck and others on the committee staff during my time at DHS. I think I have created an office that is completely ready for the transition. I'm the only political in the office in the programmatic area and I think we're ready. I would ask for the subcommittee's continued support of my career staff in the office.

Thank you, Mr. Chairman.

[The statement of Dr. Runge follows:]

PREPARED STATEMENT OF JEFFREY W. RUNGE

JULY 22, 2008

INTRODUCTION

Good morning Mr. Chairman. Thank you for the opportunity to testify before the subcommittee on this important and timely issue. My colleagues and I have testified before your subcommittee on several occasions on this topic, and I appreciate your continued interest in ensuring that an outbreak of a disease, intentional or natural in origin, does not threaten our homeland security, economic stability, and our Nation's critical infrastructures and key resources. I am thus pleased to have the opportunity to share our views with you and your constituents through this hearing in Providence, RI.

As you know, Mr. Chairman, this is one of the last events where I will appear as the Assistant Secretary for Health Affairs and Chief Medical Officer of the Department of Homeland Security (DHS), as I will be leaving Federal service at the beginning of August. I delayed the timing of my departure in order to testify once again to the urgency and importance of giving sufficient attention to biological threats to our Nation. At this, my last hearing, I would like to take this opportunity to thank you personally for all that you have done to ensure the success of the Office of Health Affairs and our mission to make the Nation safer and more secure.

Today I will discuss a number of important issues surrounding emerging biological threats and our Nation's preparedness, including: the current biological threat environment as illustrated by the effect a biological attack might have in a city like Providence, our approach to biosurveillance and environmental detection, and the roles and responsibilities of Federal, State, local and the private sector in response to and recovery from a biological attack. Providing this information to the public creates a more resilient public. By reducing the elements of surprise, fear and panic,

we can reduce the terror associated with such an event, making the public reaction a key part of the solution rather than the problem.

CURRENT BIOLOGICAL THREAT

The risk of a large-scale biological attack on the Nation is significant. We know that our terrorist enemies have sought to use biological agents as instruments of their warfare, and we believe that capability is within their reach.

I know many here today recall the anthrax attacks of 2001. As you know, Mr. Chairman, certain buildings occupied by Members of the Legislative branch were temporarily closed while they were decontaminated. The magnitude of that terrorist attack is miniscule compared to the larger, anthrax release envisioned by our enemies. It is nonetheless exemplary of the potential health and economic damage to which we are vulnerable. Unfortunately, the threat has not diminished since then—in fact, it has been building since well before the attacks of 9/11.

We know that, in the late 1990's, al Qaeda began developing a biological weapons program and constructed a low-tech facility in Qandahar, Afghanistan for anthrax production. Fortunately, U.S. military forces disrupted this activity and additional American and coalition operations in the region have damaged al Qaeda leadership and operational capabilities—but not their intent to use biological weapons. You will recall that in 2002, al Qaeda stated that they had the right to kill 4 million Americans—2 million of them children—and cripple thousands. An advisor to bin Laden later issued a fatwa on the permissibility of using weapons of mass destruction and increased the 4 million casualty figure to 10 million.

We have determined that al Qaeda seeks to develop and use a biological weapon to cause mass casualties in an attack on the homeland. Our analysis indicates that anthrax is a likely choice; and a successful single-city attack on an unprepared population could kill hundreds of thousands of citizens. A coordinated attack on multiple targets would come much closer in magnitude to our enemy's goal. Because of this, we see the threat of an aerosolized anthrax attack as our No. 1 bioterrorism concern, and it is that threat which we vigorously plan, invest and intend to defeat. Our efforts are not optional or discretionary. The ramifications of such an attack include tremendous loss of life, economic costs, damage to critical infrastructure, and unprecedented environmental contamination.

A biological attack would impact every sector of our society—not just the medical and public health communities. A biological attack respects no geographic or geopolitical boundary and will have an impact well beyond our Nation's emergency departments and public health infrastructure. Absenteeism across multiple sectors due to illness, fear of contagion, or public health measures could threaten the function of critical infrastructure, the movement of goods and services, and the operation of our institutions. No Federal department or agency will be exempt from the consequences of such an attack. Further, critical life-saving activities will depend on actions taken in the first few moments of the event. State and local governments will be called on to take several critical actions—alerting the public of the crisis without inciting panic; maintaining public confidence while making critical decisions; and bolstering local communities to rebound quickly.

As we work together to counter this threat, we must keep in mind that acts of biological terrorism don't go "bang." It could be hours or even days before we realize the full extent of an incident. Because of the lack of an explosion or immediate visual damage, many do not perceive the threat of bioterrorism to be as significant as that of a nuclear or conventional strike, even though such an attack could kill as many people as a nuclear detonation and have its own long-term environmental effects. This has caused a lack of public urgency in devoting significant resources to countering this threat—a luxury we simply cannot afford.

Mr. Chairman, many people ask me "what keeps you up at night?" It is the possibility of a large-scale biological attack on our homeland.

THREAT AWARENESS

Given the challenges we face in assessing current terrorist capabilities and identifying plots, it is unlikely that we will receive actionable or specific warning of an imminent biological attack. Furthermore, many of these deadly biological agents, including anthrax, are readily available in nature, relatively easy to procure, culture, and weaponize. There are numerous domestic and international biological research programs using these agents for legitimate purposes, making it more difficult to separate the ill-intentioned research initiatives. As a result, it is unlikely that we will have credible knowledge of an imminent biological threat before it occurs.

This is why it is imperative that we continue to enhance our Nation's efforts to disrupt biological plots, provide the earliest possible detection and warning of an at-

tack, strengthen our preparedness and response efforts, and increase our capacity to quickly recover.

Secretary Chertoff and I have been promoting the inclusion of health and medical expertise in our State and local fusion centers as they develop and expand. OHA is working with the DHS Office of Intelligence and Analysis to provide information on biological threats to communities in harm's way and to encourage fusion centers to tap into local expertise in public health and health care to be a part of their information fusion. We have begun discussions with the HHS Assistant Secretary for Health regarding the incorporation of officers from the corps of the U.S. Public Health Service to help communities achieve this capability. DHS will be holding meetings in the late summer and early fall with States and local representatives with the goal of providing information on the biological threat and discussing the value of public health in fusion centers.

PROVIDENCE, RI

While it is easy for us to assume that terrorists are only interested in striking major cities such as Washington, DC or New York City, we cannot ignore the attractiveness of softer targets to our enemies. On April 19, 1995 Oklahoma City experienced the horrors of terrorism when a truck bomb was detonated in front of the Alfred P. Murrah Federal Building, killing 168 people, including 19 children, and injuring hundreds more. Who would have thought that Oklahoma City would have been a target for terrorism? It is therefore imperative that all States and local jurisdictions are adequately prepared to handle events across the chemical, biological, radiological and nuclear spectrum, as well as more conventional attacks or naturally occurring outbreaks.

The city of Providence, like many mid-size cities, has a number of characteristics that make it potentially attractive as a target, such as its proximity to military assets, major metropolitan areas, and an important transportation routes. An aerosolized sprayer releasing air-borne anthrax particles into the air throughout a city like Providence would not necessarily be detected in the immediate aftermath of the release. Clinical symptoms of inhalational anthrax would not be discovered for at least 2 or 3 days after the attack occurred, yet the health effects and environmental consequences could be catastrophic.

SURVEILLANCE AND DETECTION

It is critical to receive warning of a biological attack as soon as it occurs and to identify the causative agent immediately. Such a warning would enable the prevention of most cases of inhalational anthrax, through the combined response of the CDC and its State and local partners in distributing sufficient prophylactic antibiotics to the public before the onset of disease. A delay of just 1 day in detection of an anthrax release—and therefore treatment of affected populations—would result in thousands of unnecessary deaths.

Sufficient early warning through environmental detection is one of the Department's top priorities, one for which the Office of Health Affairs, working with the Science and Technology Directorate (S&T), is responsible. We are investing significant amounts of taxpayer resources to our BioWatch program, which provides detection and warning of a biological attack in our Nation's highest-risk urban areas through a series of pathogen detectors. With S&T, we are developing the next generation of detectors, known as Generation 3, which will be automated and significantly reduce detection time to allow our health providers to get countermeasures into the hands of affected populations within the critical window of time to save lives.

Complementing our BioWatch capabilities is our establishment of a robust biosurveillance integration center, where other departments and agencies come together to monitor their biological data and analyze potential biological threats. The National Biosurveillance Integration Center (NBIC), authorized in the 9/11 Act (Pub. L. 110–53), will bring together data from other Federal departments, the public domain and eventually the private sector and States and local government to understand and characterize biological events and incidents across the areas of human health, animal health, food, water and the environment. Through robust data analysis and integration across these sectors, we aim to provide the earliest possible warning of outbreaks and threats to human and veterinary health and the food and water supply. Over the past several months, we have made great progress in our governance structure. We now have all the relevant departments coming to an "ownership meeting," which recognizes that DHS is the host for NBIC, but the system belongs to every department across the Federal Government that needs access to a bio-surveillance common operation picture (BCOP). We are working very closely

with the CDC as they develop improved human health surveillance systems, which will be a vital element of the Government's BCOP. It is in all of our interest to ensure the success of our partner agencies' improvements in their data systems.

FEDERAL, STATE AND LOCAL RESPONSE AND RECOVERY

If a large-scale biological attack occurred here in downtown Providence using aerosolized anthrax, it would likely go undetected for days, until large numbers of people begin showing up in emergency departments and doctors' offices 2 to 5 days after the attack. Unfortunately, most cases would progress quickly to a form of pneumonia that is very resistant to treatment once it has started. The sentinel cases would be those receiving the highest doses of anthrax spores, and would be the harbinger of tens of thousands more, nearly all requiring intensive medical care, including ventilatory support and the anthrax countermeasures we have in the Strategic National Stockpile (SNS). Federal, State and local law enforcement would seek to identify the perpetrators to prevent subsequent attacks. Since we do not know the extent of the exposure, Federal and local health officials would likely mobilize the SNS for antibiotics to be given to the population as environmental sensors and samples identify the affected areas. In such a scenario, State and local resources, including medical assets, would be taxed if not overwhelmed. Rather than a smoking building defining the extent of the victims, every man, woman, and child in the area—and every building and every farm in the plume—could be affected. This is not a pretty picture, so preparedness is required to minimize the impact.

In such a case, the Secretary of Homeland Security would stand up all of the power and assets of Federal Government to manage the incident. The Federal Emergency Management Agency (FEMA) would stand up its National Resource Coordination Center to bring Federal assets to bear. The responsibility for the public health and medical response lies within the Department of Health and Human Services under the Public Health Services Act and as the lead for Emergency Response Function (ESF) 8: *Public Health and Medical Response,* with the Assistant Secretary for Preparedness and Response (ASPR) as the HHS Secretary's principal advisor and as the official responsible for certain functions. In order to have the tools to execute its mission successfully, HHS has invested thousands of hours and billions of dollars to make sure we have the appropriate medical countermeasures to deal with the threats to human health. This includes research and development of new medicines, vaccines and anti-toxins, as well as their stockpiling and distribution. DHS has been their advocate and partner every step of the way.

Additionally, law enforcement and security measures are directed by the Department of Justice as the lead for ESF–13: *Public Safety and Security;* decontamination activities and environmental cleanup are directed by the Environmental Protection Agency as the lead for ESF–10: *Oil and Hazardous Materials Response;* and the terrorism crime scene investigation, as well as attribution and characterization to prevent second attacks are led by the Federal Bureau of Investigation. Our success is dependent on their success, Mr. Chairman. I encourage you to lend them your support in this effort, and encourage the support of your congressional colleagues. While homeland security may not be the primary mission of these agencies, their homeland security responsibilities are crucial to our mission.

The Department of Homeland Security is charged with leading the overall domestic incident management, including coordinating the Federal response and integrating it with the State and local response efforts. OHA leads the DHS biodefense activities, which includes oversight and management responsibility for implementation for Homeland Security Presidential Directive 10, *Biodefense for the 21st Century,* although many other components and offices have major related responsibilities. The DHS National Biodefense Analysis and Countermeasures Center, a component of S&T, is responsible for the bioforensics analysis, and working with I&A and law enforcement, to determine the likely source of the germ. Our National Operations Center (NOC) coordinates all of the Federal operations and monitors the responses and requirements of local entities. DHS would quickly stand up a Joint Information Center (JIC) with all the relevant departments and agencies to ensure accuracy and timeliness of information to the public. Under a Stafford Act declaration, FEMA coordinates Federal assistance to requesting States. In accordance to the National Response Framework and because a biological incident would likely be an unusually complex incident requiring extraordinary coordination Secretary Chertoff has named a pre-designated a Principal Federal Official (PFO) to lead the response to a biological event. The PFO would assist States, local and tribal governments by overseeing a coordinated Federal response. A PFO is a senior Federal official with proven management experience and strong leadership capabilities. Vice

Admiral Vivien Crea of the U.S. Coast Guard is our predesignated PFO for biological events and provides excellent leadership and knowledge.

RECOMMENDATIONS

Mr. Chairman, I have a number of recommendations for the subcommittee to consider to enhance the state of preparedness in the event of a biological attack or natural outbreak.

1. Continue to support our development of next generation automated detection technologies to reduce the time-to-detect to allow the necessary time to deliver life-saving medical countermeasures to the population. Because a biological attack is so challenging to accurately predict, we must continue to refine our early detection and warning capabilities. If our partners at HHS are to deliver life-saving prophylactic antibiotics, we must be able to detect a biological release sooner. Our current detection equipment has a built-in delay of up to 36 hours, which is not consistent with the requirements of disease prophylaxis. Over time, we must seek to cover more of our Nation's population with earlier environmental warning. Such an expansion must be risk-based which takes into account population density and critical infrastructures.

2. Continue to support the development of the National Biosurveillance Integration Center (NBIC). It is the one place where agencies can come together to share data across the sectors of human health, animal health, food, water and the environment. The center illustrates the very nature of DHS—to integrate the assets and resources of sister Government agencies in a protected, open environment for the purposes of subject matter expertise and information sharing. The service we must provide is a common operating picture for decisionmakers before and during events to afford them the best possible information upon which to make good decisions. The oversight of NBIC belongs to the Committee on Homeland Security in full view and participation of other congressional committees and sister agencies.

3. Support the full integration of health expertise into information fusion centers. While intended initially for law enforcement, with the threats including biological and chemical events, the expertise of the health community is needed in the information fusion process. The assistance of HHS may be available to assist local agencies where needed. DHS will work with local health directors to ensure necessary security clearances and information analysis training to ensure the success of such participation.

4. Consolidate the committee's jurisdiction over issues of homeland security. While DHS is by its authorization (Pub. L. 109–295) a collaborative agency, so must Congress work collaboratively to ensure a more secure homeland, empowering an effective yet supportive oversight environment. As Secretary Chertoff has mentioned on numerous occasions, the current threat environment does not lend itself to jurisdictional disputes in Congress over the Department's authorities and responsibilities. Homeland Security is a team sport and we all should have the common goal of a more secure Nation as our first priority.

CONCLUSION

The threat of bioterrorism against the United States remains a significant concern. We continue to face an enemy determined to acquire and develop biological agents into weapons of mass destruction against the homeland. The Office of Health Affairs and the Department of Homeland Security takes this threat very seriously and are doing significant work to prevent, enhance early detection and surveillance and integrate Federal, State and local preparedness and response capabilities to reduce the catastrophic consequences of a biological attack on the homeland.

Mr. Chairman, I sincerely appreciate your dedication and efforts to enhance the security of the Nation. Thank you again for the opportunity to testify. It has been a real pleasure working with you during my time at the Department of Homeland Security. I have created an office that is completely ready for the transition. I leave the office in the experienced and capable hands of Dr. Jon R. Krohmer, the Principal Deputy Assistant Secretary and Deputy Chief Medical Officer. I ask for your support of Dr. Krohmer over the coming months, as he is eager to work with you to better secure the homeland.

Mr. LANGEVIN. Thank you, Dr. Runge. I appreciate your testimony and for your service to our Nation. The Chair now recognizes Admiral Vanderwagen to summarize your statement for 5 minutes.

Welcome, Dr. Vanderwagen.

STATEMENT OF REAR ADMIRAL W. CRAIG VANDERWAGEN, M.D., ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY MICHAEL G. KURILLA, DIRECTOR, OFFICE OF BIODEFENSE RESEARCH AFFAIRS, AND ASSOCIATE DIRECTOR FOR BIODEFENSE PRODUCT DEVELOPMENT, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH; AND DANIEL M. SOSIN, DIRECTOR, BIOSURVEILLANCE COORDINATION UNIT, AND ASSOCIATE DIRECTOR FOR SCIENCE, COORDINATING OFFICE FOR TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE, CENTERS FOR DISEASE CONTROL AND PREVENTION

Dr. VANDERWAGEN. Thank you, sir. It's always nice to be in Providence. I think the history and beauty of this place is pretty remarkable. I've appreciated every opportunity I've had to come and visit here.

I want to add then my piece to Jeff's overview because really DHS has the overview on these issues. They provide us with threat assessments that we analyze the public health impacts of so that for anthrax, for instance, what is the real public health impact that we would expect to have and what are the tools that we have to address it?

These are the medical countermeasures that Jeff was speaking to. This begins with the research pipeline and Mike Kurilla here today I think can talk a little bit about the research pipeline activities. What are we studying? What do we know from the science that offers us an opportunity to develop countermeasures?

Then we move to develop those ideas into a productive product that can be utilized in a meaningful way to the delivery platforms owned, operated, and managed in the local environment.

Dan Sosin is going to be able to speak today to questions you may about biosurveillance that are supportive to the systems that Jeff described earlier. But our responsibility runs from the development of those countermeasures to delivery platforms at the community level to assure that those medical countermeasures get to the people who need them.

As you suggested in your opening statement, Mr. Chairman, we are much better prepared, however, we are not fully ready and part of that is because we still exist in our operational silos more than we reasonably should. That's not to say that tremendous effort has not gone into the process of developing a national response plan as opposed to a Federal, State, local response plan, but there is more work to be done to synergize and harmonize the planning from the Federal level through the local level to assure that we have a national response plan as opposed to a series of localized plans for action.

I think second there is much more work to do in the area of bringing about public and private partnerships that is shared responsibility that extends beyond the public sector, whether that's State, local, or Federal and embraces the opportunity for local, private sector entities to have an active role. This is important as Jeff suggested because of the resiliency that is built when you provide

people with the opportunity to build tools and activities that will lead to control in the face of chaos in these kinds of events.

As Jeff has said and as you have alluded to in your opening statement, Mr. Chairman, there's much focus on kinetic events, IEDs, improvised nuclear devices, and there is no question that these are threats that are significant and important. But it's our belief that the biothreats have a much broader impact in our society, both from a public health perspective and from the wider intersectoral perspective in economics, in transportation and energy, et cetera.

Therein lies another challenge that we have not fully addressed and that is the broad multisectoral involvement. DHS has done a great job in establishing the national response framework and promoting and working forward with that, but there continues to be challenges at the local and State level in assuring that all the sectors are talking to each other.

I've traveled around the country significantly over the last year and a half, much like Jeff, and one of the things that I've observed is some places there is great intersectoral cooperation, planning, action, exercise, et cetera, and that has brought about meaningful best practices. But there are other places where the guns and hoses don't talk to the health people, don't talk to the banking people, et cetera. No blame placing here. It's just a matter of the fact that people aren't necessarily working in an intersectoral way to maximize their local capability to respond.

Indeed, as Jeff has suggested, therein lies the resiliency that will be needed when we face a significant event of the kind of proportions that we're talking about here. The other thing that's uniquely problematic with bio events is unlike an IED or even an IND or a natural event like a hurricane, it is not geographically and temporally limited. This is very difficult because you're not sure exactly when it started, as Jeff pointed out. The technical challenge there is a large one and you're not exactly sure when it's going to end. Quite commonly it will extend over a wide geographic area.

Again, this argues for the fact that we need to have broad, intersectoral dialog, communication, planning, and activity. We need greater investment in tool development, the advanced development of some of these good research ideas is not progressing as fast as it reasonably could. So we think there are things ahead that will allow us to be beyond prepared and begin to become ready in effect, as you suggested.

Thank you, Mr. Chairman, for the opportunity.

[The statement of Dr. Vanderwagen follows:]

PREPARED STATEMENT OF W. CRAIG VANDERWAGEN

JULY 22, 2008

Good Morning Chairman Langevin, Mr. McCaul, and Members of the committee. I am RADM W. Craig Vanderwagen, M.D., the Assistant Secretary for Preparedness and Response (ASPR) at the U.S. Department of Health and Human Services (HHS). I appreciate this opportunity to discuss the HHS plans and initiatives in public health and emergency preparedness to respond to emerging biological threats, including pandemic influenza. HHS's Office of the ASPR has adopted an "all-hazards" approach to our preparedness and response activities, moving us from stand-alone plans to a process that addresses all of the hazards that potentially threaten the public's health. We have collaborated and coordinated closely with our

Federal interagency partners and have provided States and municipalities with funding to enhance their public health and medical preparedness.

EMERGENCY PREPAREDNESS

Our "all-hazards" preparedness involves a shared responsibility among our entire Department, our partners in the international community, the Federal, State, local, tribal and territorial governments, the private sector, and, ultimately, individuals and families. Additionally, before an event, government agencies at all levels work with the private sector to plan and exercise so they can be ready when a disaster occurs. During an emergency, local and State response agencies, including public health departments, are the first to respond. For regional or severe emergencies, the Federal Government may be asked to provide additional resources and coordinate response efforts across multiple jurisdictions.

In that context, some of the emergency preparedness efforts currently being led by HHS involve working with our Federal, State, and local partners. For instance, we support State and local authorities through the Hospital Preparedness Program and the Public Health Emergency Preparedness Program for a broad range of medical and public health preparedness activities, including the development of medical and public health plans for response, increasing the number of exercises to evaluate these plans, increasing the training opportunities in key preparedness areas, increasing epidemiological and laboratory detection capabilities, establishment of local stockpiles of critical medical equipment and supplies, improving surveillance and investigation capabilities, maintenance and distribution of countermeasures, and sharing of resources.

EMERGENCY SUPPORT FUNCTION NO. 8—PUBLIC HEALTH AND MEDICAL SERVICES

The National Response Framework (NRF) Emergency Support Function (ESF) No. 8—Public Health and Medical Services—provides the mechanism for coordinated Federal assistance to supplement State, local, tribal, and territorial resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing health and medical emergency. The Secretary of HHS; here forth the Secretary, leads all Federal public health and medical response to public health emergencies and incidents covered by the NRF. The response addresses medical needs and other functional needs of those requiring medical care and other assistance during an emergency.

Except for the personnel and assets under the command of the Department of Defense, the Secretary assumes operational control of Federal emergency public health and medical response assets, as necessary, in the event of a public health emergency. The Secretary, through ASPR, coordinates National ESF No. 8 preparedness, response, and recovery actions.

HHS has implemented an incident command system that is National Incident Management System compliant. Additionally, all States have established emergency operation centers and have also implemented an incident command system. We have trained and equipped response personnel who include not only the National Disaster Medical System (NDMS) teams, but also Public Health Service Commissioned Corps Officers.

The operational command of personnel deployed under our auspices is fully consistent with and supportive of the Department of Homeland Security's (DHS's) role as overall incident manager, including liaisons in the National Operations Center, National Response Coordination Center, and the Joint Field Office. The HHS recognizes and supports the overall lead of DHS in coordinating the Federal response and we take seriously our role as the lead Federal agency for Public Health and Medical Services through ESF No. 8, of the NRF.

PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT (PAHPA)

Consistent with requirements contained in the Public Health Service Act, as amended by the Pandemic and All-Hazards Preparedness Act (PAHPA), HHS has updated the performance measures for both the Hospital Preparedness Program and the Public Health Emergency Preparedness Program. Specific improvements include greater clarity in language, the use of definitions, and the addition of targets. For example, in fiscal year 2006, HHS asked grantees to report participating hospitals' ability to track bed status electronically, and report it to the grantee's Emergency Operations Center within 60 minutes of a request. In 2007, the numerator and denominator were defined to improve clarity. For fiscal year 2008, the target percentage of hospitals able to report was increased to 100 percent by the end of the end of the year.

HHS strongly supported the new accountability provisions included in PAHPA and is implementing these provisions. First, fiscal year 2009 award funds will be based on the successful achievement of targets during the previous budget cycle. In addition, the matching provision will be applied to the Public Health Emergency Preparedness Program (PHEP) in fiscal year 2009. We also intend, through notice and comment, to apply the matching provision to the Hospital Preparedness Program (HPP) in fiscal year 2009. The audit and carryover provisions apply to both the PHEP and HPP programs currently; the withholding provision will be applied to these programs in fiscal year 2009. The HPP and PHEP programs implemented the maintenance of funding provision in fiscal year 2007.

PUBLIC HEALTH EMERGENCY PREPAREDNESS (PHEP) PROGRAM

From fiscal year 2002–fiscal year 2008, the Public Health Emergency Preparedness (PHEP) program has provided $6.3 billion to State, local, tribal, and territorial public health departments. This amount includes targeted supplements to prepare for smallpox (in fiscal year 2003) and for an influenza pandemic (fiscal year 2005–fiscal year 2007). This program has greatly increased the preparedness capabilities of public health departments:

- All States can receive and evaluate urgent disease reports 24/7, while in 1999 only 12 could do so.
- All States now conduct year-round influenza surveillance.
- The number of State and local public health laboratories that can detect biological agents as members of CDC's Laboratory Response Network (LRN) has increased to 110 in 2007, from 83 in 2002. For chemical agents, the number increased to 47, from 0 in 2001. Rather than having to rely on confirmation from laboratories at CDC, LRN laboratories can produce conclusive results. This allows local authorities to respond quickly to emergencies.
- All States have trained public health staff roles and responsibilities during an emergency as outlined in the Incident Command System, while in 1999 only 14 did so.
- All States routinely conduct exercises to test public health departments' ability to respond to emergencies. Such exercises were uncommon before PHEP funding.

HOSPITAL PREPAREDNESS PROGRAM (HPP)

We have made considerable investments in building the health care preparedness and response capabilities required during an incident resulting in mass casualties, and are committed to performance measurement. Over the past 5 years, the Hospital Preparedness Program (HPP) has provided more than $2.6 billion to fund the development of medical surge capacity and capability at the State and local level. As a result of HPP funds awarded to States and territories, hospitals and other health care entities:

- Increased their ability to provide needed beds during an emergency;
- Can now track bed and resource availability using electronic systems;
- Engaged with other responders through interoperable communication systems;
- Appropriately train their health care workers for all-hazards approach to emergencies;
- Protect their health care workers with proper equipment;
- Have installed equipment necessary to decontaminate patients;
- Have developed fatality management and hospital evacuation plans, and
- Coordinate regional exercises.

REGIONAL EMERGENCY COORDINATION

HHS has worked diligently to partner with State, tribal, territorial, and local officials to enhance their level of preparedness and to ensure they can see how HHS will respond to disasters. Our Regional Emergency Coordination/Coordinator (REC) program has been enhanced. In the past year, we have increased the number of RECs from 10 to over 30. The REC's role is to work with the States and local jurisdictions to coordinate and enhance preparedness within the region. I have personally been to each of the 10 HHS regions to participate in local exercises and meet with State and local health leadership to discuss the level of preparedness and how HHS can support them.

U.S. PUBLIC HEALTH SERVICE, VOLUNTEER PERSONNEL

HHS has a number of resources that are rapidly available to deploy in response to a biological event. The full-time U.S. Public Health Service (USPHS) responders

include the Rapid Deployment Force (RDF) Teams, Applied Public Health Teams (APHT), Mental Health Teams (MHT) and additional USPHS Officers. Volunteer health care professionals are available through the Medical Reserve Corps, which has over 160,000 members in approximately 700 teams. The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR–VHP) ensures the availability of volunteers for quick exchange between jurisdictions.

NATIONAL DISASTER MEDICAL SYSTEM

We are also continuously improving HHS's operational capabilities to respond to emergencies. The NDMS, transferred from the Department of Homeland Security to HHS, remains the "tip of the spear" as the Federal disaster health care response capability, maintaining 6,200 medical and public health professionals and over 1,800 participating hospitals that offer definitive care services, with approximately 34,000 available beds (at most recent count). NDMS field teams include the Disaster Medical Assistance Teams (DMAT), Disaster Mortuary Operational Response Teams (DMORT), National Medical Response Teams (NMRT), and International Medical and Surgical Response Teams (IMSRT).

Since the transfer of NDMS last year, we have achieved a number of accomplishments aimed at improving the system including the integration of NDMS into the larger ESF No. 8 response framework and regionalization of NDMS response operations and caches to provide increased accountability and standardization for supplies as well as fiscal savings. Future goals for NDMS include enhancing readiness and accountability through regionalization of NDMS response operations and enhancing equipment caches.

FEDERAL MEDICAL STATIONS

The HHS Federal Medical Station (FMS) is a deployable health care platform that can provide non-acute hospital bed surge capacity and special medical needs sheltering. A standard FMS can house approximately 250 patients and is staffed by the Rapid Deployment Force teams. The FMS are useful in care of patients with suspected or confirmed exposure to biological threats, and who may require for example, observation, limited definitive care, or primary care.

PLAYBOOKS

HHS prepares playbooks for the different scenarios of man-made and natural disasters. For biological emergencies response there are separate playbooks including anthrax, *Clostridium botulinum*, small pox, and pandemic *influenza*. These playbooks are used by HHS during an event and include sections for the:

- Scenario;
- Concept of operations, or CONOPs, for the response;
- Action steps;
- Briefing and decision papers; and
- Essential elements of information.

The action steps are time-oriented, and include pre-event steps should there be credible intelligence that the risk of an event is high. The action steps are arranged into natural stages for a response and include a trigger for each stage, a recommended strategy to follow, and specific actions to take.

ASPR has written and exercised playbooks based on 11 of the 15 national exercise scenarios. The process of developing these playbooks provides opportunities for input from our ESF No. 8 Federal partners. Additionally, HHS playbooks, starting with the hurricane playbook, will be placed on the HHS web site to facilitate their examination and use by State, local, tribal, and territorial, officials. We will make additional playbooks available as they become ready for release.

THE MEDICAL RESPONSE SYSTEM FOR TRIAGE, TRANSPORT, TREATMENT

HHS has developed a response system called the TR system for Treatment, Triage and Transport in an event, that takes into account the factors and character of the agent or threat, in determining medical response. The triage of individuals will be based on medical evaluation including where they were during and shortly after the event with particular attention to special needs that they may have. The initial triage will attempt to separate people into three broad categories:

- those needing immediate medical attention, which would include those with clinical effects of known exposure to a biological agent or highly suspect exposure risk;
- those without clinical effects to the biological agent but at risk from potential exposure (due to location, etc.);

- those with minimal or no likelihood of exposure and no clinical effects from the biological agent, who do not require immediate medical care.

MEDMAP

HHS is developing an interactive geographic information system (GIS)-based mapping system, called MedMap, which will include data for resources in a response to any type of hazard such as potential medical care sites and assembly centers in the United States, evacuation routes, hazards, etc. so that up-to-date information will be immediately available by which to organize the response. Determining which local medical care and assembly center facilities are functional or not in the exposure area is essential, as is having information on what regional and Nation-wide resources are available.

RESPONSE OPERATIONS

HHS maintains an operations center 24/7/365. The Secretary's Operations Center (SOC) is directly connected to the DHS National Operations Center and the FEMA National Response Operations Center. It serves as the focal point for situational awareness, information management and response coordination for HHS. We have established relationships with subject matter experts from within HHS Operating and Staff Divisions such as NIH, CDC, FDA, and ASPR.

HOMELAND SECURITY PRESIDENTIAL DIRECTIVE NO. 18

In January, 2007 the President issued Homeland Security Presidential Directive (HSPD) No. 18, which directed the Secretary and the Federal Government in development and acquisition of medical countermeasures for weapons of mass destruction. The HSPD–18 builds on the *National Strategy to Combat Weapons of Mass Destruction and Biodefense for the 21st Century* by focusing on medical countermeasure research, development, and acquisition efforts. The HSPD–18 objectives for countermeasure include: (1) Identification of target threats with potential for catastrophic impact on public health and able to be mitigated; (2) yielding rapidly deployable and flexible capabilities to address threats; (3) integration with WMD consequence management through risk assessments of threats, vulnerabilities, and capabilities; and (4) development of realistic, effective concepts of response for an attack. With this in mind, the research, development, acquisition of medical countermeasures is driven by principles that focus on: (1) Current and anticipated threat agents with greatest potential for use, and catastrophic consequences; (2) greatest potential to prevent, treat, and mitigate WMD threats; and (3) integration with effective deployment strategies supportable by realistic current or future operational and logistical capabilities.

The biological threats focus of HSPD–18 addresses four distinct categories which present unique challenges and significant opportunities for development of medical countermeasures.

(1) Traditional agents are naturally occurring microorganisms or toxins with the potential to be disseminated to cause mass casualties. Such agents include *Yersinia pestis*, plague; and *Bacillus anthracis*, anthrax.

(2) Enhanced Agents are modified or selected traditional agents that enhance their ability to cause mass casualties. Such agents would include antibiotic resistant organisms that as such, circumvent medical countermeasures.

(3) Emerging Agents are pathogens that previously did not pose a recognizable risk to human populations, but are now identified to pose this risk, such as Severe Acute Respiratory Syndrome (SARS).

(4) Advanced Agents are novel pathogens or biomolecules that have been artificially engineered, and can circumvent current medical countermeasures to produce a more severe or enhanced spectrum of disease. In a way, genetically engineered smallpox strains could fit under this guise, as would engineered Ebola strains.

The HSPD–18 authorizes the Secretary to lead Federal Government efforts to research, develop, and acquire medical countermeasures via establishment of an interagency committee to provide advice in setting medical countermeasure requirements, research, development, and procurement activities; and establishment of a strategic planning initiative to integrate requirements, development and acquisition of countermeasures across the full range of research and life cycle development. The Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) and the *PHEMCE Strategy and Implementation Plan for CBRN Threats* address these directives respectively.

Biomedical Advanced Research and Development Authority—Development and Acquisition

Our progress in securing medical countermeasures begins with and depends on effective planning. The central framework for medical countermeasures planning and implementation in the Federal Government is the HHS PHEMCE, established in July 2006. This coordinated interagency group is led by the ASPR, and includes the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH) as well as our partners from the Department of Defense (DOD), DHS, and Department of Veterans Affairs (VA). Through this Enterprise-wide effort, we are able to ensure that Federal activities with respect to needed medical countermeasures are effectively coordinated from research and development to acquisition and ultimately deployment. This supports a range of programs that I will briefly summarize for developing and acquiring medical countermeasures for man-made and naturally occurring public health threats while building domestic manufacturing infrastructure.

HHS established the Biomedical Advanced Research and Development Authority (BARDA) to direct and coordinate the Department's countermeasure and product advanced research and development activities. In support of the mission and priorities of PHEMCE, BARDA establishes systems that encourage and facilitate the development and acquisition of medical countermeasures such as vaccines, therapeutics, and diagnostics, as well as innovative approaches to meet the threat of chemical, biological, radiological and nuclear (CBRN) agents and emerging infectious diseases, including pandemic influenza. The BARDA provides an integrated, systematic approach to the development and purchase of the necessary vaccines, drugs, therapies and diagnostic tools for public health emergencies. It directs and coordinates the Department's countermeasure and product advanced development activities and medical countermeasure domestic manufacturing infrastructure building, including strategic planning for medical countermeasure research, development, and procurement. This coordinated approach is critical to achieving success in the area of bioterrorism preparedness.

Anthrax.—Anthrax remains a top priority for ongoing public health emergency preparedness efforts at HHS. The Department is committed to developing and acquiring a robust, comprehensive portfolio of medical countermeasures against this threat. Antibiotics represent the first line of defense to protect the Nation following an anthrax attack. Today, we have over 60 million courses of antibiotics on hand and on order for the Strategic National Stockpile (SNS). Anthrax vaccines are also an essential element of our national preparedness. It is possible that vaccines given as post-exposure prophylaxis in combination with antibiotics could provide longer-term protection, or allow for a reduction in the duration of the antibiotic regimen. HHS has awarded contracts for the acquisition of nearly 30 million doses of anthrax vaccine since 2005, including the recent contract award of 18.75 million doses of Anthrax Vaccine Adsorbed (AVA, BioThrax™) in partnership with the DoD. In addition, antitoxins are necessary to treat individuals with advanced stages of infection, and may contribute to a more successful therapeutic outcome. Beginning in 2007, HHS has awarded contracts to two manufacturers to deliver antitoxins sufficient for treating 30,000 people. These vaccine and antitoxin contracts were awarded under the authorities of the Project BioShield Act of 2004. In addition, three BARDA contracts for the advanced development of other anthrax therapeutic candidates were recently awarded through a partnership with the NIH/National Institute of Allergy and Infectious Diseases (NIAID).

HHS remains committed to the development and acquisition of a second generation anthrax vaccine. While procuring and continuing to improve the currently available anthrax vaccine, HHS is investing over $40 million in the continued development of a recombinant anthrax vaccine. This investment builds on the recombinant vaccine program that has been ongoing at the NIAID since 2002. BARDA also released a Request for Proposals (RFP) in March 2008 for a recombinant anthrax vaccine contract award. In addition, BARDA and NIAID released a Broad Agency Announcement in September 2007 for vaccine enhancement that will support important improvements in storage conditions and administration for vaccines against a wide array of biological threats; these proposals are currently under USG review.

Smallpox virus.—In June 2007, BARDA awarded a contract for a next generation modified vaccinia Ankara (MVA) smallpox vaccine for use in immune-compromised Americans. This was the first BARDA contract to utilize performance-based milestone payments allowable under the Pandemic and All Hazards Preparedness Act (PAHPA). HHS/CDC has also procured ACAM–2000, a live, single-dose smallpox

vaccine developed by Acambis, which is the first new bio-defense vaccine to be approved by the FDA.

Botulinum toxin.—In June 2006, HHS awarded a contract under Project BioShield to the Cangene Corporation for 200,000 doses of a botulinum antitoxin that targets all 7 serotypes of Clostridium botulinum. The $363 million contract will expand greatly our existing stockpiles in the SNS. Deliveries of this product to the SNS initiated in 2007.

Pandemic influenza.—The pandemic influenza program is focused on vaccines, antivirals, diagnostics, and non-pharmaceutical countermeasures. In December 2005, and June 2006, Congress appropriated $5.6 billion for HHS pandemic influenza preparedness efforts. With these funds, scientists and public health experts at HHS have built an aggressive and broad-based medical countermeasures program for pandemic influenza. These funds support the acquisition of existing products, advanced development projects to produce modernized and next-generation countermeasures, and the retrofitting and construction of the facilities necessary to produce pandemic influenza vaccines.

With respect to vaccines, HHS has a number of efforts underway. These efforts supported the first U.S. licensure of an H5N1 vaccine in April 2007, which was highlighted as the No. 1 medical breakthrough of 2007. By the end of 2007, HHS in coordination with DoD had stockpiled 12 million courses of pre-pandemic H5N1. However, maintaining a domestic production capability for these priority countermeasures is also an essential component of the pandemic influenza preparedness strategy. In May 2006, HHS awarded five contracts for over $1 billion to GlaxoSmithKline, MedImmune, Novartis (formerly Chiron), Solvay, and Dynport (with Baxter) for support of advanced development of cell-based influenza vaccines toward U.S. licensure and expanded domestic vaccine manufacturing surge capacity. In June 2007, we awarded two contracts for the retrofitting of existing domestic biological manufacturing facilities to produce egg-based influenza vaccines and included warm base operations for up to 5 years. Additionally, contract awards are expected in 2008 for the construction of new domestic facilities for manufacturing cell-based influenza vaccines that is expected to quadruple the domestic pandemic vaccine manufacturing surge capacity by 2012.

A robust and groundbreaking advanced development program has led to the rapid maturation of modernized cell-based influenza vaccine production and antigen-sparing technologies. New combinations of adjuvants and products provided by multiple manufacturers are currently supported by performance-driven milestone contracts. More rapid vaccine production may be afforded by the development of next generation recombinant influenza vaccines, which HHS will support.

Antiviral drugs have become an increasingly important medical countermeasure for influenza. Today, in coordination with DoD and VA, the SNS contains 50 million treatment courses of antiviral drugs, completing the Federal stockpile 1 year ahead of schedule. HHS has also supported antiviral stockpiling at the State level. Through a federally subsidized program, States have purchased 22 million treatment courses of influenza antiviral drugs to date and are expected to reach our goal of 31 million courses by the end of 2008.

The nature of severe influenza infections has also required us to focus on preparedness through non-pharmaceutical countermeasures, such as ventilators which play an essential role in the health care of critically ill patients. The fiscal year 2009 President's budget includes $25 million to develop ventilators that are more amenable to public health emergency use. This presents a prime example of the integrative, all-hazards approach that the PHEMC Enterprise seeks. A more portable and easier to use ventilator could be an essential tool for responding to many different public health threats, when having a sufficient supply of ventilators could have an impact on the morbidity and mortality of exposure.

MEDICAL COUNTERMEASURES

Strategic National Stockpile—Distribution and Dispensing

The Division of Strategic National Stockpile (DSNS) at CDC can deploy medical countermeasures rapidly after notification to do so. In addition to medical countermeasures that can be tailored to meet the event's specific needs, the DSNS inventory contains supplies and materiel required in the medical management of burns, trauma, injuries that may be seen in conjunction with explosive threats.

The collaborative arrangements DSNS has with a variety of agencies, corporations, companies, and organizations are essential to not only increase the ability of State and local public health agencies to dispense medical countermeasures in a timely manner but also are critical to identifying and overcoming many of the inherent challenges. The broadness of the partnership is vital in that each of the partici-

pants brings not only a different perspective to the challenges but also expands the possibilities for finding answers to breach obstacles and barriers. Developing partnerships with private and public sector agencies to sponsor closed points of dispensing (PODs) is necessary to alleviate the burden on PODs for the general public. Lightening the load on these general public PODs reduces many of the challenges faced by local health agencies, i.e., staffing, security. These partnerships also reflect the directives within HSPD–21 and PAHPA to cultivate, enhance, and maintain interagency collaboration.

An example of this collaborative partnership is demonstrated as CDC/COTPER work with the Business Executives for National Security (BENS) to promote the involvement of private corporations in preparedness planning and response. BENS is working with the State of Georgia and Los Angeles County to establish a model system, to hopefully be duplicated nationally, of corporate points of dispensing. This pilot initiative is funded through the CDC PHEP Cooperative Agreement. BENS officials presented and networked with State and local planners at all four regional Cities Readiness Initiative workshops.

HOMELAND SECURITY PRESIDENTIAL DIRECTIVE NO. 21

On October 18, 2007 President Bush signed HSPD No. 21, "Public Health and Medical Preparedness," establishing a new National Strategy for Public Health and Medical Preparedness (the Strategy).

As directed by HSPD–21, HHS has been successful in establishing two advisory committees. The National Biosurveillance Advisory Committee has been established as a subcommittee to the CDC Advisory Committee to the Director (ACD) and a Disaster Mental Health Advisory Committee is being established as a subcommittee under the National Biodefense Science Board (NBSB) which advises the Secretary. Additionally, HHS leads the development of a national strategy on biosurveillance through CDC's efforts and creation of the Biosurveillance Coordination Unit charged with coordinating the necessary activities to address the mandates of HSPD–21 in the development of a strategy and implementation plan for the Nation's next-generation biosurveillance capability.

Under the leadership of CDC, the HSPD–21 requirement to ensure the adequate flow of information before, during, and after an event, including critical biosurveillance data and risk analysis has quickly drafted a strategic plan of national scope. Planning is being undertaken using a broad collaborative approach that will increase stakeholder buy-in, assure effective implementation, and guide the strategic allocation of resources.

Also delegated to CDC leadership, HSPD–21 requirements pertaining to 48-hour post attack countermeasure distribution are being addressed through the strategic development of new models of distribution and dispensing of medical countermeasures that would enhance and improve the existing capabilities of the DSNS and its State and city partners. New models can incorporate other partners into a national network, including the CDC Laboratory Network, Department of Veterans Affairs, businesses, and hospital and pharmaceutical distribution systems.

Tasked to DHS leadership, HSPD–21 requirements for health risk and threat briefings to non-health political leaders at the State and city level are being met with active involvement of HHS health experts.

Finally, HHS is implementing HSPD–21 through the establishment of the *Emergency Care Coordination Center (ECCC)*. This new center, an intradepartmental and interdepartmental collaborative effort involving the DOD, DHS, Department of Transportation and VA, will serve as the coordinating focal point for an Emergency Care Enterprise, coordinating with the Federal Interagency Committee on Emergency Medical Services. Its vision is exceptional daily emergency care for all persons of the United States and its mission is to promote Federal, State, local, tribal and private sector collaboration to support and enhance the Nation's emergency medical care.

The ECCC will assist the U.S. Government with policy implementation and guidance on daily emergency care issues and promote both clinical and systems-based research. Through these efforts, ASPR and its Federal partners will improve the effectiveness of pre-hospital and hospital-based emergency care by leveraging research outcomes, private sector findings and best practices. The ECCC will promote improved daily emergency care capabilities to improve resiliency of our local community health care systems. This will provide a stronger foundation on which to advance disaster preparedness efforts and strengthen our Nation's ability to respond to mass casualty events. Currently, the ECCC Charter is being finalized and we anticipate having the center up and running by the end of the year.

GLOBAL HEALTH COORDINATION

In addition to these domestic efforts, other approaches to improving our national capabilities include partnering with allied nations. At the recent Global Health Security Action Group ministerial meeting, there was some consideration paid to the possibility of establishing international laboratory networks among the member nations. Links with Canada would be particularly useful given the geographic proximity. Informal discussions among the scientists and subject matter experts have been ongoing for a few years but no formal arrangements have been made. We continue to explore possibilities that serve the national interest.

CONCLUSION

HHS staff work diligently to progress and expand the initiatives in public health and emergency preparedness for emerging biological threats. We continue to assess potential biological threats in the context of an all hazards approach, and compare the plans and programs available to us for mitigating these threats to ensure we are focused on the right initiatives. Through cooperation with our Federal partners, and State, local, tribal, and territorial governments, we have implemented a number of preparedness programs and assets that have strengthened our ability to respond to a biological event.

Thank you for your time and interest. I am happy to answer any questions.

Mr. LANGEVIN. Thank you, Dr. Vanderwagen, thank you for your testimony.

I now recognize Captain Peter Boynton, the Deputy PFO for Pandemic Influenza and Federal Security Director for Bradley Airport in Connecticut. He's standing in today for the Regional PFO, Admiral George Naccara.

Captain Boynton, welcome and thank you for being here.

STATEMENT OF CAPTAIN PETER BOYNTON, DEPUTY REGIONAL PFO FOR PANDEMIC INFLUENZA AND FEDERAL SECURITY DIRECTOR, BRADLEY INTERNATIONAL AIRPORT (CONNECTICUT), TRANSPORTATION SAFETY ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY

Capt. BOYNTON. Thank you, and good morning, Mr. Chairman, and Members of the subcommittee. Thanks for the opportunity to testify before the committee to discuss the Department of Homeland Security's role in pandemic influenza outbreak.

I am Peter Boynton. I currently serve as the Federal Security Director for the Transportation Security Administration in Connecticut. I am also the Deputy Regional Principal Federal Official for the Northeast Region in the event of a pandemic or biological event.

I am here today on behalf of the Regional Principal Federal Official, George Naccara, who was predesignated by Secretary Chertoff in December 2006 to serve as the Regional PFO for these issues. Region A encompasses both FEMA Regions 1 and 2 which is all of New England, the States of New York, New Jersey, Puerto Rico and the U.S. Virgin Islands.

Based on projections from prior pandemics, an influenza pandemic could result in 200,000 to 2 million deaths in the United States, depending on its severity. Further, an influenza pandemic could have major impacts on society and the economy, including our Nation's critical infrastructure and key resources as many of our Nation's work force could be absent for an extended period of time either sick themselves or caring for loved ones at home.

Under the Homeland Security Presidential Directive 5, in order to prevent, prepare for, respond to and recover from terrorist at-

tacks, major disasters, and other emergencies, the U.S. Government has established a single comprehensive approach to domestic incident management with the Secretary of Homeland Security designated as the Principal Federal Official for domestic incident management.

Understanding the complex effects resulting from a pandemic, in December 2006, the Secretary predesignated Vice Admiral Vivien Crea, Vice Commandant of the U.S. Coast Guard, as the National Principal Federal Official, and five Regional Principal Federal Officials to assist States, local and tribal governments by overseeing a coordinated Federal response. Five "pandemic" regions were established by the Secretary in order to create a manageable span of control. Each region consists of two FEMA regions combined into one "pandemic" region. In March 2008, the Secretary issued an updated pre-designation of PFOs letter to the States and to each Federal department and agency. This letter expanded the role of the Principal Federal Official for pandemic influenza to include other similar Nation-wide biological events. Also, with the anticipation that Joint Field Offices in each of the standard Federal regions would be established in a pandemic or other similar Nation-wide biological event, the Secretary also predesignated two Deputy Regional Principal Federal Officials to assist of the five Regional Principal Federal Officials.

The Principal Federal Officials serve as the Secretary's representatives to ensure consistency of Federal support as well as the overall effectiveness of the Federal incident management. It is important to note that PFOs may be utilized in situations covering the full spectrum of homeland security operations, preventing, protecting, responding, and recovering from major disasters or terrorist attacks. The Secretary activates PFOs for the most complex and catastrophic terrorist or natural disasters, pandemic influenza, and national special security events.

In the spring of 2008, the national response framework was released and the rules and responsibilities of the PFO and other unified coordination group members as described in the framework reflect the feedback given by our Federal, State, and local partners.

In the case of a pandemic influenza outbreak, the PFOs would identify and present to the Homeland Security Secretary in coordination with the DHS Office of Policy and the Office of Health Affairs any policy issues that require resolution. The PFOs promote collaboration and as much as possible resolve any Federal interagency conflicts that may arise at the operational level. The PFOs serve as part of a unified coordination group at the Joint Field Office.

Since the initial predesignation in December 2006 we have received great cooperation from the Department of Health and Human Services, the Department of Defense and components within the Department of Homeland Security by the predesignation of senior officials, defense coordinating officers, FEMA, Federal coordinating officers, and DHS infrastructure protection liaisons for pandemic influenza and other similar national biological events. By working together before a pandemic or biological threat occurs, these Federal partners have forged professional relationships and an understanding of each of their key roles and responsibilities.

Our PFO cell led by Admiral Naccara and the FEMA Regional Administrator met with the Governor of Rhode Island and his senior staff last fall, coincidentally in our parallel world of PFO for hurricanes we exercised with the Governor and his staff and held a mock press conference with the Governor and with yourself, Mr. Chairman, during the hurricane exercise in April 2007.

In closing, DHS through this PFO framework will continue to serve as State and local issues to policy officials at headquarters for resolution and to foster and improve upon the partnership with the Federal interagencies, State, local, tribal, territorial, and private sector stakeholders to complete the work of pandemic and biological threat preparedness.

Thank you again for the opportunity to testify on behalf of the Department of Homeland Security, and I'd be happy to answer any questions you may have.

[The statement of Capt. Boynton follows:]

PREPARED STATEMENT OF PETER BOYNTON

JULY 22, 2008

Good morning, Chairman Langevin, Ranking Member McCaul, and Members of the subcommittee. Thank you for the opportunity to testify before the committee to discuss the Department of Homeland Security's role in a Pandemic Influenza outbreak. I am Peter Boynton, and I currently serve as a Federal Security Director for the Transportation Security Administration. I am also the Deputy Regional Principal Federal Official for the northeast region (termed "Region A") of the United States in the event of a pandemic or biological event.

I am here today on behalf of Regional Principal Federal Official Rear Admiral (Retired) George Naccara, who was pre-designated by Secretary Chertoff in December 2006 to serve as the Regional PFO for these issues. Region A encompasses FEMA Regions I and II, which is all of New England, New York, New Jersey, Puerto Rico and the U.S. Virgin Islands.

To begin, I would like to take a few moments to review some basic facts about pandemics and their potential impacts on our Nation. Pandemic influenza occurs when a novel strain of influenza virus emerges that has the ability to infect humans and to cause severe disease, and when efficient and sustained transmission between humans occurs. This scenario creates unique challenges. Unlike other incidents, a pandemic is not a singular event, but is likely to come in waves, each lasting weeks or months, passing through communities of all sizes across the Nation and the world simultaneously making mutual aid difficult if not impossible. The complete event may last as long as 18 months. Based on projections from prior pandemics, an influenza pandemic could result in 200,000 to 2 million deaths in the United States, depending on its severity. Further, an influenza pandemic could have major impacts on society and the economy, including our Nation's critical infrastructure and key resources, as many of our Nation's work force could be absent for extended periods of time, either sick themselves or caring for loved ones at home.

Under the Homeland Security Presidential Directive 5, in order to prevent, prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies, the U.S. Government has established a single, comprehensive approach to domestic incident management, with the Secretary of Homeland Security designated as the Principal Federal Official for domestic incident management.

Understanding the complex effects resulting from a pandemic, in December 2006, the Secretary pre-designated Vice Admiral Vivien Crea, of the U.S. Coast Guard, as the National Principal Federal Official, and five Regional Principal Federal Officials to assist States, local and tribal governments by overseeing a coordinated Federal response. Five "pandemic" regions were established by the Secretary in order to create a manageable span of control. Each region consists of two FEMA regions combined into one "pandemic" region. In March 2008, the Secretary issued an updated pre-designation of PFOs letter to the States and to each Federal department/agency. This letter expanded the role of the Principal Federal Officials for pandemic influenza to include other similar Nation-wide biological events. Also, with the anticipation that Joint Field Offices in each of the standard Federal regions would be established in a pandemic or other similar Nation-wide biological event, the Sec-

retary pre-designated two Deputy Regional Principal Federal Officials to assist each of the five Regional Principal Federal Officials.

The Principal Federal Officials serve as the Secretary's representatives to ensure consistency of Federal support as well as the overall effectiveness of the Federal incident management. The PFOs would identify and present to the Homeland Security Secretary, in coordination with the DHS Office of Policy and the Office of Health Affairs, any policy issues that require resolution. The PFOs promote collaboration and as much as possible resolve any Federal interagency conflicts that may arise at the operational level. The PFOs serve as part of a Unified Coordination Group at a Joint Field Office.

Since the initial pre-designation in December 2006, we have received great cooperation from the Department of Health and Human Services, the Department of Defense, and components within the Department of Homeland Security by the predesignation of Senior Officials, Defense Coordinating Officers, FEMA Federal Coordinating Officers, and DHS/Infrastructure Protection Liaisons for Pandemic Influenza and other similar Nation-wide biological events. Pandemic/Biological Threat PFO Teams have been created, so these participating Federal agencies/departments may work together now before the catastrophic event may occur as well as to conduct outreach to States, local and tribal governments and the private sector. Each of the five Regional PFO teams would be comprised of the same members in a Unified Coordination Group described in the National Response Framework. However, by working together before a pandemic or biological threat occurs, these PFO teams have forged professional relationships, and an understanding of each of their key roles and responsibilities. In fact, our PFO cell and the FEMA Regional Administrator met with the Governor of Rhode Island and his senior staff last fall; coincidentally in our parallel role of PFO for hurricanes, we exercised with the Governor and staff and held a mock press event with the Governor and with Chairman Langevin during the hurricane exercise in April 2007. Also, the States, private sector, local and tribal governments will have familiarity of these key Federal Government officials prior to a catastrophic event.

Since the initial December 2006 pre-designation, the PFO teams have performed a myriad of training, exercise, and outreach activities. Activities have included the following: Pandemic PFO training in February 2007; PFO Orientation in January 2007; meetings with State Governors, and State officials in both public health and emergency management operations; exercise with the Centers for Disease Control and Prevention in their pandemic influenza activities; participation in the National Governors Association Pandemic Influenza Workshops; participation in the Association of State and Territorial Health Officers (ASTHO) Pandemic Influenza Table Top Exercises; participation in an internal PFO Team Exercise Workshop in November 2007; and participation in the Assistant Secretary Principal Level Exercise at the White House in February 2008. In December 2007, Region A with great support from FEMA Regions I and II held a regional pandemic influenza exercise whereby a Regional Joint Field Office was established in Maynard, Massachusetts and the Region A States stood up their Emergency Operations Centers. In April 2008 and May 2008, Region C under Mr. Edward Buikema, the Regional PFO, hosted two pandemic influenza summits in Chicago, Illinois and Denver, Colorado, respectively, with invitations to the States in Region C to participate. Both events included a tabletop exercise sponsored by the U.S. Naval Postgraduate School in Monterey, California.

Both the national and five regional PFO teams will continue to conduct training, outreach, and exercise activities. In September 2008, Region B PFO and Vice Admiral Crea will participate in a CDC Pandemic Influenza Tabletop Exercise. In late October 2008, the Department of Homeland Security will conduct an intra-departmental exercise with participation from the pre-designated PFOs, the Office of Health Affairs, FEMA Federal Coordinating Officers, and DHS/Infrastructure Protection Liaisons. Finally, the Homeland Security Secretary recently requested the Attorney General pre-designate a national and five regional Senior Federal Law Enforcement Officers to join our respective teams.

In closing, many of these accomplishments can be incorporated into an all-hazards framework to promote the national culture of preparedness, effective outreach and partnering. DHS, through this PFO framework will continue to surface State and local issues to policy officials at headquarters for resolution, to foster and improve upon the partnership with the Federal interagency, State, local, tribal, territorial, and private sector stakeholders to complete the work of pandemic and biological threat preparedness, to promote the culture of preparedness in general and to further the Nation's ability to prepare for, respond to, and recover from all hazards.

Thank you again for the opportunity to testify on behalf of the Department of Homeland Security on these issues of critical importance to our Nation's security and well-being. I would be happy to answer any questions you might have.

Mr. LANGEVIN. Thank you, Captain Boynton, for your testimony. I should have mentioned earlier that Dr. Vanderwagen has submitted joint testimony along with Dr. Kurilla and Dr. Sosin and has given the verbal testimony for both of those gentlemen, so I know you'll be available for questions. I want to thank the panel for their witness testimony today. I remind each Member that he or she will have 5 minutes to question the panel. It's my intention, time permitting, that we will do two rounds of questions for Members for each panel.

Dr. Kurilla, tell me what is the current status of Project BioShield that was created in 2002 to try to speed new vaccines or drugs to the market to protect the public in the event of a potential attack or response to such things as Avian Flu? What meaningful treatments, antidotes, or vaccines have we produced or are we close to producing right now?

Go ahead and answer that and I'll go with the second one.

Dr. VANDERWAGEN. We have just submitted a written report for the progress through 2007 to the Congress and I would want to make sure you have a copy of that for more detailed reference.

We have used Project BioShield which is an acquisition program, not a development program, to acquire a wide variety of materials, most of which existed in the marketplace before BioShield came into place, but the authority to acquire these things was strongly enhanced by BioShield as an approach.

Congress augmented this by providing us with an advanced development authority that is significant in its impact as well. But let me speak to BioShield. The acquisitions there have been focused on readily available market products, in general. We have acquired significant products for chemical events, for radical nuke events and that would include chelating agents, KI, Prussian Blue and other radiation medications which exist in the marketplace. We've acquired antibiotics that exist under the program as well to assure that we have existing broad-spectrum antibiotics available for things like Bubonic Plague, for anthrax, et cetera.

We have through the Advanced Development Program, supported the development of the development of a number of things including anti-toxins for botulism, for anthrax, et cetera, and the acquisition to that products now are reading to delivery in the national stockpile and the other positive thing to be said is some of our international partners now are purchasing from the companies that we've supported in development so that they have a wider market base of support so that infrastructure will persist.

But I'll turn to Mike, and Mike, do you want to say some more about the research developments in this area?

Dr. KURILLA. So with the publications——

Mr. LANGEVIN. Pull the mic very close to you, if you could.

Dr. KURILLA. So with the publication by the Department of the Public Health and Emergency Medical Countermeasures Strategy and Implementation Plan, we have used that as a basis for our more advanced research and development programs in order to provide candidates that would be eligible for BioShield.

In addition, as Dr. Vanderwagen has mentioned, although there's been an acquisition for botulism antitoxin, we are continuing to assist in that development through our animal model and assay work that would be supportive of the FDA licensure. We have supported through fairly well advanced both a second generation anthrax vaccine, as well as a second generation smallpox vaccine, the MVA, modified vaccinia Ankara, for smallpox which has, in fact, been acquired by Project BioShield.

We have a number of other activities going on.

Mr. LANGEVIN. Let me question you there on that because as we know with the cancellation of the VaxGen contract, the next is developing the next generation vaccine for anthrax. That seemed to go nowhere. Give me the current status, more specifics of the next generation anthrax——

Dr. KURILLA. So given the high probability of failure for products at the point when we entered into our contract with VaxGen, we actually were supporting two separate companies, VaxGen being one. Avecia Biologics being the second one, that contract has continued successfully. That company has subsequently been purchased by Pharmathene so the names keep changing, but in fact, we have a second generation anthrax vaccine that is currently undergoing validation of its commercial scale process manufacturing and——

Mr. LANGEVIN. When do you expect that to be completed?

Dr. KURILLA. The validation, we anticipate would be done some time in early 2009 and then it would move on to generation of their fill finish, that is the final product production will be later in the year. There is currently a BioShield acquisition contract for recombinant protective antigen that is under review, but that's something for the Department to address. That's not my acquisition contract, but that has been moving forward reasonably successfully. It has completely two Phase 2 clinical trials and so far it's looking very good as a product.

Mr. LANGEVIN. Dr. Vanderwagen, Dr. Kurilla, as you know, BioShield, obviously is important, to contribute to public health security. It's too important to fail, but there have been numerous problems with the program as I mentioned earlier. To remedy these problems, Congress enacted legislation to create BARDA and how do you think BARDA has helped, if at all, to improve the coordination between HHS, NIH, CDC, et cetera and DHS and do you think that we're getting enough threat-related information from DHS to inform these efforts to develop countermeasures to make the link between threat and actual resource development for the next generation antidotes?

Dr. VANDERWAGEN. Thank you, Mr. Chair. I think that the threat determinations are proceeding along fairly well. There are emerging infectious disease that go outside the threat environment that we still have concerns about, but DHS is setting the threats very effectively and our public health modeling is working along fine.

The BARDA package goes to what I just alluded to earlier. That is, there's a limited amount of advanced development that NIH can do. They're in the research business. They can take development to a certain point that have to sort to give it up at that point. Neither

the industry and venture capital pick it up or not. What the Congress has done in providing us the BARDA authority is allowing us to pick up more of those good research ideas, help those companies develop those through the clinical trials so we don't have a failure like we have with the VaxGen, and then we can talk about an acquisition of those products.

We think that BARDA has come along very nicely in the kinds of things that Mike just talked about, that is, products that they have brought to a point that we will move forward with, for instance, in the acute radiation area, not bio, but in the acute radiation area, we had 20 products almost, come to the fore that needed advanced development. We will fund half of those in all probability through to the clinical trial base that will allow us to make acquisition decisions about them as mature products.

We think BARDA is a very effective tool and I'll let Mike comment about the transition piece between the research world and the advanced development world.

Dr. KURILLA. BARDA has been a welcome addition. At NIH we are not, and do not intend to be, a commercial manufacturer, distributor of products. So the products that we develop to a certain point in the pathway toward licensure I have to hand off to a customer. My customer is not the person on the sharp end of the needle. It's the person holding the needle. BARDA is that customer who can then carry forward with the commercial scale development because those technical issues involved in that phase of product development are uniquely dependent on the specifics of procurement and since HHS is doing the procurement, they really need to be involved in that major advanced development commercial scale manufacturing. It allows you to set the conditions that will make the product successful and bring it in on time. It has been a welcome addition and we work very, very closely such that we overlap our programs so that by having a little bit of overlap we ensure that there really are no gaps in the development which allows these products to fall through the cracks. So it has been a welcome relief.

Mr. LANGEVIN. On that point let me ask what were the lessons learned from VaxGen, that contract, and have you changed your development and clinical trials process in response to that failure?

Dr. KURILLA. The major lesson we learned that I think it is very difficult to cast your bets on products in terms of acquisition too early in the development cycle, simply because and this is not anything unique to Government, this is industry standards and industry benchmarks is that the failure rate early in clinical development is exceedingly high, getting into a Phase 1 first time in man, you are no better than a 10 to 20 percent success rate.

So what we have done in our development is that we have tried to stage them a little more so that we work with options so that if a company moves to a certain point and looks successful, we can engage the option and carry them a little further. It doesn't—it avoids us having to cast our bets on a few possibilities and allows us to expand our repertoire of candidate products that makes more available downstream for BARDA and HHS in terms of Project BioShield to select from.

Dr. VANDERWAGEN. Yes, the relevant examples occurred in pandemic influenza where we supported a number of manufacturers

through the early trial process and weeded out those that could be successful and that ultimately led to an H5N1 vaccine that's licensed and safe. That's the kind of process that Mike's describing.

Early on, there may be four or five companies that have a good idea, but they may not have the skill, capability to bring it to a safe and effective product. We can support them through that test phase and those that can't make it drop out and those that can do the job then become candidates for a broad-scale acquisition and with VaxGen there was no early indication about whether they were going to be able to do it or not. It was a high-risk venture.

Mr. LANGEVIN. Thank you for those answers. Last question I have in this round is for Dr. Runge, and then I'll go to Dr. Christensen.

Dr. Runge, you said in your testimony that you were very concerned about the threat of weaponized anthrax. Clearly, I share that concern, of course. However, we receive many biological threats for which we must be prepared, not just anthrax.

How ready are we for terrorist use of anthrax and how do you suggest preparing for this threat, while preparing for other biological threats at the same time?

Dr. RUNGE. Mr. Chairman, thank you for that question.

First of all, with respect to other agents, as Dr. Vanderwagen mentioned earlier, we—what keeps me up at night is the intentional use of a biological agent and certainly anthrax is not the only one.

The Science and Technology Directorate recently released a draft of its integrated threat assessment that—risk assessment, excuse me, that stratifies the agents by degree of risk and once again our No. 1 is still our No. 1. But there are others that are considerable.

We also have included zoonotic disease for the first time in that analysis simply because of the tremendous economic impact that something like foot-and-mouth disease might have on our agriculture economy, on our ability to export food products and so forth.

With respect to how ready are we, we are as ready as we can be at this point in time, but again as Craig mentioned we are better prepared, but we are not ready.

Every piece of our—the four pillars of biodefense have to work seamlessly or we will not be able to answer this challenge. We need improved intelligence. We need better threat defense. We need enhanced biosurveillance.

Dr. Sosin is a key part of the governance now of our new NBIC enterprise governance. The CDC is responsible for human health. USDA is responsible for animal health. We are moving forward very quickly with the more successful biosurveillance integration system.

With respect to biodetection, we are not where we need to be right now. We have a built-in delay of up to 30 to 34 hours in our ability to detect a pathogen in the air. We must press forward with the bridging technology that New York has successfully deployed, as well as the successful completion of Generation 3. Our target date for S&T is in spring of 2009 for operational testing evaluation.

We have to improve our response and recovery. The CDC can get medications out to local communities within 12 hours. That's great,

but we still do not have a uniform capability across the country of countermeasure delivery within that very narrow time window for both plague and for anthrax.

With respect to environmental recovery, EPA, HHS, and DHS have been working very, very closely on protocols as to how we would even begin to sample a building. How clean is clean? We are codependent then on the development of vaccine, on third generation antibiotics, for anthrax strains that may be resistant to doxycycline or suprafloxicine, our current weapons for medical prophylaxis. So every piece of this has to work. We don't have a double-fail-safe mechanism for this. So this integration, the working together and the concepts of operations all the way down to the local level where if an attack like this occurred our PFO cadre has to be trained along with their Federal coordination officers and State and local emergency management officials in order to do this work.

So I wish I could say that we were done, but we're not done.

Mr. LANGEVIN. Obviously, we need to continue to make these things a priority, especially as you know, we just had the hearing last week on Project BioWatch and the NBIC and I'm anxious to get those next generation detectors deployed as soon as possible as I know you are.

With that, I'm going to turn now to Congresswoman Dr. Christensen for her questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you for holding this hearing which happens to include the Virgin Islands since we're in the same region and I want to thank the testifiers, I want to thank all of you for your service, but as Dr. Runge is getting ready to leave us I want to particularly thank him for the work he's done in really creating the Office of Health Affairs. When you came there, we were not quite sure what it was going to be. Now it's a little clearer.

I wanted to follow up on the biosurveillance question because you spoke in your testimony about soft targets and the importance of those and the impact it could have, a bioterrorism event could have because of the slowness of picking up the agent.

So I wonder if—well, to the best of my knowledge, BioWatch detectors are in major cities and I wonder if there's a plan for expanding to a second round of bio detectors in softer areas and to what extent would the delay, the 1-year delay in the Gen 3 biodetectors impact any expansion of BioWatch?

Dr. RUNGE. Thank you, Dr. Christensen. It's almost rhetorical to say that if we had our way we would have completely automated detection systems covering the entire U.S. population. That is neither practical nor affordable. We have modeled a number that we believe would cover the part of the population that we believe is at risk. For instance, with an intentional anthrax attack, one can probably draw the line where it would simply not be worth the while of the terrorists to use that weapon on a very sparse part of the population.

So we have a number in mind for what it would take to cover the entire country in the areas that we consider the highest threat. When BioWatch stood up, it stood up, I'd like to remind the committee in 32 days. It was a phenomenal piece of work that we did

with the CDC, with the State and local governments and the model that was created was to franchise the detection and decisionmaking to local laboratories.

With the advent of automated detection systems, we can actually move beyond that and will have to work out a better partnership arrangement with local governments and with a central biosurveillance system, along with the CDC so that we can actually see things in real time.

I'm a little distressed about—there are naysayers out there with respect to whether we actually need to do this sort of environmental detection. Even to the point that the House Appropriations Committee in their House report cut the budget for BioWatch by $22.8 million to buy that bridging technology which we've successfully deployed in New York City. It's inexplicable to me. The Center, of course, included it. So I would ask your attention to that as well when it comes to be conference time.

But we will continue to enhance this program and we'll to do this and we'll have to cover more of the population over time until we have a universal vaccine and the policy becomes that we can take this germ off the table with a recombinant antigen that is safe and effective. So it's a long answer, I'm sorry, but I hope I answered your question.

Dr. CHRISTENSEN. We recognize that the Appropriations Committee had had those kind of questions and I think they were answered. We asked questions when we had that hearing back a couple of weeks ago to the people who run the program in your office. I think it was answered to my satisfaction.

Dr. Sosin, would you like to comment on that?

Dr. SOSIN. Thank you, Dr. Christensen. Thank you for the honor and privilege of being here representing biosurveillance as an area broadly, nationally, and CDC.

It strikes me that your job is particularly challenging in that it's not really a matter of weeding out unuseful or wasteful solutions to biosurveillance or preparedness, but weighing the relative values of them.

From where I sit and the public health community that I reside in and in this exchange that we've having over the last 6 months around a national biosurveillance strategy, it's striking that top all hazard, all jurisdiction capability for biosurveillance falls in the context of our clinical public health relationship. You're spending a lot of time talking about partnerships and those relationships. Those have improved dramatically. In the years that we've been funding preparedness and building the capabilities of health departments to interact with their clinical environments, to share information effectively, and that keeping that strong and strengthening that which is strained is a critical resource that we need to consider.

As we look at the mass release aerosolized release of agents such as anthrax, we anticipate that large exposures to aerosolized anthrax can cause disease within 12 hours, so that our clinical presentation and not just of single cases as has been our experience with anthrax to date, but large number of cases mixes virtually impossible not to be recognized in clinical environments, not initially as anthrax, per se, but to set up alarms and to initiate the types

of investigation on public health and clinical providers undertake for unknown diseases.

So to think in terms of the capability that we need to strengthen that's all hazards and all jurisdiction, it's really important to keep the infrastructure of the health system in mind.

Mrs. CHRISTENSEN. You're singing my song. I'm glad to hear the emphasis on the public health response side.

Dr. Vanderwagen, in your testimony, you talk about $2.6 billion having been spent over 5 years on surge, increase in surge. How much surge have we bought with that $2.6 billion? Can you quantify the increase in surge capability across the country and can you tell us, for example, in terms of the States, territories, and tribes, a ballpark percentage of who is prepared, who has built capacity—sufficient capacity to meet the standards you've set?

Dr. VANDERWAGEN. Right. Doctor, it's a great question. What is surge?—and surge, to me, is a challenge.

It's wholly different if you're expecting to meet the challenge of a train bomb as we saw in Madrid or if we're expecting to deal with a pandemic flu. So surge capability I think incrementally has improved significantly from the perspective of can we meet the challenge of things like IEDs, kinetic events, geographically, temporally limited, yes, we've made significant improvement.

Here in Rhode Island, there are 15 hospitals, 14 of them participate in hospital preparedness program. They've made significant strides forward in training their staff, developing things like IED capability, management of beds, management of traffic, patient flow, et cetera.

I think these are the hallmarks of what's happened over the last 5 years with funding in the surge, medical surge world. In 2006, there were over 9,500 exercises conducted by hospitals and facilities involving their staff and action. That's pretty dramatic stuff. What has happened is that JHACO and the other accrediting organizations have begun to internalize these higher standards of expectation into their performance requirements for hospitals to get accredited and so the profession, if you will, and the industry itself has begun to internalize many of these kind of changes, what is effective sheltering in place? What does it take to shelter in place? Your generator shouldn't be two floors below ground level, things like this, that become normative in the industry.

Where we have difficulty and the GAO report highlighted this, is in a large-scale event where the demand far exceeds the asset base that's available. What kind of decisions will we be making about triage, about changing standards of care, alternate care sites, et cetera.

Some communities are addressing this very aggressively. Miami, the Board of Education and the schools and the public health system have partnered to develop alternate care sites using mothballed schools which they've warm based, they can use them.

Other communities really have not done the heavy lifting. In August, we met with Costco executives, Starbucks executives, public health and hospital people in Seattle and they admitted up front they hadn't done the heavy lifting to deal with some of these issues yet.

Last week, we met in Indianapolis, 31 States, District of Columbia and four territories, including the Virgin Islands and Puerto Rico, to map out an approach to national consensus generation in dealing with the ethics of high-demand, short availability of assets. It will require community, State, regional and national activity and the GAO report I think was on target that now is the time people are ready and while we will not dictate from a Federal perspective, we can facilitate and provide guidelines for dealing with those tough issues.

So we've moved a long way in the last 5 years. Notwithstanding that, we have not dealt with the worst event which is high-demand, low-asset and that's the next challenge in front of us.

Mrs. CHRISTENSEN. We'll come back to that somewhat in the second round.

I wanted to ask Captain Boynton, we've spent a fair amount of funding and lot of time and exercises on pandemic flu which everyone is pretty sure at some point it's going to come, we don't know when. Can you tell me how this preparation may have prepared us better for a more all-hazard kind of biologic event?

Another part of my question is: How does the national PFO relate to Admiral Vanderwagen?

Capt. BOYNTON. Thank you. From my perspective, and I'm coming at this from a perspective of the regional perspective as the Deputy PFO, we think that there are a lot of synergies to be gained from our work in preparing for pandemic influenza and other biological hazards. It doesn't mean that all aspects of the incident response that the PFOs will be focusing on, the incident response part of the operation. It doesn't mean that they're all the same, but we do believe that there are a lot of synergies that can be gained.

The five regional PFO cells have been, the cells have been built. They all include PFOs, Deputy PFOs, senior health officials, senior defense coordinating officials, and we have exercised both regionally and nationally with the national PFO team led by Admiral Crea, so we think there are synergies there between them even though not every aspect of an incident response would be the same.

Dr. VANDERWAGEN. The quick answer Vice Admiral Crea and I are very close. She's a good person and right up front when Secretary Chertoff named her, she got support from Dr. Runge, but she reached right over to us and said: "How do we play?"

She has my Deputy Assistant Secretary, Kevin Yeskie, assigned to her to answer and work with her on any questions related to the House sector, but as was alluded to here, this will not be an ops response much like we would have in a hurricane and so on. This is going to extend over time. So she has used our health players in conjunction with the PFOs to begin to reach out to the wider community to bring all the sectors into play.

Mrs. CHRISTENSEN. One more question in this round that sort of comes out of that.

Dr. Runge, Mr. Kilday will testify later about a newly imposed ban on using Federal resources for local emergencies and are you aware of that?

Dr. RUNGE. I'm at a loss, Congresswoman. No. Recently imposed ban?

Mrs. CHRISTENSEN. I probably can't locate the exact place in his testimony, but they used to be able to use the Federal resources that were here. "Until recently nearly all of the team's equipment was Federal property and, as such, would not be available for use within the State of Rhode Island." If I understand that correctly, at one point they were able to use it and now they have to purchase their own equipment. This is in DMAT.

Dr. VANDERWAGEN. What you're referring to is the Disaster Medical Assistance Team. There's one located here in Rhode Island and it's had a long and illustrious history.

When NDMS, the National Disaster Medical System was initiated back in 1982, 1983, 1984, it was designed to meet a Cold War challenge, that is, the transport of a large number of wounded warriors from Europe to the United States, how do we get them to definitive care? How do we receive them at the airheads, et cetera?

Emergency response teams were developed. Mobile emergency rooms. Increasingly, that concept was extended into use in the domestic response environment. These Disaster Medical Assistance Teams of which there are about 56 active Medical Assistance Teams at the moment, were predicated on they managed their own assets, et cetera. They were required under the Federal domain and they managed their assets.

What we have determined is that given the challenge we have with wide domestic response capability that we believe that regional caching and delivery of those caches on a regional basis with the teams coming to play is a much more effective way to assure that we have people and equipment in place and it's allowed us to expand up to an additional 15 teams who are available to play.

There are challenges to the existing teams because the question of what will they train on and so on are still issues that have not been fully resolved to their satisfaction, but I would tell you that the regional caching of that equipment has subserved our response capability significantly. My chief logistician came to us from the Army Medical Command where she was the director of logistics for a number of years and she knows this business. FedEx is delivering for us on a Q6 hour turnaround time. So we think there's been improvements in our response capability overall. There are questions of how we support the training requirements of the teams and that's still an open question that will need further resolution.

Mr. LANGEVIN. We're going to come back to this DMAT issue in a lightning round, in the second round of questions. With that, the Chair now recognizes the gentleman from New Jersey, for his questions.

Mr. PASCRELL. Thank you, Mr. Chairman, good morning. Thank you for your service to your country.

I would like to ask an open question with a brief, hopefully, a brief answer. Then we'll get into some other questions.

It appears that you all agree that the risk of the possibility of slowly detected outbreak of a specific situation is more acceptable than the risk of vaccination. I would like your responses to that.

Dr. Runge, why don't we start with you?

Dr. RUNGE. I'm not sure—my answer will be very brief, sir, because I'm not sure I really understand the question. We have to make choices.

Mr. PASCRELL. Yes. We're not going to have a seamless defense concerns. We passed that hurdle, is that correct? Is that correct, gentlemen?

Do one of you believe we can create a seamless way to protect the populations against the very diseases we're talking about today?

Let's be straight about this.

Dr. RUNGE. Yes, I think we can approach it, sir. I'm not sure that we can ever reach that perfection.

Mr. PASCRELL. Then let me go back to my original question. Is it better that we move toward the direction of vaccinating everyone against a particular problem or is it best that we develop the quickest means of responding after we realize that—and after we detect something?

Is it an either/or?

Dr. RUNGE. I get it now. I don't think it's an either/or. I do believe that until—and first of all, if we project into the future that there actually will be a vaccine to take certain of these threats off the table, it then becomes an issue of policy that this Nation is going to have to face together, all branches of government. Do we vaccinate against a highly—excuse me, maybe not highly, but against a relatively improbable event than measles, mumps, rubella, or chickenpox, which are going to happen every season and we want our children protected against that?

So then we really do have to rely on our health policy folks as to the relative merits of a vaccine because there are side effects to vaccines and if we universally vaccine everyone against a disease, yes, that is probably the best deterrent we could ever have for terrorists using that against us. But the cost of that is some degree of untoward effects of those vaccines and I think we have to have that dialog.

Mr. PASCRELL. Admiral.

Dr. VANDERWAGEN. I agree with Jeff, I mean ideally I'd like to have the vaccines, take this off the table. For instance——

Mr. PASCRELL. Are we developing those vaccines?

Dr. VANDERWAGEN. We're moving ahead pretty aggressively. The challenge here is—for instance, we have an H5N1 vaccine that we know is safe and effective, but we don't know that that's the bug that we could be hit with. So the events we are moving to go after those threats that we know to try and develop the appropriate vaccines. The emerging infectious diseases present us a challenge with is it going to be the right one.

I think the next horizon and I'll let Dr. Kurilla speak to this because he's the expert, but the next horizon we're looking for is can we develop a carrier that would allow you to vaccinate with a single vaccine for a wide variety of diseases as opposed to have to give unique vaccines for each and every disease, but I'll let Mike comment on that dream.

Mr. PASCRELL. Captain or Dr. Kurilla.

Dr. KURILLA. Well, I would agree with you and I agree with Jeff and Craig that the prophylaxis is always desirable. However, it's

very clear even in the instance of vaccines we have today that we require children to receive before they go to school, there is still a considerable fraction of the population that does not get vaccinated, and so as a result we still need to focus on and develop countermeasures that would address those situations.

In terms of universal vaccines, such as example for flu, we are still back at the conceptual stage, but that is a direction we are moving to to get us out of the requirement for an annual flu vaccine every year that needs to be updated. We think it will come down the way, but we are still some years away from even having something that we can move into development at this point in time, but it is a strategy and a concept that we are pushing on and moving forward on. We think we will get there.

Mr. PASCRELL. Thank you. Doctor or Captain, either one of you want to respond?

Capt. BOYNTON. I'll defer to the medical experts.

Dr. SOSIN. Because this is not really a medical question, but more of a societal policy question, I think everything you've heard, sir, does reflect the state of balanced decisionmaking that has to be made.

Mr. PASCRELL. Dr. Runge, thank you for your service. You've brought some sanity to a real insane situation down there and I think Chertoff has tried to clean up the act. I don't know how far he's gone. You made a recommendation in your presentation which I find very fascinating. It goes to the very heart of a lot of problems in homeland security. I was just on the phone concerning another problem, the question of evacuation.

We've had total bifurcation here of who is responsible, who pushed JCAHO? You say that while DHS is by its authorization, Pub. L. 109–295, a collaborative agency so must Congress work collaboratively to ensure a more secure homeland empowering an effective, yet supportive, oversight environment. Is the fact that we have a bifurcated situation between DHS and HHS, do you see that as essential to understand, that is essential to getting over the humps that exist between those two big departments?

Dr. RUNGE. I think it is very, very important that the oversight committees on the Hill are in lockstep. We have gone from a kind of creative dissonance to a much more collaborative and synchronous relationship.

It's no surprise to you, Mr. Pascrell, that Secretary Chertoff has said on numerous occasions we're sort of in an environment where we have incoming coming from 360 degrees and that happens you tend to get deeper into your foxhole. That's not productive for collaboration.

We really need to be able to focus on our oversight committees, transportation, energy, commerce and T&I and the Senate commerce. It was very easy to form a relationship with the Members, very easy to form a relationship with the staff and there were very few extraneous issues that would parachute in from other sides.

Since I've been at Homeland Security for the last 3 years we have not enjoyed that sort of relationship. So I'm not sure how leadership is going to get it done, sir, but I do think it's essential, just as we have created a much more harmonious and synchronous relationship with the CDC on bi-surveillance, with ASPR on

threats and countermeasures that that—if you can get that to happen, that would be terrific.

Mr. PASCRELL. We had some warnings about this through the Chair in 2002 when we were putting this dinosaur together. The Government's health care experts, it seemed anyway at the time, would be split between health and human services and the proposed homeland security deployment. In some cases the new department would become a customer of HHS, contracting for services. This is a splintered process rather than a centralized one. That problem within those folks who get paid for doing, protecting America, as compared to the committees, 83 of which—that's mind boggling.

Dr. RUNGE. Yes, sir.

Mr. PASCRELL. How do we get to the central point here? How do we get to see who is in charge?—and it would seem in many areas including this one, we can't answer the question. So we didn't bring them together. In fact, it was proposed in 2002 that there would be an undersecretary that would have that responsibility. There's no such animal.

Would you like to take a swipe at that?

Dr. RUNGE. I'm not exactly sure what the administration policy would be on that, sir, so I will defer right now.

Mr. PASCRELL. The administration's policy is to protect America.

Dr. RUNGE. Yes, sir.

Mr. PASCRELL. It doesn't matter, it doesn't have to do with politics, it has to do with protecting Americans and Americans aren't going to accept the half-answers that we've been getting.

Dr. RUNGE. DHS has been in the precarious position of having responsibility without the authority.

Mr. PASCRELL. I think you put it better than I could have put it.

Dr. RUNGE. The thankless job of coordination among departments and agencies that don't necessarily want to be coordinated has been pounding one's head against the wall.

Mr. PASCRELL. Mr. Chairman, I salute you and Dr. Christensen for the work that you've done from the very beginning on this. Not only that—it's not only important that we talk to each other. We need results. The Chairman has been there and the result has been changing the culture. It is a culture. If we don't do that, then we're not doing our jobs on this side of the table. You should be badgering us to make the changes that are necessary.

Eighty-three committees examine homeland security. How in God's name does anything get done? Then when they come to us they don't give us the truth half the time anyway, so if you're watching this and wondering who did push JCAHO?

I'm telling you, Mr. Chairman, thank goodness for this committee and what your work is and I'm blowing smoke, I'm telling you. You know I like to say it like it is.

Mr. LANGEVIN. I've noticed that.

[Laughter.]

Mr. PASCRELL. This is a very critical issue and we need to bring some changes that have to get done so that the people on the front lines know that they're getting support in our rhetoric. Thank you.

Mr. LANGEVIN. I thank the gentleman. We're going to go to round two and I'm going to adhere us to the strict 5-minute rule. We gave latitude on the first round and we appreciate our guests here and the Members for traveling, but we have a lot of questions we want to get in, so I'm going to go to a very strict 5-minute rule in this last round of questions.

I want to begin with going back to Dr. Christensen's question for Dr. Vanderwagen on DMAT issues.

Dr. Vanderwagen, it is my understanding that the original vision for the national disaster medical system included having at least one DMAT per State and territory. However, as you were talking about recently, just a minute ago, the decision was made by HHS to regionalize DMAT assets.

Can you explain that decision? How do you foresee regionalized DMATs deploying, for example, and what I'm concerned about primarily when an entire region or the entire country is affected by widespread biological disease, per se, for example, if there were to be a widespread outbreak of a highly infectious disease in New England, how would DMAT assets currently centralized near Boston be deployed to respond to the needs of Rhode Islanders, for example, or those in nearby States?

Would you answer that?

Dr. VANDERWAGEN. Yes. I think in the circumstance you just described it's unlikely that we would be deploying any assets for much more than the first 2 or 3 weeks of that event because all this will become local inherently as the disease spreads across the country.

Our current concept of operations, whether it's for Federal assets or MRCs or any asset is that we're unlikely to be deploying people from Point A to Point Z in a pandemic event for response operations because once you get beyond the first four or five cities that are involved everybody is going to need to be in place in their location taking care of their own community as opposed to looking to the feds to move people from here to there.

Mr. LANGEVIN. But doesn't that kind of speak though to why it's so important to have one in each State as it was originally planned?

Dr. VANDERWAGEN. Indeed, and in fact, the States themselves now have gone to much more extensive investment in team processes. When the group was over in FEMA it was determined that these could not be used for State assets, that they were only Federal assets available for Federal deployment.

We have encouraged States and are now supporting State efforts to develop State-based DMATs and have them at the call of States first and foremost. You've got 26 teams in North Carolina. You've got six teams in California, et cetera, that have been developed.

We will provide the original cash support to those folks if called upon. If they need additional Federal assets, we would bring people from Point A to Point Z, but we believe that our job is to really try and build local capacity to the maximum possible degree and where we have Federal assets, place them regionally so they're more accessible to the local requirements.

Texas is preparing for the storm to hit on shore. We have predeployed two Federal medical stations, 500 beds' worth. We have

deployed the caches for DMAT teams to San Antonio well ahead of the process. Those FMSs reside in Texas full-time.

Mr. LANGEVIN. Well, we're going to keep following up on this, on the DMAT issue, and I know our second panel, the State folks, probably may have a slightly different perspective and we're interested in hearing their input.

Dr. Runge and Dr. Vanderwagen, when we conduct exercises, obviously, it's important to be as realistic as possible to the extent that we can and use current requirements to show us how well we might do in a future situation.

During a pandemic, DHS and HHS obviously will be the lead, with Federal agencies managing the response. At a hearing I held last September I stated that we should test our systems now using seasonal influenza as a proxy for pandemic influenza.

Dr. Vanderwagen, starting with you, I also asked you to take last year's influenza season and make a concerted effort to see how many people we could vaccinate in the shortest period of time, basically, intending that seasonal influenza is actually pandemic influenza. The way I see it, we should be testing our distribution systems now, stressing our organizations in these sorts of real-time, real-world contexts while improving the health of our citizens throughout the Nation.

You agreed, and you also—I also told you that I'd be asking about this again. So here we are at this hearing. Did HHS do this? If so, how? What was the outcome? If not, why not?

Then for Dr. Runge, you were not at that hearing, but I did ask Dr. Jolly a similar question, asking the Office of Health Affairs to get the national biosurveillance integration system in this to start tracking seasonal influenza during influenza season and treating it as if it were pandemic influenza. I also asked that the Department get our CBP offices on the board to identify people who are obviously ill with something that looks like the flu and divert them to secondary screening. Did these and other activities occur and if so, how and if not, why not?

Let's start with Dr. Vanderwagen.

Dr. VANDERWAGEN. Yes, the primary event that can be tested in seasonal flu that would approximate pandemic is immunization practices and immunization access. In the first instance, that's going to be the primary event response. In fact, many States and localities have done extensive testing and evaluation of various modalities from drive throughs to on-work site to the standard go to the County Health Department approaches.

We believe that there are best practices out there, but increasingly we're engaging with local business to participate in these processes as well, that they can become dispensing sites and capture a significant number of people in those events.

That's not only useful for pandemic flu, but it's also useful for management of distribution of prophylactic antibiotics and in other biological event, the use of antivirals if we can expand to prophylactic, post-exposure prophylaxis use. So a wide variety of those were tested last year. Again, folks have been driving this train pretty hard, depending upon where they are.

We've put it into the requirements for hospital preparedness program and it's built into the FEP as well, that they test and exercise

these distribution schemes. What is problematic is what about alternate care sites? That's the next frontier, if you will, of exercising what are those alternate care sites? What will the standards of care be that are applied in those kind of environments? That's a little different than the logistical challenge of how we get drugs into people's arms.

Mr. LANGEVIN. Thank you. Dr. Runge.

Dr. RUNGE. Mr. Chairman, with respect to the biosurveillance piece, I can tell you—first of all, I cannot tell you that there was an additional exercise that went on within the NBIC. However, the domain of human health surveillance is the CDC's contribution to NBIC. CDC has been consistent in having a detailee in the Center who has access to the human surveillance data, and thresholds are decided upon over which they will enter into the situation report every day.

I do not believe that seasonal influenza met that criterion and I don't recall seeing it in the daily situation report or in the weekly summary. They do produce weekly summary on H5N1 which is based again on CDC's human surveillance efforts. I will defer to Dr. Sosin for more detail on that.

With respect to CBP, I don't know that any special effort went into looking for people with the flu. I can tell you though that these law enforcement officers who are not trained medically do a pretty darn good job of weeding people out and sending them to secondary for additional screening when they do appear ill. It is not an unusual occurrence for them to send someone to secondary who appears ill and to summon health authorities or in the case of the stations where we have quarantine stations to summon a CDC officer for a second look at the individual. I will inquire though as to whether additional efforts were undertaken.

Mr. LANGEVIN. That would be important. With that, I now recognize Congresswoman Christensen for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I think it might be easier, I'm going to ask my three questions and then just leave it to them and I think I may be able to make it in 5 minutes that way.

Dr. Vanderwagen, in your testimony you talk about the 2009 funding based on how well previous targets were achieved. So if a State or a jurisdiction didn't meet its target, would funding be denied or reduced? Might they not be the jurisdictions that need the most funding and help? So how would you address that?

When you talk about matching requirements coming in, I assume that meant that States would have to match at some formula. Many States have already paid a lot of—spent a lot on communications, training and how would that be accounted for?

I just came back from Louisiana. The second question, just came back from New Orleans and I'm wondering why is there not a mobile hospital or two in New Orleans? More than wondering why they're not needed and I'd like to see at least one placed there.

Last question is on this altered standard of care. I share health with the Congressional Black Caucus. We see altered standards of care every day, including disparities in people of color and I'm very leery about these alternate standards of care and I wonder ways do you see to ensure that—I understand when you're overwhelmed

and the resources aren't there, the staff isn't there. It's not going to be tip-top medicine and the best of facilities, but I want to know how do you see ensuring that we won't be facing some of that systemic and institutional discrimination that people face because of language or color or gender in that situation?

Dr. VANDERWAGEN. What was the first one, ma'am?

Mrs. CHRISTENSEN. The first one was about the funding.

Dr. VANDERWAGEN. Oh, matching.

Mrs. CHRISTENSEN. Being tied to meeting targets.

Dr. VANDERWAGEN. All right, all very good questions. I'll try not to be too windy.

As you know, I spend most of my—I was raised on a reservation. I spent most of my career in Indian Health Service. Indian Health Service, Congress has funded at about $2,600 per capita per year and that's a 2005 figure, compared to the general U.S. population of about $7,000.

Mrs. CHRISTENSEN. And prison population, which is higher.

Dr. VANDERWAGEN. The running joke is if you want to get better health care in Indian County, commit a Federal crime so you can get better health care.

I have lived with that horrific, in my view, reality of those kind of rationing decisions throughout most of my life and career. This is a problem.

What we're talking about, however, is where you have too few assets how will you reasonably and equitably consider your triage decisions in that reality? No physician wants to be in that position, but in fact, and indeed, this is a reality that could occur.

It's our view that communities really need to think that through ahead of time about how they will deal with those kind of challenges. The answer of what constitutes equitability is an ethical challenge that people at the community level really need to work through and answer. I have my notions about that, but I don't feel it's the Federal role to tell communities what that standard should be, at least from the Executive branch perspective and as a health professional.

So I understand your concern and the constraints and the ground rules for that discussion have to be monitored closely if we're going to assure that there's equity in that thought process. It's a difficult challenge.

Mrs. CHRISTENSEN. Should we reduce the funding to places that haven't met their targets when they may be the most needy?

Dr. VANDERWAGEN. Congress in the passage of the Pandemic and All Hazards Preparedness Act required that we institute a matching program with appropriate penalties to be assessed in the event that people did not meet the standards in the requirements. We are acting against that authorization requirement. Now it's our belief that we should have no one fail, that it's our affirmative responsibility to work with those communities, with those programs with our partners, both Federal and State, to assure that we don't have that failure.

Notwithstanding that, I think it's a useful exercise in assessing what is the investment that's needed across the spectrum in this country to assure that we have sustainable preparedness and response capability because I don't think we understand fully what

those costs look like. We know what some Federal investments are. We know what some State investments are. But part of my conversation with our State and industry colleagues is this has been official tragedy and that it may allow us to quantify more effectively what it takes to sustain these kind of programs. We don't want to penalize. We're acting under the law. We believe we should work to assure there is no failure in this environment.

Lastly, in NOLA—I lived in that school for the blind for months and this is my family now. My concern about NOLA is it's not about the hospital biz, it's about what are doing at the community level to provide effective chronic disease care, effective primary care access, because if that exists, you don't live in the emergency room.

In Indian Country where we could not afford hospitals, it's our investment in that kind of chronic disease management and primary care that led to health improvements in our population that would be otherwise unexpected without those investments in that part of public health and medical services. So I don't know that the answer to NOLA is more hospital beds. They had the highest per capita Medicare rate in the country and the forty-eighth worst health status and yet they had 11 hospitals sitting there in Orleans Parish. I don't know that hospitals are the answer. I think there has to be a better solution to meeting the health needs of their people than that.

Mrs. CHRISTENSEN. I'd like to follow up back in Washington on that.

Mr. LANGEVIN. The Chairman now recognizes the gentleman from New Jersey for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Admiral Vanderwagen, you make a lot of sense in what you say. As you know, and as the Chairman is aware, we've been closely tracking progress on the national preparedness efforts for pandemic influenza outbreak, particularly the implementation of the national strategy on pandemic influenza which was released back in November 2005.

One of the key parts of the plan is that in addition to Federal stockpiles of key medicines and supplies, we also need States to act to establish their own stockpiles. It's very clear in that charge to us. But the stockpile of antivirals, in particular, the national plan calls for enough to treat 25 percent of the population and to reach that goal States have to act. Am I doing all right so far?

To date, the Federal Government has purchased 50 million courses of treatment as recommended under the NSPI. I understand that States, on the other hand, have still only stockpiled approximately 22.2 million of the 31 million courses of antivirals which were called for in that strategy on pandemic influenza, leaving us obviously short of the requirement.

In New Jersey, we purchased about 880,000 courses of treatment as of June, 2008, which is about 97 percent of the State's allocation. It was done with some difficulty despite the Federal match.

Obviously, with the economy as it is, many States are struggling to meet this goal. So let me ask you this, for those States that have not yet purchased or those that want to purchase more, are you considering renewing a reduced national price under which

antivirals can be purchased either to complete orders or to replace orders?

Dr. VANDERWAGEN. Yes.

Mr. PASCRELL. You are considering that?

Dr. VANDERWAGEN. Through December.

Mr. PASCRELL. If States can't purchase at the reduced price and with a Federal subsidy, what are the chances we ever complete the States' share of the national stockpiling goal?

Dr. VANDERWAGEN. I believe that we will achieve the 81 million doses that were called for which would cover 25 percent of the population. I do not believe that every State will have a State stockpile because of the decisionmaking in that State and local environment and this is a Federal republic, after all, and there are decisions.

In New Mexico, for instance, which is where I'm from really elected to not participate because they wanted to acquire these antivirals both for use in the seasonal influenza as well as and they didn't want to be constrained by the Federal program, so they're making their own acquisition. There are only a couple of States that have totally said we're really not going to buy any at this point. There is a question of equity there, but——

Mr. PASCRELL. That's my next question.

Dr. VANDERWAGEN. But again, this is a Federal republic and we can't force States to make those determination where money and their local considerations prevail. Again, they would get their pro rata share of the Federal asset, but they are at risk for the piece they didn't buy to cover their own.

Mr. PASCRELL. Let me ask this question, if you have funds left over that haven't been used to subsidize State purchases, I certainly hope you would use those for additional Federal antiviral purchases since this would directly affect any national stockpiling shortfall.

Does that make any sense?

Dr. VANDERWAGEN. Yes, after December, we would reexamine what remained in the balance for that subsidized acquisition and we'd be likely to purchase antivirals for Federal use beyond. It looks like that could be as much as $60 million which would be about 3 million treatment courses. We'll just have to see how this plays down as we go to the end of the calendar year.

Mr. PASCRELL. My final question to you, Admiral, is this. You heard me discuss with Dr. Runge about the bifurcations which exist throughout homeland security at the detriment, at all of our detriment. Do you have any specific recommendation that you would make to overcome these bifurcations that exist all over the place in terms of your own specific experience?

What can we be doing to make your job easier and we haven't done it?

Dr. VANDERWAGEN. Well, see, I believe that as Jeff alluded to, I think we've worked through these issues between HHS and DHS pretty well. In short, certainly DHS is the disaster government, but within the organic assets of our department we have tools that need to play in disaster response. What we've come to understand is that it's our responsibility to build up those assets so that they are available to play under the direction of DHS and its elements in an event under the national response framework.

I'm responsible for the ESF8, the public health and medical. My DOD colleagues, my VA colleagues, HHS colleagues, all need to be there to play when DHS needs us for the disaster events.

I feel very comfortable that we've come to terms with that. Now that's tough. You talked about a culture. Our culture is subject matter expertise. We've got scientists and so on. They live in that world. We have bureaucrats, law, regulation, policy, procedure. They manage in that world to giving out contracts and grants. For those of us in the preparedness and response world, it's strategy, operations and tactics. It's how do we talk across those three cultures that is the challenge and that's an educative and mission-focused issue that I'm not sure, sir, that the committees can influence as directly as we in the leadership role have to be clear about the mission and we have to be clear about those cross-cultural communications.

Mr. PASCRELL. We need to put egos aside because otherwise we cannot accomplish the goal.

Dr. VANDERWAGEN. Exactly.

Mr. PASCRELL. We have problems in the Congress with that. We have more chairmen and ranking members who serve on homeland security than another committee I know of and everyone is protecting their turf. So thank you for being a leader here.

Dr. VANDERWAGEN. It's about mission, not turf. It's mission, not turf. The people expect us to be there. Thank you.

Dr. RUNGE. May I make one observation, Mr. Pascrell, if you'll permit me? One of the reasons that there was this dissonance between HHS and DHS is that the Congress actually created an entity within HHS to do this work. Now they're not unique as a department. We have requirements of many departments to do their job of emergency support functions. I would maintain that if all of the other relevant departments had an entity, and by the way, these guys are sort of—they're kind of weird within the HHS framework. They do operations and they do preparedness and response. As you said, the rest of the culture of the department, they pay for medical care. They do science. USDA, DOD, State, EPA, all of those departments need an ASPR-like function so that we can create more of that dissonance with our departments so that we can get those issues resolved. I would maintain that that's really something that the Congress should look at and the reason that there appears to be a bifurcation is that there was and frankly it took a while to reach a more consonance.

Mr. LANGEVIN. I will ask one parting question to Captain Boynton. We appreciate you being here. I'd like to know what activities have you personally undertaken as Deputy Regional PFO for this region and for Rhode Island specifically, and do you expect to be named Deputy Regional PFO for any other biological events? I think that would be important to get on the record.

Capt. BOYNTON. Thank you, Mr. Chairman. For Rhode Island, it's principally been the Deputy PFO that's also the FEMA Regional Administrator, Art Kleves. Admiral Lakai has two deputies. One of those deputies is that FEMA Regional Administrator, Art Kleves. He participates in most of the PFO cell-related activities in FEMA Region 1 and as the second Deputy PFO, I participate in most of the PFO's cell activities in Region 2 which would be New

Jersey and New York. So that's been where most of my activity has been and I have also been named as a Deputy PFO for hurricane in Region 2.

Mr. LANGEVIN. Thank you very much. I thought that would be important to get on the record. With that, the first panel will be dismissed. I want to thank you all for your testimony today. I want thank you very much for your service to your country. We obviously have great challenges before us again with emerging biological threats and public health preparedness. We stand ready to work with you as partners in this effort to better protect the country. Again, I want to thank you all for your service, particularly, Dr. Runge, as you will be departing now and leaving your current post. You've given great service to the people of the United States and I thank you for your service and your testimony.

Thank you. With that, this first panel is dismissed. Thank you. I call up the second panel.

The hearing will come to order. I want to welcome our second panel of witnesses here today, beginning with Dr. Gifford, who is the Director of Health for the State of Rhode Island Department of Health. Our second witness is Major General Robert Bray. General Bray is the Adjutant General of Rhode Island, the Commanding General of the Rhode Island National Guard, the Director of the Rhode Island Emergency Management Agency, and the Homeland Security Advisory for Rhode Island. Welcome to you, General.

Our third witness is Mr. Thomas Kilday, Homeland Security Program Manager at the Rhode Island Emergency Management Agency. Welcome, Tom.

Our fourth witness is Peter Ginaitt, Emergency Preparedness Director for Lifespan Hospital Network here in Rhode Island. As many of us here know, Mr. Ginaitt is, of course, no stranger to public service—he was eight-term Rhode Island State Representative and a Veteran of the Warwick Fire Department. So I want to welcome you, Peter, and again all of our witnesses here, thank you for your service to our State and to the Nation and for being here.

Without objection the witnesses' full statements will be inserted into the record and I now ask each witness to summarize his statement for 5 minutes, beginning with Dr. Gifford. Because time is tight I should mention we'll have to stick strictly to the 5-minute rule, both for statements and for Member questions. So Dr. Gifford, welcome.

STATEMENT OF DAVID R. GIFFORD, DIRECTOR OF HEALTH, RHODE ISLAND DEPARTMENT OF HEALTH

Dr. GIFFORD. Thank you, Chairman Langevin and Representative Christensen and Representative Pascrell, welcome to Rhode Island.

As the Director of the Department of Health, the Agency that is responsible for promoting and protecting the public's health, I'd like to thank you all for your continued focus on the health and safety of Rhode Islanders and U.S. citizens.

As you know, all 50 States, the District of Columbia and the territories receive public health emergency preparedness and hospital preparedness through cooperative agreements with the CDC and

the Assistant Secretary for Preparedness and Response. State health agencies use these Federal investments to not only prepare for biological threats such as influenza pandemic or bioterrorism, but also to enhance our capacities and capabilities to address more frequently encountered incidents.

Public health agencies are often at the forefront of natural and unnatural events that impact all of our citizens. During the 2007 calendar year, nearly all State health agencies were involved in a response that required activation of their incident command system, a system adopted Nation-wide as a result of the Federal preparedness funding. More than a quarter did this six times or more a month.

In my written testimony, I provided brief descriptions of responses by health departments from around the country to such incidents as weather-related disasters, tornados, blizzards, floods, infectious disease outbreaks, food-borne illnesses, drinking water contaminations, technology disasters, and acts of violence. Each of the States were able to address these because of their capabilities and capacities from the emergency preparedness funding that you all have authorized.

Over the course of the past few years, the Department of Health in Rhode Island has utilized the incident command system on an average of every 3 to 4 months. We maintain a low, but appropriate threshold when determining whether to utilize the ICS to respond to health care issues and incidents, therefore, we utilize the ICS structure for both major regional incidents as well as for minor, less widespread events such as the TB skin testing at a local high school in Central Falls, Hepatitis A vaccine distribution to restaurant workers and to restaurants are two recent examples.

These events also allowed us to test our medication distribution plans developed for pandemic and bioterrorism events. This approach has made us more efficient and effective in our response to these situations and our response to these situations has, in turn, made us better prepared to respond to other potential emergencies such as a pandemic or bioterrorism.

Emergency preparedness funds and requirements have also helped us purchase equipment and supplies that will help us not only respond to unlikely events, but to more common health issues. For example, we made significant upgrades in modernizations of State laboratory equipment that can rapidly detect biological agents and a whole array of chemical poisons. This equipment and training in turn has helped us to better test for pertussis, whooping cough, and mercury in cord blood. By using this equipment for those nonemergency purposes has helped our staff remain proficient and ready to use the equipment for emergencies. For example, recently, we were able to respond to a credible, white powder incident and provide an answer to the FBI and law enforcement agencies in a matter of hours, confirming that the powder was harmless and it was not one of several possible biological agents such as anthrax or ricin.

The funding has also helped us work more closely with other State agencies with the health care provider community and with the non-health care provider community such as the schools and business. For example, we've worked closely with hospitals to cre-

ate a web-based hospital bed capacity system which provides real-time information concerning hospital bed capacity 24 hours, 7 days a week. We use this system on a routine basis which ensures that the hospitals are able to utilize it more effectively during a major health incident.

We work jointly with the Rhode Island Disaster Medical Assistance Team, DMAT, and the Medical Reserve Corps to develop a database to register health care volunteers who can assist during emergencies. This system allows us to check information and credentials on potential volunteers long before an emergency. With the next round of Federal funds, we'll be able to upgrade the system to include an automated 2A alert system that notifies and gives instructions to volunteers during an emergency.

We've also worked with the Rhode Island Management Association to create a special needs emergency register. This registry targets Rhode Islanders with disabilities, chronic conditions and other special health care needs which comprises nearly 20 percent of the population in Rhode Island. This registry will allow us to better plan for, but also to ensure the delivery of needed services during emergencies. Future funding will help us actually pilot test and actually implement this.

As you consider reauthorizing the funds for this program, I would recommend that you consider what you've heard here today. Hopefully, I've highlighted the importance of supporting an all-hazards approach to preparedness, rather than a focus on just pandemic or just specific bioterrorist events.

Similarly, the training and equipment supported by these funds must be incorporated into the routine activities of agencies and tested on a regular basis, similar, Chairman, to your suggestion of testing pandemic flu during the seasonal influenza process.

Otherwise, without that incorporation in our daily routines, it's much less likely that they will be utilized or will be as effective when implemented during an emergency. I've heard the military often say you should train the way you fight which applies aptly to emergency preparedness.

In conclusion, I'd like to thank you and the committee Members for your continued support to ensure that the Nation is as best prepared as possible to respond to any incidents impacting our public's health. I can confidently say that I believe we as a State and for that matter as a Nation are better prepared today to deal with a myriad of natural and unnatural biological events. However, while the Nation has made tremendous progress in a short amount of time, continued support is necessary to ensure that we have the ability to meet the challenges associated with each new event affecting the citizens we all serve.

Thank you, and I'll be available for questions.

[The statement of Dr. Gifford follows:]

PREPARED STATEMENT OF DAVID R. GIFFORD

JULY 21, 2008

Congressman Langevin and committee Members, as the Director of the Rhode Island Department of Health, an agency that is responsible for protecting and promoting the public's health in Rhode Island, I would like to thank you for continuing to focus on our Nation's health and safety. This hearing today on "Emerging Biologi-

cal Threats and Public Health Preparedness: Getting Beyond Getting Ready" is just another example of the attention by Congress to emergency preparedness that has helped us become better prepared. The events of the world have not only changed our mindset but have changed how we do our business in public health. I can confidently say that I believe we as a State and as a Nation are better prepared today to deal with a myriad of natural and unnatural biological threats that we may encounter [Attachment A]. This is due in large part to the funding and leadership provided by Congress and the Federal agencies whom have worked in close partnership with the States and local public health agencies.

All 50 States, the District of Columbia, five territories, three freely associated States and three large metropolitan areas (New York City, Chicago, Los Angeles County) receive Public Health Emergency Preparedness funding from the Centers for Disease Control and Prevention (CDC) and Hospital Preparedness Program funding from the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) through cooperative agreements. The CDC and ASPR cooperative agreements are the primary source of preparedness funding for State and territorial health agencies. Since 1999, the Federal Government has invested more than $8 billion in public health and health system preparedness at the State and local levels.

Public health agencies are often at the forefront of natural and unnatural events that impact our citizens. Core public health functions, such as disease outbreak investigations and prevention, are traditional responsibilities of State and territorial health agencies. Yet, health agencies play surprising—and critical—roles in all types of incidents. Natural disasters, environmental emergencies, infrastructure failures, foodborne outbreaks and mass acts of violence all have one thing in common—large numbers of people who must be protected.

State health agencies have used Federal investments in public health and health system preparedness to not only prepare for biological threats which have a low probability of occurring, such as pandemic influenza or bioterrorism incidents, but to also enhance capacities, build new capabilities, and strengthen the overall public health infrastructure Nation-wide that can help us address more frequently encountered incidents that have a direct or indirect impact on the public's health. Federal funding and requirements have helped health agencies in 48 States plus the District of Columbia and Puerto Rico to adopt National Incident Management System (NIMS). NIMS is a systematic approach for seamless incident management at all levels of government. When responding to incidents, State and territorial health agencies follow the Incident Command System (ICS), an organizational structure that integrates operations, logistics, planning, finance/administration, and command functions across all responders at the scene. The physical location where incident management activities are coordinated is the Emergency Operations Center (EOC). Depending on the scope of an incident, State health agencies may use their own agency-specific EOC or they may be integrated into the EOC of another entity, such as that of a State emergency management agency. In Rhode Island, we have determined that all employees should have an understanding of the ICS system since any employee of the Rhode Island Department of Health may be called on to respond in an emergency. Therefore, every employee at the Department of Health is required to be trained at an ICS level that is commensurate with their job duties and responsibilities.

Whether a federally declared disaster or an everyday occurrence, State and local public health agencies are now able to respond faster and more effectively to meet the health and medical needs of their populations because of national emergency preparedness efforts. During the 2007 calendar year, nearly 90 percent of State health agencies were involved in a response that required activation of their Incident Command System or participation in an Emergency Operations Center. More than a quarter did this six times or more. Emergency preparedness and response has become an integral service provided by State and territorial health agencies. Attachment B provides a brief description of some of the types of responses by our Nation's health departments in the past year to such threats as weather-related disasters (e.g., floods, hurricanes, blizzards, tornados, etc), infectious disease outbreaks (e.g., meningitis, measles, mumps, or TB), food-borne illnesses (e.g. salmonella, E. coli, etc), drinking water contamination (e.g. salmonella), technology disasters (collapsing bridges, dam/dike failures), acts of terrorism or acts of violence (e.g. Virginia Tech shootings). In Rhode Island, we have had to respond to several highly significant disease outbreaks, food-borne illnesses, contaminated drinking water and weather-related events, using our ICS. The funding for emergency preparedness has made us much more effective in our response to these situations; and our response to these situations has in turn made us much more effective for other potential emergencies.

Over the course of the past few years, the Department of Health has utilized the Incident Command System (ICS) on average every 3 months. The Department maintains a low but appropriate threshold when determining whether to utilize ICS to respond to a health care issue or incident. Therefore, the ICS structure has been utilized not only in major regional incidents such as the Mycoplasma outbreak in January 2006, but it also has been utilized in less widespread events such as the recent large scale TB skin testing at the Central Falls High School as part of an outbreak investigation and a hepatitis A exposure related investigation, leading to immunization of a large number of restaurant workers at two local restaurants. Not only has this allowed us to be more efficient and effective in our response but has provided us an opportunity to train HEALTH staff and improve our ability to utilize ICS. Consistent use of the ICS system when responding to major infectious disease outbreaks has built ICS skills and teamwork within the various units of the Department of Health that will assist in future disease outbreak responses that are either natural (e.g. pandemic) or unnatural (e.g. bioterrorism).

Emergency preparedness funds and requirements have helped us develop stockpiles of critical equipment and supplies intended for use in a large-scale incident such as a bioterrorism event or pandemic and have been invaluable in helping our department respond to highly significant but smaller-scale events. Our department has utilized supplies stockpiled in response to public health emergencies such as a Mycoplasma related outbreak and the Central Falls High School TB outbreak. There have been enormous logistical benefits realized for responding in an expedient and efficient manner to such events, leveraging State-wide and departmental resources when the core unit responding to the situation had exhausted its resources. The Department of Health has created and equipped an operations center within the Cannon Building that can be utilized when responding to any public health emergency that does not rise to the level requiring activation of the State EOC. In addition another room in the Cannon Building has been equipped with phone lines and data ports that are utilized to house the Department's emergency hotline system. These resources are possible because of Federal funding and are utilized on a regular basis by response personnel, which as a result not only helps provide better care to the citizens of Rhode Island during health-related events but also make us better able to respond should we have some unusual natural (e.g. influenza pandemic) or unnatural incident (e.g. bioterrorism).

In Rhode Island, the Department of Health works in partnership not only with other State agencies such as the Emergency Management Agency, but also the health care provider community such as hospitals and the non-health care community such as schools, integrating them in our planning, training, and our responses to events that have either a direct or indirect impact on the public's health.

Using Federal funds, we have worked closely with hospitals to create a web-based Hospital Capacity System which has provided the State with a significant resource when dealing with emergency situations. This system operates 24/7 and provides real-time information concerning hospital bed capacity. In addition, this system supports an event calendar that details upcoming State-wide trainings, exercises and drills. In addition, interoperable communication mechanisms are being utilized on a daily basis by hospitals within the State. The hospitals currently have 6 redundant forms of communication. There will soon be an additional system with the addition of the 800 MHz radios. Their daily use ensures that the system will be utilized correctly and effectively during a major health incident.

Funds available through the Federal emergency preparedness grants have permitted significant upgrades and modernization of State laboratory equipment. The Division of Laboratories has been able to introduce rapid molecular methods of biological agent detection and a whole array of chemical detection equipment. These gains enhanced not just preparedness for emergencies, but also day-to-day laboratory operations. This equipment and training has also been used to help us better test for Pertussis (whooping cough) and mercury in cord blood. Such capacity development not only helps us serve to contribute to public health laboratory functions, thus benefits the public's health but also keeps our staff proficient, trained and ready to use the equipment whenever required. For example, we were able to respond recently to a "credible" white powder incident and provide an answer in a matter of hours, confirming that the powder was not one of several possible biological agents (e.g. anthrax) or biotoxins/poisons (e.g. ricin). This was only possible because of the equipment and training provided by emergency preparedness grants as well as the coordination we have with the FBI and other Law Enforcement agencies required to be developed through emergency preparedness training activities.

We work with each municipality in RI to support a point of distribution (POD) plan that enables them to distribute medication or administer vaccines to their entire population. As part of a Medical Emergency Distribution System (MEDS) plan

we provide municipalities with "Go Kits" to be used at Point of Distribution (POD) locations. "Go Kits" are a conglomeration of supplies that would serve to facilitate the operation of an established POD site in a municipality that has been tasked to dispense medication. The "Go Kits" contain such items as office supplies (pens, highlighters, clipboards, etc), cleaning supplies (paper towels, garbage bags, etc), crowd control/information dissemination items (bullhorn, whistles, lanterns, etc), medical supplies (disposable thermometers, stethoscope, etc), sign holders, communications devices (weather band radio, two-way radios, etc), and logistical support/utility devices (batteries, extension cords, etc).

We have developed in partnership with the Rhode Island Disaster Medical Assistance Team (DMAT) and the Medical Reserve Corp (MRC), a database called State Emergency Registration of Volunteers in Rhode Island (SERVRI). The triad of resources from SERVRI, MRC and DMAT is called "RI Responds" and has the capacity to register, verify and mobilize health and medical volunteers in an emergency response scenario. "RI Responds" is an advanced registration system utilizing a secure database of verified information provided by health care professionals who have expressed an interest in assisting in the event of a public health emergency or other disaster requiring trained medical professionals. Once registered, volunteer professional information is immediately verified prior to an emergency, so that health care professionals may be deployed quickly and efficiently. When a decision is made to request the services of emergency volunteers registered within the system, they are presently notified manually (via e-mail and telephone). With maintenance of Federal funds we will be able to upgrade the system to include an automated two-way alert system. Volunteers will be able to receive instructions for response, when activated during a significant disaster or public health emergency, through the electronic notification system (ENS) that will be procured to facilitate deployment and utilization of all volunteers found within the database. This ENS system will also link to our program for tracking the deployment activations and locations of "RI Responds" volunteers to provide a comprehensive management tool.

The Department of Health has establish a standing internal Special Populations Emergency Preparedness Workgroup (SPEP). The Special Populations Work Group is charged with: (1) Making recommendations about our Emergency Response Plan to reflect the needs of special populations; (2) coordinating activities related with special populations during public health emergencies; and, (3) participating in the Incident Command Structure. We also work with the Minority Health Promotion Centers (community-based organizations targeting primarily racial and ethnic minority populations) to assess community and agency preparedness for risk communication and response to public health emergencies.

We have worked in partnership with the Rhode Island Emergency Management Agency, to create and implement a Special Needs Emergency Registry. This registry targets Rhode Islanders with disabilities, chronic conditions and/or other special health care needs. The primary objective of the registry is to develop a reliable system for the identification of Rhode Islanders who require special assistance during emergency events by collecting key information for use by emergency personnel to plan and respond to emergency events. Populated through the submission of online or paper enrollment forms, the system is being developed with the capability to generate electronic reports for individual city and town use for emergency planning and response and will be activated by the operation of the Incident Command System. Currently 20 percent of the total State's population fall into the 5 areas the registry covers: Life support: includes dialysis, respirators, oxygen; Mobility; Hearing/visual related issues; Cognitive issues; Mental health-related issues. To date the registry has reached approximately 3,500 people.

SUMMARY

Public health agencies are often at the forefront of natural and unnatural events that impact the health of our citizens. Health agencies play a critical role in all types of incidents: natural disasters, environmental emergencies, infrastructure failures, food-borne disease outbreaks and mass acts of violence, all of which have public health impacts. The CDC and ASPR cooperative agreements are the primary source of preparedness funding for State and territorial health agencies but the proposed funding for the ASPR cooperative agreement is 25 percent less over the same time period (see attachment C).

State health agencies have used Federal investments in public health and health system preparedness to not only prepare for those threats which have a low probability of occurring such as pandemic influenza or bioterrorism events but to also enhance capacities, build new capabilities, and strengthen the overall public health infrastructure Nation-wide that can help us address more frequently encountered

incidents that have a direct or indirect impact on the public's health. Strained economic conditions across the country combined with steadily decreasing Federal funding for public health and health system preparedness threaten the progress that State and territorial health agencies, along with their local, tribal and Federal counterparts, have made within the last decade.

Rhode Island has used these funds to build capacity in both personnel training and equipment purchase both internally within the Department and with key partners in the community to not only be better prepared to respond to biological threats but to all types of natural and unnatural incidents as well as enhancing capacity for our core activities. Without this support, we would not have been able to address several health incidents as effectively or efficiently. As you consider reauthorizing funds for these programs, I would recommend that you consider what you have heard here today to not only make decisions on the funding level but on the requirements related to the use of these funds. Hopefully my testimony has highlighted the importance of supporting an all-hazards approach to preparedness, not restrictions that focus just on pandemic or specific biological threats. Similarly, the training and equipment supported by these funds must be incorporated into the routine activities of the agencies and tested on a regular basis. Otherwise they are much less likely to be utilized or effective when an unusual incident occurs. I have heard the military say one "should train the way you fight," which applies aptly to emergency preparedness.

In conclusion, I would like to thank you and the committee for their continued support in ensuring that the Nation is as best prepared as possible to respond to incidents impacting the public's health. The Nation has made tremendous progress in a short amount of time but continued support is necessary to ensure that we continue to have the ability to meet the challenges associated with each new event affecting the citizens that we serve.

ATTACHMENT A.—STATE HEALTH AGENCY EMERGENCY PREPAREDNESS

All 50 States, the District of Columbia, five territories, three freely associated States and three large metropolitan areas (New York City, Chicago, Los Angeles County) receive Public Health Emergency Preparedness funding from the Centers for Disease Control and Prevention (CDC) and Hospital Preparedness Program funding from the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) through cooperative agreements. The CDC and ASPR cooperative agreements are the primary source of preparedness funding for State and territorial health agencies. Since 1999, the Federal Government has invested more than $8 billion in public health and health system preparedness at the State and local levels.

The CDC began funding several State health agencies in 1999 and expanded its cooperative agreement to 62 grantees following the September 11, 2001 terrorist attacks and the anthrax attack that soon followed. The CDC Public Health Emergency Preparedness cooperative agreement supports more than 3,500 State and local public health agency staff working on preparedness activities Nation-wide. Funding under the ASPR Hospital Preparedness Program cooperative agreement to the same 62 jurisdictions began following the 2001 terrorist attacks. While CDC and ASPR distribute preparedness funds to State and territorial health agencies and four large local health departments, 75 percent of the funds directly or indirectly support local public health departments and hospitals. State health agencies use ASPR cooperative agreement funds to support preparedness activities for more than 5,000 hospitals Nation-wide. Additionally, State health agencies provide non-financial support to many of the local health departments and other partners within their jurisdictions. According to a National Association of County and City Health Officials (NACCHO) survey of local health departments, "64 percent received technical assistance for planning; 56 percent received laboratory support; 55 percent received surveillance support; and 53 percent received support for exercise planning and administration." Thus, Federal public health and health system preparedness funds are used to improve response capabilities at all levels in communities across the country.

State health agencies have used this investment in public health and health system preparedness to enhance capacities, build new capabilities, and strengthen the overall public health infrastructure Nation-wide. This investment has paid off. Whether a federally declared disaster or an everyday occurrence, State and local public health agencies are able to respond faster and more effectively to meet the health and medical needs of their populations.

State and territorial health agencies have played integral roles in responding to a wide range of emergencies. In 2007 alone, there were 63 federally declared disas-

ters and health agencies played a role in responding to almost all of them. During the 2007 calendar year, nearly 90 percent of State health agencies were involved in a response that required activation of their Incident Command System or participation in an Emergency Operations Center. More than a quarter did this six times or more. Emergency preparedness and response has become an integral service provided by State and territorial health agencies.

Public health agencies are often at the forefront, just as anyone would expect. Core public health functions, such as disease outbreak investigations, are traditional responsibilities of State and territorial health agencies. Yet, health agencies play surprising—and critical—roles in all types of incidents. Natural disasters, environmental emergencies, infrastructure failures, foodborne outbreaks and mass acts of violence all have one thing in common—large numbers of people whose health must be protected.

Health agencies at the State, territorial, local, tribal and Federal levels are incorporating emergency management principles into their activities to be consistent with the National Response Framework (NRF). The NRF details response principles, roles and structures for all-hazards national response and how they should be applied at the State, local, tribal and Federal levels as well as by private sector and nongovernmental partners. Health agencies in 48 States plus the District of Columbia and Puerto Rico have reached National Incident Management System (NIMS) compliance certification. NIMS is a systematic approach for seamless incident management at all levels of government. Incidents are natural or manmade occurrences or planned events that require a response to protect lives or property. When responding to incidents, State and territorial health agencies follow the Incident Command System (ICS), an organizational structure that integrates operations, logistics, planning, finance/administration, and command functions across all responders at the scene. The physical location where incident management activities are coordinated is the Emergency Operations Center (EOC). Depending on the scope of an incident, State health agencies may use their own agency-specific EOC or they may be integrated into the EOC of another entity, such as that of a State emergency management agency. In most States, the health department is the lead agency for Emergency Support Function 8 (ESF–8), meaning they are responsible for health and medical resources during an incident. Health agencies may also support some of the other 15 total functions, such as ESF–6, which is mass care, or ESF–10, which is oil and hazardous materials response. With trained staff who understand NIMS, health agencies are able to work side-by-side with their response partners, regardless of agency or jurisdictional boundaries.

ATTACHMENT B.—PUBLIC HEALTH PREPAREDNESS IN ACTION: EXAMPLES FROM OTHER STATE OR LOCAL HEALTH AGENCIES

State and territorial public health agencies and the health care system are stronger today because of the investment in preparedness. State and territorial health agencies make a difference every day in protecting the health and preserving the lives of Americans across the country. Using Federal cooperative agreement funds provided through the Center for Disease Control (CDC) Public Health Emergency Preparedness Program and the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program, State health agencies strategically invest in personnel, equipment, supplies and training that are drawn on during critical incidents, whether they are infectious disease outbreaks, natural disasters, or foodborne outbreaks and Nation-wide product recalls. Public health agency personnel work with their response partners every day in all types of incidents and are therefore always simultaneously preparing for disaster through an all-hazards approach to emergencies.

These are just some of the high-profile examples from last year.

DISEASE OUTBREAKS

Recognition and response to agents of bioterrorism are predicated upon effective foundations of disease surveillance, outbreak investigation and response. These are core elements of public health practiced daily by departmental units of clinical epidemiology and infectious disease.

Mycoplasma pneumoniae.—When five children in the community were diagnosed with severe neurological illnesses, the Rhode Island Department of Health [RIDOH] stopped a worrisome infectious disease cluster in its tracks by activating ICS and its mass dispensing plan to provide antibiotics to more than 1,000 at-risk individuals, launching an extensive public risk communication effort, and closing schools to encourage social distancing to interrupt disease spread. In December 2006, RIDOH learned of five school-aged children with severe neurological illness, includ-

ing one who died. The Rhode Island Department of Health contacted the Center for Disease Control (CDC) for assistance with the disease cluster on December 22, 2006. CDC laboratory testing confirmed the first positive results for *Mycoplasma pneumoniae* on December 29. *Mycoplasma* infection clusters are rare and there was an unusually large number of severe cases in a single school. As a precaution, the RIDOH activated Incident Command System (ICS) and with the assistance of State DMAT offered antibiotics via a mass dispensing clinic to all 275 students, 40 staff members and their families between December 31, 2006 and January 2, 2007. In total, 1,183 people received medication.

Operating within ICS, State health agency staff used the mass prophylaxis training they had received as part of their Strategic National Stockpile planning to dispense medication over the holiday weekend. One hundred percent of the affected population was accounted for and many participated in voluntary blood testing. State health officials and CDC personnel reviewed medical records from the school clinic and interviewed students and staff. Health officials, including the State health director, also held community information sessions with parents to address their concerns and set up a telephone hotline and Web site for those seeking additional information. The school was closed until January 8, 2007 to interrupt the transmission of illness and so that 5-day antibiotic treatment courses could be completed before students and staff returned to school.

Health officials also investigated reports of higher-than-normal absenteeism in other schools in the area. On January 4, 2007, RIDOH recommended the closure of three school districts, impacting 20,000 students and their families. This was a precautionary measure to control disease and give the State health agency and the CDC time to further investigate potential cases. The CDC is using this incident to study the social and economic effects of school closures as part of a community containment strategy in the event of an influenza pandemic.

RIDOH's success in containing this outbreak was, in part, due to the investments made in its Medical Emergency Distribution plan, risk communication strategy, and ICS training of all staff as part of its all-hazards approach to emergencies.

Meningitis.—When meningitis sickened ten young people and killed two, the Chicago Department of Public Health [CDPH] launched a mass vaccination campaign to boost coverage rates and provide years of health protection to more than 7,200 at-risk children. The Department also used the incident as an opportunity to test its mass vaccination planning.

By April 23, 2008, the city of Chicago had ten cases of group C meningococcal invasive disease and two deaths for the year. The city only had 13 cases in all of 2007. Meningococcal disease is a bacterial infection that can cause meningitis and infect other tissues. The two individuals who died of the disease in Chicago lived in an area of the city with a low compliance rate for receiving the new vaccine. CDPH decided to pre-empt the situation to avert a potential epidemic. To do so, they launched a mass vaccination campaign to accelerate vaccine coverage rates in the community. Focused on children aged 11 to 18, vaccination teams targeted 10,000 children in 50 Chicago schools. Staff from the CDPH and five suburban health departments administered vaccine to 7,213 children in 2 weeks. The vaccine coverage rate of more than 70 percent among the targeted population is an impressive improvement over the historic rate of 20 to 30 percent. No additional children died of the disease, and the success of the vaccine campaign will continue to protect the at-risk population from future outbreaks in the years to come.

In addition to protecting the community's health, CDPH seized on the opportunity to use the vaccine campaign to implement their mass dispensing and mass vaccination planning it has developed with support from the Federal preparedness cooperative agreements. The ability to vaccinate or dispense medication to large numbers of people is one of the core capabilities that health agencies across the country are working to develop. Being able to implement a mass vaccination or mass dispensing plan would be essential during a bioterrorism attack with an agent such as anthrax or smallpox or a natural disease outbreak such as pandemic influenza. Prior to the heavy investment in public health preparedness, CDPH would not have been able to accomplish a response of this size in such a short amount of time.

DRINKING WATER CONTAMINATION

A system that supports early detection and response to potential threats to our drinking water supply are critical public health functions.

Salmonella.—When the water distribution system for the city of Alamosa became contaminated with salmonella, sickening more than 400 people, the Colorado Department of Public Health and Environment [CDPHE] used all its resources to identify the source of the problem, provide extensive risk communications to the public,

work with partners to implement a solution, and restore safe drinking water to homes and businesses. The first case of salmonella was reported in Alamosa on March 6, 2008. Through case interviews, epidemiologists discovered that breastfed infants were not getting sick while those fed formula mixed with tap water were. Laboratory samples collected from individuals, from water in homes and from businesses confirmed that the same strain of salmonella was present in all. Further investigation determined that the aquifer supplying the drinking water was not contaminated. Epidemiologists and water experts concluded that the source of salmonella was somewhere in the water distribution system.

On March 17, Alamosa County established its Emergency Operations Center (EOC) and CDPHE notified Federal partners of the outbreak. CDPHE issued a bottled water order on March 19 and advised residents not to use their tap water. The health agency also activated its public information hotline and issued a mutual aid request for water experts. The State public health laboratory, with personnel and equipment supported by Federal preparedness funding, conducted sampling for salmonella, total coliform bacteria and heavy metals. This was the first time the laboratory had to conduct testing for human and environmental outbreaks at the same time.

The Water Quality Control Division coordinated with the city to develop and implement a plan to flush the city municipal water system and conducted water sampling for bacteria and heavy metals before, during and after the system flushing. The division also provided guidance for water use during each stage of the system flush. CDPHE and the local Joint Information Center continually updated Web sites, issued news releases, developed information flyers and fact sheets, and worked with local officials to activate Reverse 911 to get the word out. Community volunteers delivered much of the information door-to-door.

The boil-water order was finally rescinded by CDPHE on April 11. As of April 30, there were 424 cases of salmonella, including 117 that were culture-confirmed. Twenty-two people were hospitalized and one death was attributed to the salmonella outbreak. The successful conclusion of this outbreak was made possible by the significant investment in laboratory services, epidemiology, Incident Command System (ICS) and communication through emergency preparedness.

NATURAL DISASTERS

Natural disasters are predictably unpredictable in that we can be certain that they will occur varying by location, nature and severity. Natural disasters such as hurricanes, wildfires, earthquakes, tornados, snowstorms and floods can have catastrophic public health consequences and require a high level of preparedness.

Wildfires.—Twenty-three wildfires struck southern California in October and November 2007. The wildfires caused ten deaths and 139 injuries, and forced the evacuation of 321,500 residents—the largest evacuation in California's history. The California wildfires were just one of 63 federally declared disasters in 2007. State health agencies were on the front lines of most, if not all, of them. The California Department of Public Health (CDPH) responded to the wildfires immediately, deploying its 2,000 alternate care site bed cache to Qualcomm Stadium to support the primary shelter set up for evacuated residents. Health agency staff, including Director Mark Horton, were at Qualcomm Stadium to ensure the shelter operated smoothly and that medical needs were adequately met. At the same time, the CDPH coordinated evacuations from threatened health care facilities, including 12 nursing homes, two acute care facilities and a psychiatric hospital. Throughout the response, the CDPH provided critical information to local health agencies and providers through its Health Alert Network. When the fires were contained and people returned to homes and businesses, the CDPH and local health agencies evaluated drinking water systems potentially contaminated by the wildfires. Thanks to State health agency assets that were not available before the recent focus on preparedness, the CDPH now has increased capacity to respond to wildfires, earthquakes, hurricanes, tornados, blizzards and other natural disasters.

Snowstorms.—When a record-breaking snowstorm dropped over 2 feet of snow in October and knocked out power to 400,000 homes and businesses, some for as long as a week, the New York State Department of Health successfully partnered with local health agencies to protect residents of western New York from carbon monoxide poisoning, food-borne diseases, and other health threats while working with local hospitals to assure appropriate staffing by deploying volunteer nurses. The New York State Department of Health [NYSDH] activated its risk communication plan and jointly issued a press release with the New York State Emergency Management Office. The agencies cautioned the public on cardiac risks resulting from the physical exertion of shoveling snow, warned of carbon monoxide dangers due to

the use of generators and alternate heating sources, reminded of the importance of the safe use of candles and heaters in preventing fires, and offered advice on the safety of refrigerated food unable to be kept cold due to electricity loss. As the extent of the storm damage became clear, NYSDH also issued advice for those with end-stage renal disease who might not be able to get to their dialysis treatments. Throughout the storm response, NYSDH monitored public water supplies, conducted water sampling, and provided guidance through county health departments to restaurants and food establishments on safe food handling. The State health agency activated its Emergency Medical Volunteer Database to identify and deploy nurses from other parts of the State. Using CDC cooperative agreement funds, NYSDH set up the database following the September 11 attacks. From the registry of 11,242 medical professionals throughout the State willing to volunteer during emergencies, the State health agency deployed nurses from unaffected areas of the State. The State-based Health Emergency Response Data System (HERDS) system was also widely used at the county level. The Erie County Health Department detected an elevated number of carbon monoxide exposures using HERDS. The Erie County Health Department worked with the media to publicize a carbon monoxide fact sheet.

Tornados.—When a tornado killed 11 residents and destroyed the town of Greensburg, the Kansas Department of Health and Environment [KDHE] helped make the town habitable again by assuring access to health and medical services, restoring identities, and protecting residents and recovery workers from environmental and safety hazards. The Center for Public Health Preparedness was instrumental in helping to secure medical supplies, personal protective equipment and sanitation equipment for some of the response and recovery workers. One of the immediate needs of Greensburg residents was met by the Department's Center for Health and Environmental Statistics. The tornado destroyed approximately 95 percent of the town, including personal records such as birth and marriage certificates that people need to prove their identities. Set up at the Disaster Recovery Center, KDHE staff assisted Greensburg residents in filling out simple application forms that were printed and faxed to the Department's headquarters for overnight processing. KDHE reissued 355 birth and marriage certificates for Greensburg residents. The environmental component of the KDHE also played a major role. Staff from the Bureau of Air and Radiation inspected commercial and public buildings for asbestos. While not generally a health risk when used in building materials, asbestos can cause serious lung diseases if airborne particles from damaged buildings are inhaled. Bureau of Air and Radiation staff labeled risks with red tape to indicate the presence of asbestos. This triggered clean-up crews to use special precautions when removing debris within the marked boundaries. While the KDHE would have had the same responsibilities if the Greensburg tornado had occurred 10 years earlier, what changed in 2007 was the way the Department was able to respond. Health agency staff trained in ICS with CDC preparedness funds were able to integrate into the emergency response structure alongside other responders such as police and firefighters who have been using Incident Command System (ICS) for years.

Floods.—When flooding hit nine counties, the Ohio Department of Health [ODH] maintained State-wide situational awareness to support local public health agency response efforts and test new surveillance systems. As in other States, ODH works with local health departments on preparedness planning. This collaborative effort was effectively tested during flooding in nine Ohio counties in August 2007. In Allen County, the local health department used its upgraded communications equipment to share information with State and local officials about flood damage and the needs of the community. Public information staff, who had been trained with funding from the CDC cooperative agreement, worked with the media to get consistent health information to the public about building clean-up, mold prevention, and the appropriateness of tetanus and other vaccines. Mass dispensing plans developed as part of Strategic National Stockpile preparations were used to rapidly set up a tetanus vaccine clinic using volunteers from the Medical Reserve Corps. Mutual aid agreements established with other local health departments enabled a more efficient response to calls for assistance. All of these tools enabled the Allen County Combined Health District to maximize its personnel and other resources and to effectively determine resource gaps to be filled by the ODH and other local health departments.

The flood also tested ODH's Real-time Outbreak and Disease Surveillance (RODS) System. RODS provides for real-time analysis of emergency department chief complaint data and over-the-counter drug sales information and may be useful for the early detection of clinical syndromes due to agents of bioterrorism. The system is used by more than 300 health department and hospital personnel to detect and track health events such as bioterrorism, outbreaks, influenza, and seasonal illness. Currently, more than 85 percent of Ohio's emergency department visits and approxi-

mately 70 percent of over-the-counter drug sales are captured and analyzed by the system.

Using chief complaint data from the RODS system, the ODH's Early Event Surveillance Unit's analysis found a statistically significant five-fold increase in chief complaints related to insect bites in the flooded region 2 weeks after the flooding began—the approximate amount of time it takes for a mosquito to reach maturity. Public health officials have long known that many diseases, such as West Nile virus, are spread among the human population by mosquito bites. They also know that standing pools of water, which are common following floods, are major breeding sites for mosquitoes and other insects.

TECHNOLOGICAL DISASTERS

The Minnesota Department of Health (MDH) activated its regional response plan following the August 2007 interstate bridge collapse that killed 13 and injured nearly 100. The MDH used its Health Alert Network, funded through the CDC cooperative agreement, to notify MDH staff, local health agencies, hospitals and emergency management partners of the bridge collapse, inform recipients to be ready to respond, and provide updates throughout the response. The MDH, hospitals and EMS used MNTrac, a decisionmaking tool implemented with ASPR cooperative agreement funds, to monitor ambulance runs, status of patients, and coordination of patient care transport and emergency room/trauma care. Based on information provided through MNTrac and the Health Alert Network, area hospitals activated their response plans and were able to handle all of the victims. Using its ESAR–VHP system, the MDH identified and credentialed behavioral health volunteers and provided their information to the city of Minneapolis and the family assistance center to be called upon to assist the victims, their families and first responders in the immediate aftermath and the weeks that followed. During the recovery phase, the MDH worked with environmental agencies to identify and assess potential health risks related to the air and water. As our physical infrastructure ages, State health agencies will likely have to respond to more technological disasters.

FOODBORNE OUTBREAKS

Foodborne diseases cause approximately 76 million illnesses, 325,000 hospitalizations and 5,000 deaths in the United States each year at a cost of $5 billion. State and territorial health agencies use Federal cooperative agreement funds to support food-borne outbreak response, including epidemiologists to conduct outbreak investigations, public health laboratory personnel and equipment to confirm outbreak causes and communications professionals to notify the public of risks.

In July 2007, the Indiana Department of Health and the Texas Department of State Health Services independently notified the CDC of suspected food-borne botulism cases. In both States, epidemiology staff investigated patient food histories to determine the cause of illness, laboratory staff tested patient and food samples, and health agency officials requested and distributed botulinum antitoxin from CDC. Once CDC confirmed botulism as well as the source, the FDA issued a consumer advisory and the manufacturer voluntarily recalled its canned chili products from about 8,500 retail outlets. State health agencies across the country engaged in extensive public education campaigns to get the products off store shelves and out of people's homes to prevent additional botulism cases. Thanks to improvements made to the public health infrastructure with Federal preparedness funding, State health agencies and their partners limited the botulism outbreak to eight cases in three States.

TERRORISM & ACTS OF VIOLENCE

In 2006, 20,000 deaths resulted from 14,000 terrorist attacks world-wide. The last acts of large-scale terrorism on United States soil occurred in 2001, but major acts of violence continue to occur. After these events, State health agencies and the health care system must mobilize to protect lives while coordinating with law enforcement officials to preserve evidence.

The Virginia Department of Health (VDH) immediately responded when a gunman killed 33 and injured 27 others at Virginia Tech in April 2007. Using CDC cooperative agreement funds, the VDH had established five regional response teams as part of its State-wide preparedness system. Under the Chief Medical Examiner, the VDH deployed three public information officers, a planner and a team of forensic scientists to assist the regional team already in place. With Assistant Secretary for Preparedness and Response (ASPR) cooperative agreement funds, the VDH set up Regional Healthcare Coordinating Centers in each of the State's six hospital regions. ASPR funds also support yearly upgrades to the WebEOC system installed

in hospitals throughout Virginia, hospital staff training, purchase of redundant communications, and sustainment of the Regional Healthcare Coordinating Centers. Using the State-wide Web Emergency Response Center (WebEOC) system, the VDH, hospitals, the 35 local health districts, and emergency management partners tracked the transport and condition of all injured victims, checked the diversion status of hospitals, and monitored and responded to resource needs of the affected hospitals. The VDH also provided risk communications to the public, identified victims, supported family services established by the university, and kept Federal and international entities informed. This tragic example is a reminder of the importance of coordinated, State-wide public health and health care preparedness systems for rapid responses to mass casualty incidents.

While these incidents were among the most widely publicized of the last year, State and territorial health agencies respond to similar events around the country every single day. For more examples, please visit States of Preparedness on (Association of State and Territorial Health Officers) ASTHO's Web site at *www.astho.org*.

ATTACHMENT C.—FEDERAL BUDGET APPROPRIATION DECLINING

Continued cuts to State and territorial public health and health system preparedness programs threaten the ability of jurisdictions to respond as rapidly and effectively to future events as to those that occurred over the last year-and-a-half. Lives have been saved and diseases and injuries have been prevented through the significant support that the Federal Government has provided public health agencies through the CDC and ASPR cooperative agreements. However, the proposed fiscal year 2009 budget calls for a funding level for the CDC cooperative agreement that is 33 percent less than in fiscal year 2005. The proposed funding for the ASPR cooperative agreement is 25 percent less over the same time period.

These continued funding decreases, combined with the difficult economic conditions in many States, will hinder the ability of State and territorial health agencies to sustain and continue the progress that has been made in public health and health system preparedness. State and territorial public health agencies are beginning to cut response personnel; limit opportunities for staff to train, plan and exercise with other first responders; lose their ability to maintain supplies and technology such as surveillance systems, laboratory equipment and communications devices; and decrease their capacity to produce and distribute public safety information. These changes will make it difficult for State and territorial health agencies to duplicate the successful responses seen to date. A sustained commitment to public health preparedness will ensure that health agencies will continue to be able to rapidly respond to all hazards by protecting the health and lives of the public.

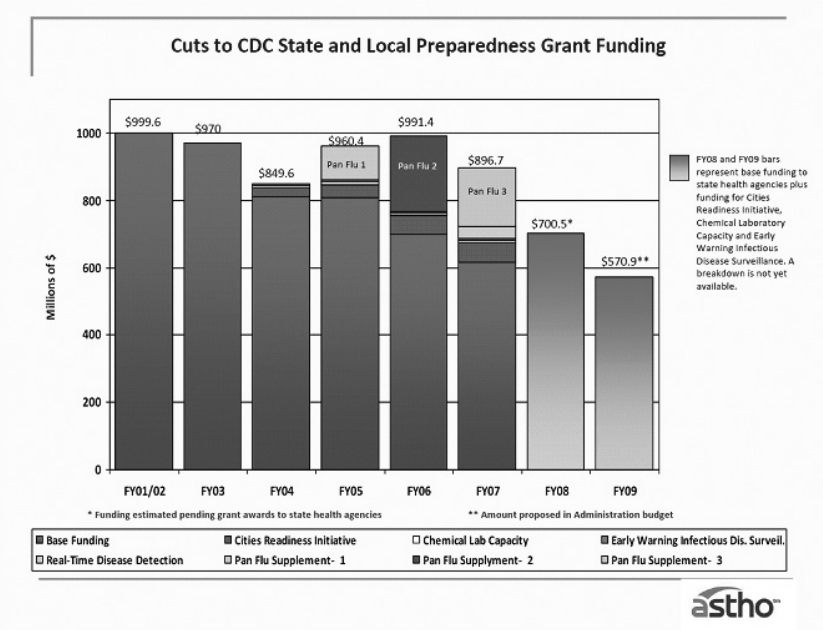

Figure 1. CDC Public Health Emergency Preparedness Cooperative Agreement Funding Trend.

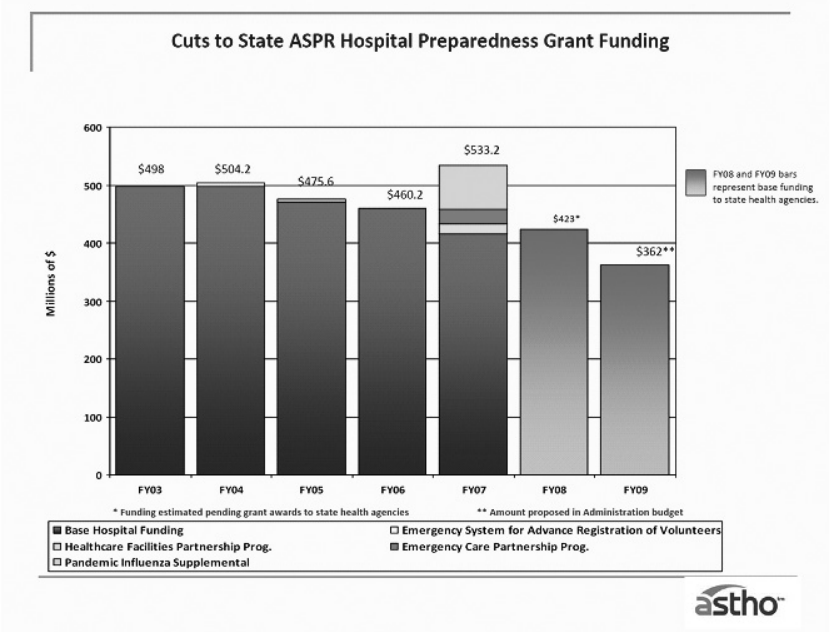

Figure 2. ASPR Hospital Preparedness Program Cooperative Agreement Funding Trend.

Mr. LANGEVIN. Dr. Gifford, thank you for your testimony. I now recognize General Bray for 5 minutes.

STATEMENT OF MAJOR GENERAL ROBERT T. BRAY, ADJUTANT GENERAL, RHODE ISLAND; COMMANDING GENERAL, RHODE ISLAND NATIONAL GUARD; DIRECTOR, RHODE ISLAND EMERGENCY MANAGEMENT AGENCY; AND HOMELAND SECURITY ADVISOR, STATE OF RHODE ISLAND

Gen. BRAY. Mr. Chairman, committee Members, thank you for the opportunity to provide testimony regarding National Guard planning and preparations to address emerging biological threats. In addition to my duties, roles, and responsibilities as the Adjutant General, you've noted many hats that I wear. This management structure provides one focal point for the Governor as well as for the Federal agencies.

As of today, the Rhode Island National Guard's primary asset to assist local authorities is the Rhode Island National Guard 13th Weapons of Mass Destruction Civil Support Team. The Civil Support Team is a highly trained, full-time unit specifically designed to assist local authorities in the event of a chemical, biological, radiological, nuclear, or high-yield explosive incident. The team is available 24/7 and located centrally within the State to ensure maximum response times of no more than 90 minutes. The CST maintains a close working relationship with the first response agencies, including the hazardous material response units in the State as well as with CST units in other States for joint training exercises and mutual aid assistant.

The National Guard is not intended to be a first responder or the lead agency. We are the State's larger response option and as such we remain proactive in providing support through training, preparation, and planning. The National Guard is committed to the fundamental principle that each and every State and territory must possess ten core capabilities for homeland readiness. Amidst the most extensive transformation of our Army and Air Force in decades, the National Guard intends that every Governor has each of these essential ten capabilities. Those capabilities are a Joint Force Headquarters for command and control element with immediate access to a quick reaction force; a Civil Support Team; engineering capabilities; communications capabilities; all-terrain ground transportation capabilities; aviation capabilities; medical capabilities; security forces capabilities; logistics expertise; and maintenance capabilities.

The Rhode Island National Guard is uniquely situated to provide each of these ten core capabilities in support of civil authorities for responding to a biological or other domestic incident. Our ability to quickly assemble and deploy a critical mass of disciplined personnel is our greatest asset.

Allow me to speak to this issue as I know there has been national concern about this capability given our robust operations template in support of the global war on terror. As of July 15, 2008, the assigned strength of the Rhode Island National Guard was 3,274 soldiers and airmen. As of July 15, 2008, minus mobilized, deployed, and those in training, 71 percent or 2,327 soldiers and airmen were available to support domestic operations if requested by civil authorities, exceeding the 50 percent threshold goal established by the Chief National Guard Bureau to respond to domestic incidents in support of civil authorities. Clearly, the

Rhode Island National Guard provides the State of Rhode Island with a robust, all-hazard capability to include biological incident response. All is not perfect to be sure. At the core of capability is the need for clearly defined roles, missions and responsibilities. The default for response should not be the National Guard, due to a lack of capability at the local response level.

Accordingly, local, State and Federal funding is essential for adequate personnel, equipment, training, facilities, and planning capabilities at these levels. Additionally, our ability to assist civil authorities is dependent on our being a properly- and full-resourced organization. We are now an operational force. As such, we need 100 percent full-time manning, 100 percent of authorized equipment, State, and Federal support for our military construction budget, and full funding of our operational and maintenance budgets. This will also best posture us for civil support and disaster response and recovery capabilities.

Consequently, I support the National Governors Association letter to the Chairman and Ranking Member of the House and Senate Committee on Armed Services which opposes past House amendments to the Federal Insurrection Act. The National Guard must not be ordered to Title 10 duty without the consent of the Governor, particularly for natural disasters.

In closing, planning, preparation, resourcing, and responding to a biological threat or other domestic incident is a continual process that must adapt to a complex and changing secured environment. The role and mission of the National Guard and the command and control of the Adjutant General with the Governor as Commander-in-Chief, past, present, and future, is essential to the success of domestic preparedness and response. Partnerships and resources at both the State and Federal level are vital in our efforts to ensure that we stand ready, relevant, reliable, and accessible in support of civil authorities in the event of a biological or other domestic incident.

Thank you for this opportunity to testify and I am available for questions.

[The statement of General Bray follows:]

PREPARED STATEMENT OF ROBERT T. BRAY

JULY 22, 2008

Mr. Chairman, committee Members, thank you for the opportunity to provide testimony regarding National Guard planning and preparations to address emerging biological threats.

It is expected that in the event of a biological incident such as pandemic influenza, the entire United States will be affected within a matter of days. The impact will likely affect all dimensions of our national infrastructure. In addition to actions at the local, State, and Federal Government level in a coordinated response to the needs of the public it should be noted that private sector resources will be expected and needed. Included in a response to a biological incident will be the National Guard of each State in concert with the Department of Defense (DoD) and other Federal agencies in both a Title 32 and Title 10 capacity.

INTRODUCTION

As always by law, the National Guard's primary mission is support to local authorities in a domestic crisis. The National Guard is not intended to be a first responder or the lead agency for any emergency response effort. The National Guard will nevertheless be pro-active in providing support through training, preparation and planning. The close relationship, in the State of Rhode Island, between the Di-

rector of Military Support and the Emergency Management Agency through the Rhode Island National Guard Joint Operation Center and the State Emergency Operation Center under the organization of the Office of the Adjutant General facilitates the constant situational awareness required to alert and mobilize the National Guard in a timely manner.

Presently, the Rhode Island National Guard Joint Operation Center is minimally staffed for 24/7/365 operation. The State Emergency Operation Center is presently staffed during regular business hours with a "call service" during other hours to key personnel, unless an anticipated situation demands that we implement 24-hour staffing. A model for merging the capabilities between the two entities to ensure a 24/7/365 staffing of a single Joint Interagency Coordination Center for full situational awareness toward a State-wide common operating picture is being prepared for consideration. The limitations of facilities, personnel, funding, and statutes impede progress toward this necessary organization in support of the Homeland Security domestic response.

The National Guard Bureau (NGB) and by extension the Rhode Island National Guard, is committed to the fundamental principle that each and every State and territory must possess ten core capabilities for homeland readiness. Amidst the most extensive transformation of our Army and Air Forces in decades, the National Guard intends that every Governor has each of these "essential 10" capabilities:

- A Joint Force Headquarters for command and control;
- A Civil Support Team for chemical, biological, and radiological, nuclear and high-yield explosive (CBRNE) detection;
- Engineering assets;
- Communications capability;
- Ground transportation;
- Aviation;
- Medical capability;
- Security forces;
- Logistics and maintenance capability.

A RHODE ISLAND NATIONAL GUARD PERSPECTIVE

The Rhode Island National Guard possesses all of these capabilities in the following organization:

- A Joint Force Headquarters for command and control located at the Command Readiness Center in Cranston, Rhode Island under the command of a Brigadier General.
- The Civil Support Team for chemical, biological, and radiological detection, nuclear or high-yield explosive (CBRNE) mission is assigned to the Rhode Island National Guard's 13th Weapons of Mass Destruction (WMD) Civil Support Team (CST) located in Coventry, Rhode Island.
- Engineering assets are provided by the 861st Engineer Company located in East Greenwich, Rhode Island and the 143d Civil Engineering Squadron in North Kingstown, Rhode Island.
- Communications provided by the 281st Combat Communications Group and 282nd Combat Communications Squadron located in North Smithfield, Rhode Island.
- Ground transportation capability is supported by all the organic units of the Rhode Island Army and Air National Guard with HUMMWV and medium truck assets.
- Aviation support is provided by the 143rd Airlift Wing and the 1/126th Army Aviation Battalion located at Quonset Point, Rhode Island.
- Medical capability is limited through the Rhode Island Army National Guard Medical Command, the 143d Air Wing Medical Group and unit assigned medical personnel.
- Security forces are supported by the 43rd Military Police Brigade located in Warwick, the 143d Security Forces Squadron in North Kingstown and through the detail of the Quick Reaction Force.
- Logistics and maintenance capability is supported by the United States Property Book Office located in Providence, Rhode Island and the Combined Support Maintenance Facility, as well as the Forward Support Company of the 1/103d Field Artillery Battalion.

The primary National Guard asset, in Rhode Island, to assist local authorities with their response to a biological incident is the Rhode Island National Guard 13th Weapons of Mass Destruction (WMD) Civil Support Team (CST). The CST is an operational, State-based, full-time unit specifically designed to assist local authorities in the event of a chemical, biological, radiological, nuclear or high-yield explo-

sive (CBRNE) incident. The team is available 24/7 and located centrally within the State at the Coventry Air National Guard Station and is able to respond to a request by civil authorities within 60 to 90 minutes. The CST maintains a close working relationship with first response agencies, including the Hazardous Material Response units in the State as well as with the CST units of the other States for assistance.

In the event of a biological incident, we anticipate that in addition to the 13th CST, civil authorities will request personnel, transportation and communications support to augment their response efforts. Additionally, the CBRNE Enhanced Response Force Package (CERF–P) and the CBRNE Consequence Management Response Force (CCMRF) are two national assets supported by the National Guard and the Department of Defense designed to provide regional support for a catastrophic homeland event.

As of July 15, 2008, the assigned strength of the RING was 3,274 soldiers and airmen (2,107 Army National Guard and 1,167 Air National Guard). Mobilizations and training requirements reduce the amount of available personnel who are able to support domestic operations.

As of July 15, 2008, 71 percent (2,327 soldiers and airmen) were available to support domestic operations if requested by civil authorities. This figure exceeds the threshold goal established by the Chief, National Guard Bureau when he ensured Governors that his goal was to maintain a minimum of 50 percent of a State's personnel and equipment in the State to respond to domestic incidents in support of civil authorities. We anticipate that civil authorities will request personnel to conduct security, logistics, transportation, and communications operations.

In the planning process, we make the assumption that that individuals currently assigned to the RING and working in civilian health care, police, emergency medical service and fire professions will not be available for mobilization with the Rhode Island National Guard. The limited medical assets within the Rhode Island National Guard's current force structure will primarily support the medical needs of service members activated to conduct domestic support operations.

The current force structure and projected force structure provides sufficient resources to conduct security and logistic operations. We anticipate that civil authorities will request personnel to man traffic control check points and establish area security. Our military police, security forces and other units provide the RING with sufficient capability to accomplish these operations. Additionally, we anticipate that civil authorities will require National Guard support to move supplies and manage points of distribution. Current personnel levels and the transportation assets described below provide sufficient capabilities to conduct these operational tasks.

The RING maintains a variety of transportation assets which include wheeled vehicles, helicopters and fixed wing aircraft. These assets provide civil authorities with a capability to move personnel, supplies and equipment to critical areas. Additionally, the airstrip at the Quonset Air National Guard Base provides civil authorities with an alternate port of embarkation/debarkation for resources transiting in and out of Rhode Island.

Communications assets within the RING provide a valuable capability to civil authorities. In addition to those assets assigned the 13th CST, the Joint Command, Control, Communications, and Computer (J4) Coordination Center, which is commonly referred to, as the JCCC is located in North Smithfield, Rhode Island. The JCCC is a sub-component of the Joint CONUS Communications Support Environment (JCCSE). The JCCC assists in maintaining situational awareness, planning, and coordination during homeland defense and civil support operations. The JCCC serves as a single control agency for the management and direction of the joint force command, control, communications, and computer systems. Rhode Island also has the capability of another component of the JCCSE which is the Joint Incident Site Communications Capability (JISCC). The JISCC is a satellite package that can be towed or airlifted to an incident site. It contains communications assets that can communicate via high-frequency radio, telephone, video and satellites to interface a variety of communications equipment used by first responders, State, and Federal agencies and can be operational within 90 minutes upon arrival at the incident site. Additionally, the NGB has the capability to deploy a Joint Enabling Team (JET) to the State. JETs assists in the collection, reporting and sharing of information in order to identify potential response needs, coordinate the response, and facilitate the support requested by civil authorities.

PARTNERING WITH STAKEHOLDERS

While the RING has sufficient capabilities to support civil authorities in the event of a biological incident or other domestic support operation, we recognize the chang-

ing nature of the security environment. We recognize that gaps may exist between our capabilities and those needed by civil authorities. As we identify challenges and opportunities we continuously engage our strategic partners. For example, in an effort to engage our Emergency Management Assistance Compact (EMAC) and other strategic partners within FEMA Region I, we recently hosted the Regional Interagency Steering Committee (RISC) conference.

The RING, specifically the 13th CST, is currently partnering across all sectors of the State in the areas of planning, training, and response thereby increasing the State's ability to respond to incidents of national significance. We are currently experiencing tremendous success at the second tier response level (State level) and have established partnerships with a myriad of State agencies and Federal agencies to include:

- RI Emergency Management Agency;
- RI Department of Health;
- RI Department of Environmental Management;
- Rhode Island State Weapons of Mass Destruction Tactical Team (RI–WMD–TT);
- RI regional HAZMAT teams;
- RI regional DECON teams;
- RI HAZMAT Working Group;
- RI Disaster Medical Assistance Team (DMAT);
- RI State Police Fusion Center;
- U.S. Attorney's Office Anti-Terrorism Advisory Council;
- Newport Naval WMD Decontamination Team;
- Boston FBI Office, CBRNE Division, Hazardous Response Team;
- U.S. Army North;
- Northern Command;
- National Guard Bureau;
- FEMA Region I.

Current examples of joint training conducted with these partners include the RING's recent hosting of the Defense Threat Reduction Agency (DTRA) CST Radiological Response Course, and the 13th CST Advanced Chemical Special Topics Laboratory Scale Preparation of Field Expedient and Improvised Chemical Weapons with Hazard Assessment Laboratory. In addition, the Rhode Island National Guard conducted numerous regional training exercises focused on support to civil authorities during which we exercised our collective response capabilities to include our National Guard Response Force (NGRF), WMD CST, Joint Operations Center (JOC) and Joint Incident Site Communication Capability (JISCC). Ongoing initiatives include participation in the Ingestion Pathway Response Plan Annual Review, CST Critical Facilities Informational Site Packets, the development of tabletop and situational training exercises with the Providence Urban Area Security Initiative (UASI), Transportation Security Administration (TSA), Army North (ARNORTH) and U.S. Northern Command (NORTHCOM). Additionally, three out of the four General Officers currently assigned to the National Guard are trained and certified as Joint Title 10 and Title 32 Task Force Commanders for domestic operations.

TAG DUTIES, ROLES, AND RESPONSIBILITIES

The duties, roles, and responsibilities of my position in the State create a positive environment for partnerships and cooperation. In addition to my duties, roles and responsibilities as The Adjutant General of Rhode Island and the Commanding General of the Rhode Island National Guard, I also serve as the Homeland Security Advisor for the State of Rhode Island and the Director of the Rhode Island Emergency Management Agency. This unique management structure provides one focal point for the Governor, as well as for the Federal agencies. Additionally, it helps to ensure a common direction for all stakeholders. Clearly defined goals and objectives facilitate a unity of effort, common operating picture and situational awareness.

CONCLUSION

Clearly the Rhode Island National Guard provides the State of Rhode Island with robust all-hazard capability as well as for biological incidents. All is not perfect to be sure. At the core of capability is the need for clearly defined roles, missions, and responsibilities. The default for response should not be the National Guard due to a lack of capability at the local response level. Therefore, local, State, and Federal funding is essential for adequate personnel, equipment, training, facilities, and planning. As an operational war fighting organization, the Rhode Island National Guard must be properly resourced. The Rhode Island National Guard is an operational force. It is an all-hazard, full-spectrum force engaged today in combating terrorism, war fighting, and domestic support. The Rhode Island National Guard needs 100

percent full time manning, 100 percent of TO&E equipment, State and Federal support for our military construction budget, and full funding of its operational and maintenance budget. Consequently, I support the National Governors Association (NGA) letter to the Chairman and Ranking Member of the House and Senate Committees on Armed Services, which opposes House amendments to the Federal Insurrection Act. If enacted as part of the 2009 National Defense Authorization Act, these provisions would empower the President to order military Reserve components other than the National Guard to Title 10 duty for domestic missions, including natural disasters and emergencies for which States qualify for Federal funding under the Robert T. Stafford Act.

In closing, planning, preparing, resourcing, and responding to a biological threat or other domestic incident is a continual process that must adapt to a complex and changing security environment. The role and mission of the National Guard under the command and control of The Adjutant General with the Governor as Commander-in-Chief, past, present, and future is essential to the success of domestic preparedness and response. Partnerships and resources at both the State and Federal level are vital in our efforts to ensure that we stand Ready, Relevant, Reliable, and Accessible in support of civil authorities in the event of a biological or other domestic incident.

Mr. LANGEVIN. Thank you, General Bray, for your testimony.

The Chair now recognizes Tom Kilday for 5 minutes.

STATEMENT OF THOMAS J. KILDAY, JR., HOMELAND SECURITY PROGRAM MANAGER, RHODE ISLAND EMERGENCY MANAGEMENT AGENCY

Mr. KILDAY. Thank you, Mr. Chairman, and Members of the committee. I want to thank you for inviting me to speak with you today to discuss the current successes and on-going challenges in planning and preparing for all-hazard events here in Rhode Island.

I need to share with you my dual perspective as a homeland security program manager for the Rhode Island Emergency Management Agency and a former public health response coordinator at the Rhode Island Department of Health.

The Rhode Island Emergency Management Agency serves as the State's primary coordinating agency for State-wide preparedness and response to all-hazards events. Prior to 2001, preparedness efforts in Rhode Island, as in many other areas of the United States, were focused only in the State's Emergency Management Agency. Work was limited to the new domestic preparedness grant activities and preparing for natural disasters. The events of September 11, 2001 followed by the October 2001 anthrax attacks catapulted public health into the preparedness arena and forced cooperation with emergency managers and other first responders.

Rhode Island EMA and Health, in coordination with Federal, State, and local partner agencies implemented many preparedness systems and response capabilities since that time. Rhode Island's small geographic size, diverse ideas, lack of county government, and close working relationships among government, public, and private sectors are some of the key agreements that enable Rhode Island to have an effective preparedness planning program.

Rhode Island's EMA is currently working on multiple projects including developing situational awareness tools to common operating solutions in order to link numerous, disparate systems currently utilized in the State into a consolidated information hub to facilitate planning and response, building the Rhode Island communications network, RISCON, which is a border-to-border, 800-megahertz digital radio system designed to provide seamless digital

voice communications to all responders. Most recently, we're in the process of purchasing 1,400 radios for placement in front line fire, police, and EMS vehicles. State-wide continuity of operations planning, including the development of State-wide pandemic flu plan in cooperation with the Department of Health.

In addition, Rhode Island EMA participates in Federal, 15 Federal preparedness grant programs, including the application process, development, monitoring, and subgrant support. A common grant concept that has fostered interagency cooperation has been surge capacity management and planning over the years.

In Rhode Island the Station Night Club fire served as an important event highlighting the need for improved coordination and management of surge capacity. In February 2003, the Station Night Club in West Warwick, Rhode Island caught fire with an estimated 400 persons attending a rock concern. Hundreds were sent or self-transported to area hospitals. The fast-moving fire caused 100 fatalities, making it the fourth-deadliest fire in the United States history at that time. This tragic event provided Rhode Island with a real-world mass casualty fatality response experience. Since then, the emergency planning community in Rhode Island continues to revisit actions and lessons learned from this incident and have, to date, established procedures and protocols for the activation of surge capacity plans, implemented bed tracking, web-based software, expanded interoperable communication system within the hospital and first responder community, redesigned our emergency operation center, expanded the State-wide mutual aid plan, established regional mass casual response teams, and enhanced the capability of the Rhode Island Disaster Medical Assistance Team.

I want to talk a little bit about DMAT. Rhode Island DMAT is a category 1 team of the National Disaster Medical System. The team has more than 250 medical professionals and support personnel with its Federal cache of medical and logistics equipment and is prepared to deploy anywhere in the country within 6 hours' notice. The State has acquired a cache of medical and logistical equipment that will enable Rhode Island DMAT to act as an alternative care site, a stand-alone emergency department or a mass immunization and medication clinic within the State, even if the team has been deployed out-of-State with their Federal cache.

NDMS recently regionalist DMAT Federal caches and closed multiple team warehouses throughout the country, including those of Rhode Island DMAT. This move effectively eliminates the ability of Rhode Island team to utilize their Federal cache to serve their own community during disasters and limits their maintenance and training capabilities. This is of special concern during a pandemic flu event when State borders may be closed and movement of materials is restricted.

In conclusion, Mr. Chairman, efforts outlined in this testimony are just a snapshot of the numerous programs and activities designed to enhance the preparedness of Rhode Island. I ask for your support in leading congressional efforts to increase surge capacity management and response capabilities, enhance, interoperability among hospitals and first responders, encourage common operating picture solutions in place of disparate systems, emphasize the im-

portance of developing nontraditional partnerships, and finally, continue support for the development of the Disaster Medical Assistance Team.

Additionally, at this time, it is important to also mention that multiple grant programs, disparate time lines, numerous reporting requirements and a continually changing Federal focus detract from our programmatic preparedness efforts. It is critical that all Federal preparedness grant programs be more closely aligned and coordinated, while locally a larger grant management team would be helpful, Federal support, such as combining grants, multi-year funding, and alignment of program deadlines would allow for much more efficiency.

Mr. Chairman and Members of the committee, I thank you for this opportunity to discuss these important issues with you this morning and I'd be happy to answer any questions.

[The statement of Mr. Kilday follows:]

PREPARED STATEMENT OF THOMAS J. KILDAY, JR.

JULY 22, 2008

Mr. Chairman and Members of the committee, my name is Thomas J. Kilday, Jr. NREMT–P. I serve as the Homeland Security Program Manager for the State of Rhode Island Emergency Management Agency. Additionally, I serve as a practicing Paramedic for the Rhode Island Disaster Medical Assistance Team. I previously served as the Emergency Response Coordinator at the Center for Emergency Preparedness and Response, at the Rhode Island Department of Health where I worked on public health preparedness activities.

Since 1999 I have worked in various capacities serving in local, State, Federal and international arenas. Most recently, I served as a public health preparedness manager who transitioned to working in the field of emergency management. This experience provides me with a broad perspective on the all-hazards approach to preparedness focusing on the collaboration between public health and emergency management, which is the focus of this testimony.

I want to thank you for inviting me to speak with you today to discuss the current successes and ongoing challenges in planning and preparing for all-hazards events. I am eager to share with you my dual perspective as both the Homeland Security Program Manager and a former public health preparedness team member for our Nation's smallest State. As of today, although the progress made in preparing Rhode Island has been significant there is still considerable work that needs to be done, and there are challenges both of scope and depth of preparation that need to be addressed.

RHODE ISLAND EMERGENCY MANAGEMENT AGENCY (RIEMA)

The Rhode Island Emergency Management Agency serves as the State's primary coordinating agency for State-wide preparedness and response to all-hazards events. Rhode Island Emergency Management is provided authority under RI General Law 30–15 to provide the following:

- To reduce vulnerability of people and communities of this State to damage, injury, and loss of life and property resulting from natural or man-made catastrophes, riots, or hostile military or paramilitary action or acts of bio-terrorism.
- To authorize and provide for coordination of activities relating to disaster prevention, preparedness, response, and recovery by agencies and officers of this State, and similar State-local, inter-State, Federal-State, and foreign activities in which the State and its political subdivisions may participate .
- To provide the State with the ability to respond rapidly and effectively to potential or actual public health emergencies or disaster emergencies.

Additionally "The mission of the Rhode Island Emergency Management Agency is to reduce the loss of life and property in natural and man-made incidents by utilizing an all-hazards approach to prevention, preparedness, response and recovery through a program of leadership and expertise in comprehensive emergency management while providing strategic partnerships, innovative programs, and coordination of State, regional and Federal resources."

The Emergency Management Agency provides this support to the citizens of Rhode Island through the efforts of our 27 employees led by its Director Major General Robert T. Bray, Adjutant General, Homeland Security Advisor and Executive Director J. David Smith who is responsible for day-to-day operations and agency coordination.

RHODE ISLAND'S HISTORY OF PREPAREDNESS

Prior to 2001, preparedness efforts in RI were focused in the State's Emergency Management Agency. This work was limited to managing the new Domestic Preparedness grant program activities and the continuing mission to prepare for natural disasters. The events of September 11, 2001, followed by the anthrax attacks in October 2001 catapulted public health into the preparedness arena and forced cooperation with emergency managers and other first responders. The Rhode Island Department of Health (HEALTH) was charged with managing both the CDC's Bioterrorism Preparedness Program and HRSA's National Hospital Bioterrorism Preparedness Program. With the implementation of the preparedness grant programs, the State and HEALTH, in coordination with Federal, regional, tribal, State, and local partner agencies, have implemented many preparedness systems and response capabilities.

A CULTURE OF PREPAREDNESS

The strength of Rhode Island's preparedness efforts rests in the ability of the Government, public, and private sectors to organize and plan through multiple committees and working groups, all focused on the primary goal of preparing Rhode Island for the worst, most probable disaster. Rhode Island's small geographic size, diverse culture, lack of county government and the close inter-working relationships are the key ingredients that enable Rhode Island to have effective preparedness planning program. At the core of Rhode Island's preparedness program is the Emergency Management Advisory Council (EMAC). Chartered by statute, this group advises the Governor on preparedness activities within the State. EMAC is co-chaired by the Lieutenant Governor and the Adjutant General, who also serves as the Homeland Security Advisor for Rhode Island. The group has a total of 30 representatives from all sectors of Rhode Island. The challenge encountered with the above described committee is ensuring that all partners remain actively engaged in the planning process.

INTERSTATE REGIONAL COORDINATION

Rhode Island has a strong relationship with our regional partners at many working levels. Given current systems and Government structures, these regional activities focus primarily on planning. Because no overarching governmental system and therefore, no oversight, exists at the regional level, there is great disparity in the types and levels of planning that occur at the regional level. Despite this lack of oversight, Rhode Island has forged forward to involve other New England partners in building relationships and discussing response mechanisms.

Current agency goals pertinent to this testimony include the following:

- Development of Situational Awareness (SA) tools and Common Operating Picture (COP) solutions linking the State and local agencies with RI Emergency Management.
- Development of RI State-wide Communications Network (RISCON) which is a border-to-border 800MHz Digital Radio System to provide seamless digital voice communications to all responders.
- Grant management activities including the coordination of more than 15 Federal grant programs and their reporting requirements.
- State-wide continuity of operations (COOP) planning including the development of the State-wide pandemic flu plan in cooperation with the Department of Health.

SITUATIONAL AWARENESS (SA) COMMON OPERATING PICTURE (COP)

Rhode Island's small geographic size, coupled with its ample supply of critical energy and transportation infrastructure, suggests that the State's first responders and public safety community would have seamless and discreet interoperable capabilities second to none. Yet, our 39 cities and towns, and a number of State agencies have fostered a stovepipe mentality with limited guidance for implementation of consistent and comprehensive technological systems and policies. To date a number of systems both linked and disparate have been created to enhance Rhode Island's operability and interoperability within the technological environment of day-to-day

operations as well as systems designed to enhance emergency response capability. Examples include the following:

- Hospital Capacity System (HCS);
- Web EOC;
- Port Security Camera System;
- Traffic Management System;
- Mesh Network System.

Many of these systems serve useful purposes, however; there is little integration of the systems currently in use in the State. RIEMA is working to link the disparate systems into a consolidated information hub to facilitate situational awareness and common operating picture for all responders and policy decisionmakers.

RHODE ISLAND STATE-WIDE COMMUNICATIONS NETWORK (RISCON)

The vision of the RISCON project is to have interoperable communications which will enable all public safety and first responder agencies to communicate within and across departmental and jurisdictional borders. The system is APCO 25 Compliant data capable system. The current capabilities of RISCON include 11 sites in the Washington County (southern) system and four in the North Providence system and five in the Providence system with three in construction stage and two in the site assessment stage. Over 2,500 subscriber units have been purchased for local, State, and tribal agencies. Radios have been purchased for each front line fire, police and EMS vehicle in the State. Also, both U.S. Coast Guard Stations in Rhode Island, Capitol Police, Regional Teams including the Urban Search & Rescue, Disaster Medical Team, HazMat, Decon and Law Enforcement WMD teams and cabinet level State agencies just to name a few have equipment and network access enabling them to operate on the RISCON network. Current funding will allow the system to expand to a total of 19 sites and provide 90+ percent coverage State-wide. The total users on the system will increase to close to 4,000 by 2009. Additionally, a cache of radios and repeaters are being developed.

GRANT MANAGEMENT AND FEDERAL REPORTING

RIEMA currently facilitates numerous grant programs, has an established monitoring program and is able to assist sub-grantees with questions regarding allocated funds and also with the grant application process. Additionally, the agency is required to submit reports to Federal agencies describing current programmatic activities.

As the State Administrative Agency (SAA) to over 15 grant programs the small team that is currently managing these funds is not sufficient. RIEMA aims to have a more robust grant management team who can accurately and fastidiously award and monitor grant funding and complete reporting requirements. Presently, we complete a number of Federal reports, of which the purpose is not clear. We are told we are completing them "for Congress", but are unsure if that is actually the case. We seldom receive constructive feedback on the reports that we submit, which would be helpful in evaluating our efforts and future planning. The multiple grant programs, disparate timelines and numerous reporting requirements detract from our programmatic preparedness efforts. Locally, a larger grant management team would help, but Federal support such as combining grants, multi-year funding and alignment of program deadlines would allow for much more efficiency.

CONTINUITY OF OPERATIONS AND PANDEMIC PREPAREDNESS

Over the past few months, the State of Rhode Island took unprecedented steps to enhance our pandemic flu preparedness. In response to the *Federal Guidance to Assist States in Improving State-Level Pandemic Influenza Operating Plans*, the Rhode Island Emergency Management Agency and the Rhode Island Department of Health led a collaborative effort to respond to this request for submission.

Under an unrealistic deadline, new partnerships were forged on the State level. Non-traditional partners such as the Department of Labor and Training, the Office of the General Treasurer, and the Department of Education were included in the planning effort and provided important insight on areas of responsibility which allowed them to learn more about emergency management. The relationships that were created have allowed for further offshoots of preparedness including training State workers in Incident Command System (ICS) and a Pandemic Flu/Continuity of Operations Working Group with the State's colleges and universities. This effort served as an important gap analysis and relationship builder. It now allows the State of Rhode Island to target our planning efforts to specific areas which will bolster overall State preparedness. Additionally, Rhode Island, along with many other States, has begun to focus heavily on our ability to provide continuity of operations

(COOP) during a pandemic influenza event. This process has allowed us to produce many COOP plans for our various State government agencies and our critical infrastructure areas based on what appears to be the worst-case scenario threat of pandemic influenza.

Despite the successes Rhode Island has enjoyed in State COOP and pandemic planning, considerable work needs to be done. The challenges include:

1. Training and Exercising existing COOP and Pandemic Plans.
2. Limited funding to purchase equipment needed to support COOP and pandemic-related planning for information technology and redundant systems.
3. Inadequate Department of Homeland Security support for Critical Infrastructure Protection programs as it relates to COOP and Pandemic Preparedness.
4. Guidance fails to take into account the unique organizational environment found in States like Rhode Island.

Mr. Chairman, in addition to the responsibilities that my agency is involved in, I also feel it is important to mention the following preparedness efforts that I have been involved in over the past several years.

MEDICAL SURGE CAPACITY EFFORTS

From the beginning of the implementation of the Health Resources and Services Administration (HRSA) grant, surge capacity was identified as a planning priority. In Rhode Island, the Station Nightclub fire served as an important event highlighting the need for improved coordination and management of surge capacity and patient management. The Station Nightclub in West Warwick, RI caught fire at 11:12 p.m. on February 20, 2003 with an estimated 400 persons attending a rock concert. The fast-moving fire caused 96 immediate fatalities and hundreds were sent to or self-transported to area hospitals. Four victims subsequently died in hospitals making it the fourth-deadliest fire in United States history.

The emergency planning community in Rhode Island continues to revisit actions and lessons learned from this incident. The response of the first responders and hospitals to the incident has provided Rhode Island with a real-world exercise of the capabilities of the first-responder community and hospitals to a mass casualty/fatality event. RIEMA and HEALTH have worked with hospitals to establish procedures and protocols for the activation of surge capacity plans in the event of a similar incident. Over the last 5 years, the hospitals and health centers have established and exercised their plans for a surge of patients. HEALTH, in conjunction with RIEMA, has established notification procedures and communications protocols to activate a Mass Casualty Response. The Southern New England Mutual Aid Plan was established with support of RIEMA to coordinate a response by first responders to intra- and inter-State emergencies. A mutual aid agreement amongst all hospitals within the State to share personnel, supplies, and equipment during a public health emergency has been implemented.

Pandemic flu planning has necessitated the expansion of hospital surge capacity planning to surge management of the entire health care system. HEALTH has established health care service regions to allow hospitals to facilitate the management of resources within their regions and to establish Alternative Care Sites (ACS).

RHODE ISLAND DISASTER MEDICAL RESPONSE TEAM (RI–1 DMAT)

The Rhode Island Disaster Medical Assistance Team (RI–1 DMAT) is a Category One team of the National Disaster Medical System (NDMS). The team consists of more than 250 medical professionals and support personnel, supported by a cache of medical and logistical equipment and is prepared to deploy anywhere in the country with only 6 hours notice. In the event of a Federal deployment of the team, approximately 35 members would accompany the entire Federal cache for up to 2 weeks, and provide medical care to patients without outside support for up to 72 hours. Until recently nearly all of the team's equipment was Federal property and, as such, would not be available for use within the State of Rhode Island if the team were deployed. This shortfall in equipment would leave the un-deployed 200 members of the team without the resources needed to care for patients within the State.

Through efforts led by Department of Health the State acquired a comprehensive cache of medical and logistical equipment that will enable RI–1 DMAT to provide care to patients within the State even if the team has been deployed out-of-State with their Federal cache. The team is also able to deploy its field hospital as an alternative care site for a mass casualty incident, or situate it in the proximity of a hospital emergency department to care for patient overflow. The structure, its equipment and supplies could also be configured to serve as a mass immunization or medication distribution facility almost anywhere in the State or deployed through the emergency management assistance compact to other States. The RI Medical Re-

serve Corps is a Federal initiative which is managed in Rhode Island by the RI DMAT team. The addition of this corps of volunteer healthcare providers has had a positive impact on the team's ability to manage its mission in Rhode Island in the wake of the removal of the RI team's Federal cache and the current inability of HHS to enroll new members on the DMAT teams.

Until recently, DMAT category one teams under the National Disaster Medical System (NDMS) have been supplied with a cache of logistics and medical equipment that they used to support the treatment of the victims of disasters in the country. This cache, termed the "Basic Load", was also available to be used by the teams to serve their local communities, and there are many positive examples of this from around the country.

NDMS leadership has recently decided to regionalize DMAT caches & close multiple team warehouses throughout the country. The RI DMAT cache was relocated to north of Boston at the end of June and their warehouse was closed. This move effectively eliminates the ability of the Rhode Island team to utilize their cache to serve their own community during disasters, and denies them access to the equipment for maintenance and training. This is of special concern to State planners during a pandemic flu event when State borders are closed and movement of materials is restricted.

While NDMS claims cost savings, in the case of the Rhode Island team, there is a GSA lease that will have to be paid for the next 4½ years for a now empty building. The total bill to the Government for this lease will be more than $700,000, again, for an empty building. Apparently GSA will be responsible for the rent, but NDMS will see a positive impact on their budget. This development reinforces the foresight of Rhode Island in developing and supporting their DMAT team's local capability.

CONCLUSION

Efforts outlined in this testimony are just a snapshot of the numerous programs and activities designed to enhance the preparedness of Rhode Island. There are many agencies and individuals that work hard each day to make Rhode Island a safer place to live and work.

It is important to mention that the ever-increasing number of grant programs, reporting requirements and unfunded mandates all require considerable planning time and utilization of resources in order to be effective. In many cases, these resources are being stretched very thin, both at the State and local level. It is critical that all Federal preparedness grant programs be more closely aligned and coordinated so that we at the State level can more effectively develop an appropriate response to whatever emergency may occur.

Lastly, we cannot discuss local, State and national emergency preparedness if we do not discuss the aggressive efforts needed to impress upon the American people the need and critical requirement for personal and family preparedness. I feel that personal and family preparedness is an integral part of the overall preparedness continuum.

Mr. Chairman and Members of the committee, I thank you for the opportunity to discuss these important issues with you this morning and would be happy to answer any questions at this time.

Mr. LANGEVIN. I thank you for your testimony. The Chair now recognizes Peter Ginaitt for 5 minutes.

STATEMENT OF PETER T. GINAITT, DIRECTOR, EMERGENCY PREPAREDNESS, LIFESPAN HOSPITAL NETWORK

Mr. GINAITT. Thank you, Mr. Chairman and Members of the committee. Thank you for the invitation to be here today. I preface my remarks and I want to thank the Federal panel, the group that was here. They have made a difference. I will tell you, there's been an incredible difference that has been felt in the State of Rhode Island and I'm sure across this Nation, as well as my partners to the right. Our State agencies, the RIEMA and the Guard, have made a tremendous impact on our ability to respond.

I'm here today representing hospitals. Hospitals are our lifeline within this country and there are many concerns out there, especially when we deal with major events such as pandemic influenza.

Here in Rhode Island, we've strived to develop an integrated and coordinated system for the benefit of the public health and for the health of our health care system. We have worked toward a response to a pandemic influenza which has been both enlightening and to a degree somewhat daunting. The development of ten health care coordinating service regions in the State, through the Department of Health have been identified as an effective method of addressing the expected influx of patients throughout the State of Rhode Island. These hospitals would utilize the hospital incident command system and would manage health care within a prescribed region of the State. They would each report directly to the Department of Health which would be the coordinating entity for all ESFA activities.

In a planning phase for any hazard where a mass casualty situation could exist it is imperative that the health care system remain functional and that the ability to deliver acceptable quality of care to preserve the greatest number of lives be preserved. This philosophy is made more challenging with the need to allocate scarce resources in a manner that will optimize the saving of lives.

The challenge, however, is the allocation of these resources in a fair, open, and transparent way while maintaining a safe, infection-free environment for the delivery of care. These challenges have been discussed throughout this country and a solid understanding seems to be in place. Hospitals willingly accept challenges every single day and even more so as the impacts of reduced reimbursements affect hospitals, increased uncompensated care requirements, impact our community hospitals and our daily patient census numbers hit record levels.

Rhode Island Hospital, just last week, had 355 patients come through its emergency room in one 24-hour period. That is an alarming number to manage. Granted, it's the largest hospital within the State and it is a Level 1 trauma system, but 355 patients and that is becoming a normal number.

Hospitals attempt to organize their care through the sharing of resources and even attempt to merge operations in a further attempt to maintain their high levels of quality care through resource-sharing and functioning under economies of scale.

It has been a practice to plan within a facility, but further encouraged to integrate these facility level plans into regional systems. The systems continue to build their plans through an expanded involvement of private and public community stakeholders and the need for a unified response continues to be stressed, since individual preparedness will stress rapidly during a major event. These plans must also be consistent with all integrated—integrated into all Federal, State, and local plans.

Rear Admiral Vanderwagen alluded to the intersectoral interaction. It is very, very important that we regionalize all of our efforts and I feel that in Rhode Island we've done a very good job of that.

Altered standards of care need to also take into consideration and recognition that a reduction in the work force will further complicate and compound the stresses in health care during major events. While identifying the needs of hospitals and the expected volumes of patients in both the clinical settings within the hospital,

as well as the activation of an alternate care site, personnel will play a major role in the operational successes and/or failures of these types of events. It is estimated that staff reductions could reach upwards of 50+ percent in the case of pandemic influenza.

This degree of clinical care reduction will further stress the actual health care delivery system and will require that we operate under different ratios to care for people. The expectations for current standards of care, while we strive to achieve these expected levels, will most likely be stretched during these labor- and care-intensive periods while experiencing large staff reductions and increased patient numbers.

Hospitals face daily diversions of patients due to increased volumes within their facilities. Managing these influxes are extremely complicated while also maintaining the quality of care within these facilities. With the addition of alternate care sites, it is extremely difficult to predict the actual impact that will be felt within the system.

Hospitals have experienced tragedies in the past and I can assure you through planning and professional level of these employees, responses have always been effective, well-coordinated and resulted in good, patient care. However, the unexpected event that stresses an entire health care system due to sheer volume or resource limitations could be tantamount to the proverbial house of cards. I can assure you that readiness has been in the past effective. Readiness continues to be imperative and again I thank this body for addressing that.

We must continue to build on these plans, but also the need to address the needs of these patients. The simple stockpiling of supplies needs to be further addressed by the Federal Government. The hospitals simply cannot support stockpiling of resources with limited storage as well as limited to no funding to support these caches of pandemic and all-hazards supplies. If these resources are identified as essential and I support that premise, assistance must be given by other agencies to purchase and support the delivery during a time of necessity and guarantee a timely delivery of the same. We have implemented the Chem Packs which is something that was exciting to do because we're putting nerve agent antidotes right into our backyards now, something the military has enjoyed for 30 years. But up until the last couple of years we're starting to experience that.

Representative Pascrell, you talked about the increase of antivirals. It is important that we have them within hospitals and have more than a thousand courses within our hospital while we're expected to deal with 150,000 patients in the city of Providence alone.

We must move toward a clear and understandable goal within the Federal Government and support that goal with a plan of funding and implementation. Funding cycles must be beyond a single year and progressive buildout of a system of resources and staff support must be clearly delineated. While grant funding is essential, working under unrealistic time parameters with the hope of an extension or face loss of grant funding is all too often counterproductive and often results in quick fixes.

Multi-year funding, while federally problematic to manage is the only real answer to build the structural framework for system saving response. We clearly understand that the plans will always be labeled with the word draft. As I talk to my senior management and I tell them our plans are always going to say the word draft, but that's because of the world that we're in. We're constantly improving our plans so therefore to put them back on the shelf and say that they're functionally finished and can sit there for 2 or 3 years is the wrong thing to do, so we're constantly working to improve.

We realistically also comprehend that any reliable plan of action will take years to appropriately accomplish, but building toward those goals through planning and implementation is where we will succeed. I believe we are in that direction and I have offered my full testimony for the committee and I'm open to questions.

Thank you very much.

[The statement of Mr. Ginaitt follows:]

PREPARED STATEMENT OF PETER T. GINAITT

JULY 22, 2008

Mr. Chairman and Members of the committee, my name is Peter Ginaitt, R.N., EMT–Cardiac. I serve as the Director of Emergency Preparedness for the Lifespan Health System and recently retired as a professional firefighter/EMT with the city of Warwick Fire Department after 21 years of service. Also, I served in an elected position as a State Representative from District 22 in Warwick for over 16 years until retiring from public office to assume my current position at Lifespan. My concentrations in public policy were both environmental protection and health care.

I would like to thank you for inviting me to testify today to discuss the challenges that lie ahead of health care in preparation for the potential of emerging biological threats as well as the need to be better prepared for the "all-hazards" approach of preparedness within the health care community.

While I would like to report that I feel we as a country are sufficiently prepared to handle a major biological outbreak, or even further, are ready to handle the influx of victims if a catastrophic event were to impact Rhode Island and Southern Massachusetts, I feel I cannot report complete success. I do however feel strongly that we have made major advancements in our levels of preparedness and are better off today then ever in the past.

LIFESPAN

Lifespan, Rhode Island's first health system, was founded in 1994 by Rhode Island Hospital which includes its pediatric division Hasbro Children's Hospital and The Miriam Hospital. A comprehensive, integrated, academic health system, today Lifespan partners also include Bradley Hospital and Newport Hospital.

As a not-for-profit organization, Lifespan is overseen by a board of volunteer community leaders who are guided by its mission to improve the health status of the people it serves in Rhode Island and Southern New England. The mission of Lifespan is to improve the health status of the people whom we serve in Rhode Island and New England through the provision of customer-friendly, geographically accessible and high-value services. We believe that this can best be accomplished within the environment of a comprehensive, integrated, academic health system.

In September 2007, Lifespan President George Vecchione and senior leaders recognized the need to be better prepared for any threat that existed. The Office of Emergency Preparedness was developed and an emergency preparedness council of CEO's and senior leaders was developed. Preparedness within hospitals underwent a paradigm shift and emergency preparedness and protection of our facilities to protect the delivery of patient care became paramount. Recognizing the need to assist and coordinate, the office of emergency preparedness continues to develop its role of system support and resource building.

In my role as Director of Emergency Preparedness, I serve as the Principal Investigator for a Hospital Preparedness and Healthcare Facilities Emergency Care Partnership Grant through HHS and under the Assistant Secretary for Preparedness

and Response. The program administered will better prepare our State in the event of a disaster through the implementation of a robust patient tracking system that will track all EMS patients every day from the scene to the hospital, this program will be the first of its kind in the United States. The need for patient tracking was identified after the Station Nightclub fire on Feb. 20, 2003 in West Warwick, Rhode Island where over 400 people were attending a rock concert. A fast moving fire caused 96 immediate fatalities and hundreds were sent to or self transported to area hospitals. Four victims subsequently died in hospitals making this the fourth-deadliest fire in our country's history. The findings were referenced in the After Action report assembled by the Titan Corporation in the months following that deadly blaze and recommendations made for the tracking of patients. The program will also develop voice and data communications systems for health care and proposed alternate care sites, a current system whose frailties were evidenced during and after Hurricane Katrina when communications failed. Last, the program will promote Incident Command adoption and training to promote better unified responses within the State of Rhode Island.

While pandemic planning continues to actively occur within all of the State's hospitals, it does present an ongoing challenge that requires constant planning and exercising in this and other areas. They continue to be better prepared as the State and Federal Government have requested but challenges are frequently discovered. The Lifespan system hospitals take particular pride in the planning efforts given to prepare for such an even as they work diligently to develop robust plans to deal with any "all-hazard" event.

RHODE ISLAND

The successes to date in pandemic preparedness in Rhode Island have been successful due to the partnerships and working relationships within the State and the New England region. As partners here today at this very table, I must acknowledge the hard work and efforts on behalf of Dr. David Gifford, Director of the Rhode Island Department of Health. Dr. Gifford has been challenged with the task of pandemic preparedness and with the cooperation of the Center for Emergency Preparedness and Response (CEPR) under his leadership, hospitals have been provided an incredible amount of support through resource allocations and pandemic cache development. On-going subcommittee work dealing with all aspects of the pandemic influenza and our State's response continue as plans develop.

Major General Robert T. Bray, the State's Adjutant General and State Homeland Security Advisor continues to work diligently in the development of plans to respond to catastrophic events within our State, including the support for a pandemic outbreak. This agency has made tremendous strides toward a robust response within this State to an event under an "all-hazards" scenario utilizing resources within our State military services and emergency management agency.

And also, Mr. Thomas Kilday, as outlined within his testimony, I am sure you will notice that Mr. Kilday has assumed many roles which include health care response prior to his emergency management career as Homeland Security Program Manager. This broad knowledge provides a clear and educated perspective to the very events we are here to discuss today.

In Rhode Island, we have strived to develop an integrated and coordinated system for the benefit of the public health and for the health our health care system. We have worked toward a response to a pandemic response which has been both enlightening and to a degree somewhat daunting. The development of ten health care coordinating service regions in the State through the Department of Health have been identified as an effective method of addressing the expected influx of patients throughout the State of Rhode Island. These hospitals would utilize the Hospital Incident Command System and would manage health care within a prescribed region of the State. They would each report directly to the Department of Health which would be the coordinating entity for all ESF–8 activities.

While these regional plans are aggressive and require us to utilize all of the health care resources we as a State possess, we clearly understand that the scope of response will most likely overwhelm us as single facilities. We are better preparing by the use of shared resources, but we also recognize that the available on-hand resources may not be adequate if the event is as large as predicted. Many of the challenges we predict we will experience include:

EMERGING ISSUES

As in any mass casualty, the ability to deliver customary care to everyone is just not possible. Hospitals today face increased census numbers and the availability of

clinical space continues to be a challenging issue. Our challenges to these extraordinary situations should take into consideration our ability to:

- Be compatible with day-to-day operations;
- Be applicable to a broad spectrum of event types and severities;
- Be flexible through a graded response for the circumstances faced with;
- Be tested, to determine where gaps and improvements are needed.

In the planning phase for any hazard where a mass casualty situation could exist, it is imperative that the health care systems remain functional and the ability to deliver acceptable quality of care to preserve the greatest number of lives be preserved.

This philosophy is made more challenging with the need to allocate scarce resources in a manner that will optimize the saving of lives. The challenge, however, is the allocation of these resources in a fair, open and transparent way while maintaining a safe, infection-free environment for the delivery of care.

These challenges have been discussed throughout this country and a solid understanding seems to be in place but no real tangible cure to this challenge has been offered. Hospitals willingly accept challenges every day and even more so as the impacts of reduced reimbursements affect hospitals, increased uncompensated care requirements impact our community hospitals and our daily patient census numbers hit record levels. Hospitals attempt to optimize care through the sharing of resources and even attempt to merge operations in a further attempt to maintain their high levels of quality care through resource sharing and functioning under economies of scale.

It has been a practice to plan within a facility but further encouraged to integrate these facility level plans into regional systems. The systems continue to build their plans through an expanded involvement of private and public community stakeholders. The need for a unified response continues to be stressed since individual preparedness will stress rapidly during a major event. These plans must also be consistent with and integrated into Federal, State and local plans.

As with any major change in policy or practice, an adequate legal framework must be further developed, endorsed and placed into action due to the requests placed upon facilities when activating any regional plan of care. These should include rapidly instituted executive orders declaring a disaster with the enabling language to support altered standards of care. These changes either through executive order or statutory change must be clear and concise for ease of communication and implementation and should further be free of confusion through interpretation of meaning. As with any disaster, these directives should also take into account the need to accommodate the demands of varying sizes of events and should not be primarily based on catastrophic levels of need.

These altered standards of care need to also take into consideration that a reduction in the work force will further complicate and compound the stresses in health care during major events. While identifying the needs of hospitals and the expected volumes of patients in both the clinical settings within the hospital as well as the activation of an alternative care site, personnel will play a major role in the operational successes and/or failures of these types of events. Estimates vary around the 50 percent staff reduction numbers. This degree of clinical care reduction will further stress the actual health care delivery system and will require that we operate under different ratios to care for people. The expectation for current standards of care, while we will strive to achieve these expected levels, will most likely be during these labor and care intensive periods while experience large staff reductions and increased patient numbers.

Hospitals face daily diversion of patients due to increased volumes within their facilities. Managing these influxes are extremely complicated while also maintaining the quality of care within each facility. With the addition of alternate care sites, it is extremely difficult to predict the actual impact that will be felt within the system. While the State has adopted a memorandum of understanding between all hospitals to share staff and resources, a State-wide or regional event would render that agreement useless, not to mention that the capacities of these other hospitals are already stressed with their own patient census.

Hospitals have experienced tragedies in the past and through planning and a professional level of employees, responses have always been effective, well-coordinated and resulted in good patient care. However, the unexpected event that stresses an entire health care system do to sheer volume or resource limitations could be tantamount to the proverbial "house of cards".

We must continue to build on these plans but also the need to address the needs of these patients. The simple stockpiling of supplies needs to be further addressed by the Federal Government. The hospitals simply cannot support major stockpiling of resources with limited storage as well as limited to no funding to support these

caches of pandemic and all-hazards supplies. If these resources are identified as essential, and I support that premise, assistance must be given by other agencies to purchase and support their delivery during a time of necessity and guarantee timely delivery of the same. The following continue to make planning problematic and they remain outstanding challenges.

We must move toward a clear and understandable goal within the Federal Government and support that goal with a plan of funding and implementation. Funding cycles must be beyond a single year and progressive build-out of a system of resource and staff support must be clearly delineated. While grant funding is essential, working under unrealistic time parameters with a hope of an extension or face loss of grant funding is all-too-often counter-productive and often results in quick fixes. Multi-year funding, while federally problematic to manage, is the only real answer to building the structural framework for a system saving response. We clearly understand that the plans will always be labeled with the word "draft" since it will be a constantly improving tool. We realistically also comprehend that any reliable plan of action will take years to appropriately accomplish but building toward those goals through planning and implementation is where we will succeed.

Beyond funding, I would further recommend that the Federal Government establish a smaller department within HHS or DHS to provide hands-on technical support in each of the States and regions that have realistic and attainable goals. I am not suggesting that this be the solution, but any interaction beyond paid consultants will be beneficial. Hospitals will respond well to systematic integration into a well-formatted structure of needs. I see the need to have designated Federal directors assisting the State governments and health care with the guidance necessary to achieve our goals and objectives. I further see the need for regular interaction with all regional partners while these systems further develop. I understand that this is currently being performed but see the need to better organize and deal with the "All-Hazards" response.

As stated earlier in this testimony, I feel strongly that the Federal, State and local plans and responses are better than ever before. Hospitals State-wide are better prepared and truly understand the impact that could face them if a major event ever occurred. It is further reinforced by The Joint Commission who accredits these facilities through recurring surveys and new standards currently placed in the survey tool. These new standards in place require increased readiness compliance in 2008 and expected newer standards for January 2009 will only strengthen hospitals' preparedness and overall responses.

Please accept my thanks for the opportunity to present this testimony before this subcommittee and I remain available for questions.

Mr. LANGEVIN. Very good. Thank you, Mr. Ginaitt. With that, I want to thank the panel for all of their individual testimonies and we look forward to learning more on the full testimony that you submitted for the record, but I just want to remind Members we'll each have 5 minutes for questions and I'll recognize myself for 5 minutes.

Dr. Gifford, let me start with you. With respect to public health preparedness, being able to monitor day-to-day activities and to obviously be well aware of emerging threats that are actually occurring, in your opinion has bioterrorism preparedness been integrated with pandemic influenza preparedness and how have you been able to integrate these activities into the existing framework in Rhode Island for public health emergencies that occur more frequently or currently. Can you give us a few examples of how you've done that here in Rhode Island?

Dr. GIFFORD. I applaud, Mr. Chairman, your desire to try to get us to integrate things in our daily activities and that includes the theme of my presentation.

We have utilized some of the emergency preparedness funding, as many States, to implement what's called the ROD system which is a real time monitoring of diseases in the emergency room. So we actually have a—as individuals are registered in the emergency room for symptoms, we get actually a real-time alert into a data-

base. We actually have an algorithm that screens that and looks for outlying events. When we see a certain number of people coming in with respiratory illness or high fever or diarrhea or some different symptoms, it triggers us an alert. We look at the individuals to see if they clustered by zip code. We look to see if they cluster by town, gender, any aspects. We contact the hospitals and begin to do a very quick investigation. I would say we get alerts about every other day. It's diminishing as we build the database and you get a better sense as to where they are, but that helps us look at what's going on out there.

Some of that has actually helped us, in general public health activities, identifying outbreaks of strep throat or anything, a certain school district, so I think it not only helps us from a biosurveillance standpoint, but it helps us with our day-to-day activities.

We have currently for influenza we have sentinel physicians that during the influenza season they report to us on the number of people they're seeing that have influenza-like illness and we're able to track and see when we need to put alerts out to think about using antivirals or boosting up the immunization rates as well as testing in our lab to see what the strains are—did they match with the vaccines or not?

Those are some efforts that we have done. We can clearly do a lot more. I mean with the advent of technology and health information exchanges, we should be able to have a much better surveillance process that's out there. Currently all the labs report any incidents of any—about 85 different diseases. If they culture any of it, it gets reported to us. Certainly all the bioterrorism events are in that list, but we need a better system for symptoms early on. I think as you heard from the previous panel the exposure to these types of agents will not manifest symptoms for anywhere from a few hours to several days. It could be spread out and as we get the data electronically, to be able to monitor that it will not only help us with that bioterrorism, but will also help us in our day-to-day activities as we go on.

Mr. LANGEVIN. I couldn't agree more and the further out we can push this in terms of being aware of an emerging threat actually manifesting itself, the better we will be able to respond.

Let me turn to you, Peter, on surge. You talked about that. What are the hospital system's plans for surge in the event we are overwhelmed?—and I recognize that on any good day a hospital system, the emergency room, in particular, can easily be overwhelmed with large numbers of patients, even just an average flu season.

What are we doing in terms of being prepared for the potential of thousands of people coming down with an illness, whether manmade or natural disaster, and showing up at our hospitals? I'm not talking about just a couple of hundred, I'm talking about what if it were to occur in a thousand? How are we going to deal with this? What are the contingency plans that you're aware of in place and I also want to ask where the majority of extra hospital supplies, where are they being stored and are they being vendor-managed and do you think that they should remain at this location or at the hospitals themselves?

Mr. GINAITT. Mr. Chairman, bear in mind we started to deal with surge capacity back several years ago with the Department of

Health and with the Federal Government in our level of preparedness and for the surge of people over and above our normal, daily census. We're experiencing surge every day now. We are actually actively going within surge capacity areas drawing down on expanded places to give clinical care that normally aren't being used and that's again a daunting task when it comes to personnel issues and it comes to physical space issues.

We were challenged several years ago to increase our ability of surge for 500 people within 1 hour and we did that very effectively. In the case of Rhode Island Hospital we altered our surge capacity plan and identified 196 openings within 1 hour that we could surge people into. Bear in mind that means that we're not at capacity, that we're not drawing down on those surge numbers and that we're able to effectively deliver the same level of clinical care that's expected.

It's interesting, as I travel around the country and I hear from other hospitals that have surge capacity plans and they're very proud of the fact that they can take an additional 25 people in and I sit there and I look at the grand scene of what a major event could do to this nature and I break out into a cold sweat as far as where our pandemic plans are going. That's why I'd like to really stress the all hazards. While we do talk about pandemic influenza and we reference the 1918 pandemic outbreak, I think our biggest threat is going to be from something that will be—that will fall into the all-hazards.

Hospitals around the State have individually addressed their surge capacity plans and have acknowledged that they needed to build out additional resources. Call-back, we have a new emergency notification system, thanks to the Department of Health and Federal granting and our Hospital Association of Rhode Island for rapid call-back of staff so that we can put surge capacity areas into action.

So we're working very well with the increase, the influx of people, whether it's into the thousands is another issue. That's when we fall into an alternative care site. That's where we're challenged with taking our in-house current staff and deploying many of them into a free-standing alternative that in many cases could be a school, could be a convention center and dealing with those, the actual establishment of an alternative care site is not all that difficult. The concept of a freestanding hospital, but manning it, being able to deliver care. Being able to run laboratory tests, manage reports, manage the transfer of patients is the daunting task and again, I credit the Department of Health for having an on-going ad hoc committee through the hospital association also and identifying these scarce resources and our needs.

We continue to work on that. I feel good about it. I cringe a little bit about the word thousands, but it is something that we're working toward.

Your second question: What is the management of supplies? We've received tremendous number of supplies over the course of the last few years to deal with hazardous materials and decontamination. A lot of training. We do manage and do vendor management to the best of our ability when we can do that. I reference the fact that I have several hundred thousand doses of ciprovoxin

and doxycycline. We can't get rid of enough doxycycline when you have 120,000 courses. We don't use it enough. Luckily, it's a very inexpensive drug. So we try to—many of the products that are costly, we try to do as much VMI as we possibly can.

Mr. LANGEVIN. Thank you. With that, I now recognize the gentlelady from the Virgin Islands, Congresswoman Christensen for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and good morning, and thank you for being here.

General Bray, I am in awe of how you manage four different responsibilities, especially looking at how you direct the local authority which is RIEMA and then the support authority, the Guard, and how you keep those two operational and separate is amazing.

I wanted to ask a question about the—your ability to—your local response capacity. You say you're at 71 percent strength as of July 15. The National Guard has set a standard of at least 50 percent and you don't plan to call up your police, your fire, your first responders if an event occurs that is a disaster. Without calling up your first responders, can you be at 50 percent strength?

Gen. BRAY. Thank you for the question and I wear many hats. We have a system, a tiered system of responsibilities and I delegate a great deal of those authorities down to my subordinates who are very competent. Let me just say again, the Rhode Island National Guard is not the first responder in any event.

Mrs. CHRISTENSEN. Right.

Gen. BRAY. So the first-tier response is always the first response agencies, law enforcement, fire, emergency medical services. So they will usually almost always be deployed prior to the National Guard being called upon and then subsequently deploying within the State as well.

So we will always augment those first responders in the event of an incident.

The civil support team has a very close relationship and is probably more likely to be deployed in a case of a biological incident prior to the need for the total mobilization of the Rhode Island National Guard, both Air and Army. So again, in a tiered-level of response, we feel that we are more than able to support any needs of the State.

Now I will tell you, that goes beyond that. We have the Emergency Management Compact with the other States. We also have a close regional relationship with the bordering States, and then we have several other capabilities at the national level that will augment the Rhode Island National Guard should not only its personnel assets be exceeded or close to being exceeded, but any other capability that might become a shortfall. So on a regular basis and I mean daily, my staff through our joint operations center senses that level of capability in the State and whether or not we need to use those other assets to support us.

Mrs. CHRISTENSEN. Thank you. Mr. Kilday, stovepiping is not unique to Rhode Island as I'm sure you have heard from some of us. How long has RIEMA been working to integrate across agencies and what are some of the barriers and when do you think it will be accomplished?

Mr. KILDAY. Over my years in the preparedness business here in Rhode Island, I think very early on we recognized that there was a great deal of stovepiping within agencies. It used to be called turf and I found over my experience over the years people have recognized that preparedness is important, that they need to put aside those turf issues and work on preparedness. It's about buy-in from the highest level down and I think we've achieved that.

Unfortunately, we've achieved that at some level because of some of the tragedies we've had in the State and some that we've experienced nationally. It's unfortunate that it takes that level of experience to create that buy-in.

I think in the State of Rhode Island what we've done is recognize the small size of our State, our limited resources and capabilities and forced a basis for regionalization. Most of our capabilities, recognizing that one department or one agency may be limited. We've regionalized those capabilities, whether it be hazmat and decontamination teams, whether it be urban search and rescue capabilities or the DMAT team.

We've focused these regional capabilities in linking with emergency management and reaching out to these other agencies, whether they be Department of Ed., Department of Labor, training.

Mrs. CHRISTENSEN. Is it working?

Mr. KILDAY. I believe it is, ma'am.

Mrs. CHRISTENSEN. Thank you. Dr. Gifford, I'm very impressed with what you've been able to do based on your written and your oral testimony and if we were to consider what we have heard from you today, we probably wouldn't increase any public funding for public health because you've done so well, but as you interact with your counterparts across the country are you hearing the same kinds of success stories or are you hearing the need for more Federal funding?—and Director Ginaitt, the same thing with respect to hospitals. I get the sense that maybe public health funding is—it's not adequate, a little closer to where it needs to be, but hospital funding for preparedness is not. So if both of you could answer that.

Mr. KILDAY. Well, I think it is always a shame when you reward success by cutting funding.

Mrs. CHRISTENSEN. We're not going to cut it.

Mr. KILDAY. As you know from your public health background, the greatest threat in public health is that when we start making progress and we refocus elsewhere, we see many illness reemerge. We've seen syphilis. We've seen TB come back in this country, when we thought we were making progress on it because we said we were doing so well, now let's focus somewhere else.

So I think that that is really, if we haven't learned from history and we keep making the same mistakes, I would say shame on us. I think that really applies to emergency preparedness.

I think we run the risk of saying okay, we planned for pandemic. We stockpiled for it and we planned for bioterrorist agents, okay, a new agent, we'll get ready for that. Then we call it a day. I think that really underestimates the value that this has had. While many of the events that we've had to respond to, we had to respond to before 9/11, before anthrax, we are now much better, we're better integrated with EMA. We're better integrated with other agen-

cies and we are much more effective and efficient, frankly, at responding to those events because of the emergency preparedness in those other areas.

I think that's what we're seeing across the country is the whole incident command structure was foreign to the public health sector until the emergency preparedness funds. Now you have almost every State has been certified through the NIMS system and ICS now utilizes it and while we used to respond to disease outbreaks, infectious disease outbreaks with NICS, we did okay. We're now much more effective because of that.

Now it also is clear that you need to integrate this to train and support this and as I think Mr. Ginaitt recognized by acknowledging that these plans are drafts, you need to always be revising and continually planning your drafts. So I think that there's a real need for it. As I meet with the other health directors, as I've talked with them, I think you'll see in my written testimony the many examples. Each of those examples was not something that was directly related to prior event, but it exercised a capacity or capability that was directly related to pandemic flu and elsewhere. I will tell you the first few times we stood up ICS in our department, it was disastrous and you heard about people losing sleep, I lost sleep saying oh my, if we had really had a pandemic, we're not ready. That's why we lowered the threshold and utilized ICS at a very low threshold in the department because we now have everyone trained in ICS. One hundred percent of the staff were trained in ICS. We utilize it all the time because we don't know who is going to be sick and absent. I mean we had a mycoplasma outbreak and I was on vacation in the Grand Canyon. I ended up flying back here, but we utilized a lot of the different aspects of it. But I think you need to have that training and that on-going funding. My concern, I think I have it in written testimony is you see a trending of the funding going down and I think that that puts us at jeopardy of watching some of the disease outbreaks coming back. So that's the same story I hear.

All of us like to think we're unique. All of us have sicker patients. All of us have more problems, but I will tell you, everyone across the country whether it be California or Rhode Island or the Virgin Islands or Hawaiian Islands, we all have the same issues and concerns and I think really would benefit from it. So I would hate to see us declare victory and go home in this. I think we need, this is now a new way of responding, not just to the threats, but to our day-to-day activities.

Mr. LANGEVIN. Please be brief as possible, Peter.

Mr. GINAITT. Absolutely, Mr. Chairman. Hospitals are stressed. With all due respect, we do receive as much money as we can. We're very grateful for the grant funding that we do receive through the Federal Government and through the State, however, we're faced with daily challenges in hospitals. Emergency management is a new tool. As we all remember in emergency management agency not that many years ago was called civil defense and they bagged rivers when they were overflowing. Now it's taken on a whole new meaning in this Nation. Hospitals are taking it very, very seriously and we're trying to deal with what funds we do have. We're grateful for any of the funding that comes in. As an

example, Rhode Island Hospital is a recipient of one of the ASPR grants, one of the five partnership grants to develop a patient tracking module that can be used as a model throughout this Nation, as well as a communication so that we can have sustainable communications as we saw fail down in Louisiana after Hurricane Katrina. We do try to manage those. We do try to take what money we can. It is difficult at best. We will make anything work that heads our way. However, we do need some, I think, some larger plans, larger plans of attack with some grant funding that we can look at through multi-year implementation.

Again, we're willing to work with our partners. We've done a great job, but we also understand we have a daunting task ahead of us.

Mrs. CHRISTENSEN. Mr. Chairman, I'm going to probably leave at this point so I want to thank you at this time for inviting me to the hearing and for the opportunity to be here and be a part of this.

Mr. LANGEVIN. I'll see you tonight in Washington. Thank you for your questions.

The Chair now recognizes the gentleman from New Jersey, Mr. Pascrell, 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Mr. Ginaitt, you talked about the hospital stress. Hospitals are closing and if we're planning for huge service necessities, it would seem that that's not a very good idea. But they close not because they want to. They close because they don't—they can't pay their bills. I'm sure that you've had closings in Rhode Island. So that space, where the hospital sold it to some other entity or not, that space could be much more valuable down the line and I hope you've given thought to that.

Mr. GINAITT. Representative, we have. Every morning I drive down Warwick Avenue actually Representative Langevin's previous legislative district and I drive by a Wal-Mart—not a Wal-Mart, a drug store that formerly was a small community hospital that no longer exists and it's disheartening to see what is actually happening, the fleecing of the health care within the United States and hospitals trying to sustain themselves through poor economic times.

It is cyclical and we see that, but many of the smaller community hospitals really do depend on those communities and those communities depend on them. Trying to operate a major initiative and controlling and being ready for emergency preparedness while you're trying to pay for the very people that keep the doors open in that hospital, again is a daunting task.

Mr. PASCRELL. Has anyone from the Homeland Security Department ever reached out to you personally?

Mr. GINAITT. No, other than through Homeland Security—actually grants that we've dealt with, or the local. I will say——

Mr. PASCRELL. So no one has reached out to you?

Mr. GINAITT. Directly, no.

Mr. PASCRELL. How about you, Mr. Kilday?

Mr. KILDAY. We speak to the Homeland Security folks daily.

Mr. PASCRELL. I'm sorry?

Mr. KILDAY. We work very closely with Homeland Security from the Fed side on a daily basis for grant programs and other activities.

Mr. PASCRELL. Do you get the sense that they're attempting a bottom-up kind of situation which is remove ourselves from what we're doing 5, 6 years ago to now? You don't have that feeling, do you?

Mr. KILDAY. We've seen in the organization of DHS it's shifted, clearly as was talked about earlier in the previous panel over the years and we've seen from the top-down and now we are working with the regional focus where the regional planners are out in the community working with us out of FEMA Region 1 specifically, although we are concerned that the system will flex and change again and it takes a great deal of staff time to flex with them and it takes away from program activities.

Mr. PASCRELL. Dr. Gifford.

Dr. GIFFORD. Most of our dealings are with the various agencies within HHS, but we do do some with DHS. They've reached out to——

Mr. PASCRELL. I didn't ask you who you dealt with. I asked you do they reach out to you?

Dr. GIFFORD. Yes. They've reached out to both me and my staff. As we go forward, I would say there's been an evolution over time from more of a top-down to much more of a partnership activity. I think one would not want to see the pendulum swing from either top-down or bottom-up. I think a partnership where there's a coworking is better. I think as alluded to in the previous panel, things have gotten better. Could they continue to improve? I think we can always continue to strive to improve and make it better.

Mr. PASCRELL. All right.

Mr. GINAITT. Representative, I just want to give some clarification in my response. We do deal directly with our State emergency management agency which are the program managers for the Department of Health, Department of Homeland Security, so we have been able to work very, very successfully with the Emergency Notification System, the event calendar. We have a tremendous number of things within our hospitals which is directly related to Department of Homeland Security through our State-wide providers.

Mr. PASCRELL. Thank you. General Bray, you said you're at 71 percent capacity, if I heard you correctly.

Gen. BRAY. Correct, sir.

Mr. PASCRELL. How many guardsmen do you have?

Gen. BRAY. We have just over 3,200. It varies on any given day.

Mr. PASCRELL. How many are deployed?

Gen. BRAY. At the present time we have approximately 350. Again, it varies every day. We try to maintain no more than about 500 at any given time deployed both air and Army, but again, depending on the mission, it varies on a regular basis.

Mr. PASCRELL. Not every State has incorporated the National Guard as you have here in Rhode Island into the emergency management scheme. To what extent have you done that in Rhode Island? Can you just briefly talk about that?

Gen. BRAY. What we have attempted to do is build on the relationship that the Rhode Island National Guard and Emergency

Management have had for some time. Rhode Island is very unique in that there is no county government and so the default many times from the local is directly to the State and oftentimes the Rhode Island National Guard as well as the health department becomes the next stop for the first responder. So it has become absolutely essential that that relationship take place on a regular basis.

So on a daily basis we have, as I mentioned, a joint operation center staffed 24/7 by the military and on the other side of my headquarters the State emergency operations center which we have a 24/7 capability, but only staffed during regular working hours and then a call waiting system after that. My attempt is to merge that capability into one standing joint interagency coordination center which I've been in discussion with for a concept of operations with the National Guard and try to work through the Title 32 issues that—and for that matter the labor issues on the State side that apply in that capability. That intent there is to give us full situational awareness, develop a common operating picture so that we can put critical assets at critical needs when we need them, as opposed to reacting to situations that might develop.

Mr. PASCRELL. Can you send me a summary of that operation? I'm interested in that.

Gen. BRAY. Yes, sir. I would just add that we have a great collaboration within the region and also amongst the Adjutant Generals, many of whom have the same dual hat capability that I have to discuss these very matters. General Tim Lowenberg, the Adjutant General for the State of Washington leads the Governor's Homeland Security Advisory Council and is the lead for much of that discussion. So a great deal of collaboration takes place on a daily basis.

Mr. PASCRELL. Thank you for your service to your country, as all the gentlemen. Thank you for your service to Rhode Island and the country, not just Rhode Island.

Mr. LANGEVIN. I thank the gentleman. One final question that I will pose to you, Mr. Kilday, since we're talking about getting beyond getting ready and actually being prepared, have the plans Rhode Island EMA produced been adequately tested and evaluated? If so, how and if not, why not?

Mr. KILDAY. Rhode Island maintains a comprehensive exercise program that involves the local agencies as well as a number of State agencies. We have a very small staff. We have a single individual who manages our exercise program and they receive support from other staff within the agency. Some of the challenges are the requirements under the homeland security exercise and evaluation program are quite arduous and the task of completing after action reviews as well as other plans and responses to preparedness.

I think that we have done a really good job with exercise activities in the State in spite of our limited staff and capability and I owe this to the local resources, specifically the 39 local communities who often through their emergency management programs which are either paid, volunteer, or are part-time in some manner step to the plate, participate in the exercise programs and support emergency management in our efforts by participating in these exercises.

I think we could have a more robust exercise program and hope to do that some day within the agency, but currently based on funding, staff requirements, caps on hiring, we do not have that.

Mr. LANGEVIN. With that, I do want to thank all of you for your testimony. I want to thank you for your service to the State, to the country. The issue of emerging biological threats is something we all take very seriously. It's a daunting task to try to protect our citizens from every contingency. We recognize perhaps that is not entirely possible, but to have plans in place and a robust system of prevention, detection and response is really the best strategy. Oversight sometimes is obviously, it is difficult, painful sometimes for those on the other side of the table to go through, but it's an important part of being able to evaluate where we are and where we want to get to. So I'm encouraged by what I've heard here today from the things that Rhode Island is doing and perhaps because we benefit always from being a small State, perhaps it's easier to coordinate and I hope that what we're doing right here in the State can serve as an example of what the rest of the country can and should do to better protect the rest of our citizens.

Thank you all for your efforts and we stand ready to work with you as we go forward in trying to better protect the country from emerging biological threats and making sure that we have the most robust, strongest system of public health preparedness. So with that again I want to thank you all for your testimony and your valuable insights that you've given us today. Clearly, there are great challenges ahead. We're not there yet and more work needs to be done, but thank you for the work that you're doing.

With that, I want to thank you again, the witnesses, for the valuable testimony, the Members for their questions. The Members of the subcommittee may have additional questions for the witnesses and we ask that you respond expeditiously in writing to those questions.

Hearing no further business, this subcommittee stands adjourned.

[Whereupon, at 1:04 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO DR. JEFFREY W. RUNGE, ASSISTANT SECRETARY FOR HEALTH AFFAIRS AND CHIEF MEDICAL OFFICER, DEPARTMENT OF HOMELAND SECURITY

Question 1. We know that you have considered the possibility and impact of bioterrorism and an event such as pandemic influenza occurring simultaneously or one right after another. This being the case, some have suggested that medical and public health resources should be held in reserve to address additional events. Do you think this is even possible? How do you believe the multiplicative threat can and should be handled?

Answer. In the Department's planning and preparedness efforts, we have considered the potential impacts of both multiple and/or simultaneous bioterrorism attacks and other catastrophic events. The Department participates with its interagency, State and local partners in the annual TOPOFF national-level exercises, which specifically incorporate scenarios where multiple and/or simultaneous events occur. In this year's TOPOFF–4 exercise, Federal, State and local officials responded to three simultaneous Radiological Dispersal Device (RDD), or "dirty bomb" attacks, causing casualties and wide-spread contamination in Guam and two U.S. cities. Given that virtually any catastrophic event will almost certainly include medical and public health consequences, we agree that medical and public health resources should be held in reserve in the event that there are multiple and/or simultaneous emergencies. The Department of Health and Human Services (HHS) serves as the lead Federal entity for Emergency Support Function 8, *Public Health and Medical Services*: "Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency."[1] Under ESF–8, HHS serves as the lead Federal partner in ensuring that the Nation is maintaining appropriate levels of medical surge capacity, which is a critical element of our national, State and local resiliency. The Strategic National Stockpile (SNS), which is managed and overseen by HHS, is an example of maintaining a national stockpile, or reserve, of medical and public health resources. HHS also oversees the Medical Reserve Corps, the National Disaster Medical System, and other critical medical and public health resources that can and are activated during catastrophic events. DHS/OHA supports HHS's work with State and local governments to maintain their enhanced medical surge capacity. There are a number of ways to mitigate the risk of catastrophic outcomes resulting from multiple and/or simultaneous biological events, including maintaining a strong and well-trained cadre of medical first responders, developing and exercising well-coordinated plans and mutual-aid agreements among Federal, State and local governments, and establishing rapid distribution and deployment strategies of medical countermeasures.

Question 2. Please provide information regarding the increased efforts of Customs and Border Protection regarding identifying sick persons crossing the U.S. borders, and sending them to secondary screening.

Looking back on your time with the Department, starting out with only yourself as Chief Medical Officer, and then growing the Office of Health Affairs to the larger entity it is now, tell us what you have learned and what you would have done differently in terms of helping the Nation to prepare for emerging biological threats. What advice do you have for your own Deputy, Dr. John Krohmer, who will be heading the Office of Health Affairs through the transition to the new administration, and for others that will be countering these threats?

[1] Emergency Support Function (ESF) 8: *Public Health and Medical Services;* National Response Framework; January 2008.

Answer. As was described during the hearings last summer regarding the procedures of CBP in the management of sick persons at borders and ports-of-entry, the policies, legal authorities, and spirit of cooperation between CBP and the Centers for Disease Control (Division of Global Migration and Quarantine) are well-developed, supportive, and appropriate. There were procedural issues, however, that produced sub-optimal results. Specifically with regard to screening procedures regarding anyone identified as being a possible public health concern, CBP procedures and computerized screening support systems were modified to require that anyone so identified at primary screening must be referred to secondary screening for resolution of the issue. Using well-established procedures, CBP works jointly with health authorities, including CDC and the DHS Office of Health Affairs to get medically valid advice regarding the health status of the individual in order to reach a medically and legally valid determination on both admissibility and any necessary medical/public health requirements.

Even prior to the incident of last summer, through a series of interagency efforts particularly addressing pandemic influenza, we learned that no one agency has the authorities, expertise, or capabilities to fully counter natural or intentional biological threats to the country. Such a proactive effort requires, for example, basic sciences expertise resident in CDC, applied sciences tools resident throughout HHS (especially the Office of the Assistant Secretary for Preparedness and Response), research and development efforts by both CDC and DHS Science and Technology, public health approaches involving State, local, tribal, and Federal public health agencies, and law/border security efforts by several agencies within DHS. Amongst the most important lessons learned for the Office of Health Affairs is the critical importance of taking the "50,000 foot" view to help coordinate all of these efforts as there is no other office or agency as well-positioned to take on this critical role. While DHS has the overarching mission of coordinating preparedness and incident response, in the specialized area of public health and medicine, the uniquely OHA role has been to integrate understanding of the science of health and medicine, including biological threats, with an understanding of law and border enforcement, and applying this understanding to facilitate the interagency coordination and cooperation required to successfully prepare the Nation against biological threats.

Question 3a. Aside from the National Response Framework, the Department of Homeland Security is responsible for creating operational plans that delineate what the Federal Government is going to do if each of the National Planning Scenarios were to occur. What is the status of getting those plans done?

Answer. Planning to address Federal Incident Management activities for each of the National Planning Scenarios is currently underway. The effort, while coordinated through the Department of Homeland Security's Office of Operations Coordination and Planning (OPS), is truly an interagency effort.

The Hurricane KATRINA Lessons Learned[2] report published in February 2006 established the requirement for a permanent planning element located within the Office of Operations Coordination's (OPS) National Operations Center (NOC) and the need for a standardized Federal planning process. As a result, OPS established the Incident Management Planning Team (IMPT)[3] in September 2006. The IMPT developed the National Planning and Execution System (NPES)[4] as an interim process to standardize Federal planning as they developed operational level concept plans (CONPLANS) based on the 15 National Planning Scenarios (NPS). Over the next 16 months (SEP 06–DEC 07) the IMPT developed six plans based on the NPS. These scenarios included: Improvised Nuclear Device (IND), Radiological Dispersal Device (RDD), Improvised Explosive Device (IED), Cyber Attack, Major Hurricane, bioterrorism attack and Pandemic Influenza. In December 2007, the President approved *Annex I (National Planning), to Homeland Security Presidential Directive 8* (HSPD–8). Annex I directed development of an Integrated Planning System (IPS) which replaces NPES. IPS was approved for interim Federal use in June 2008. [sic] edIn July 2008, the DHS Office of Operations Coordination became the DHS Office of Operations Coordination and Planning (DHS OPS).

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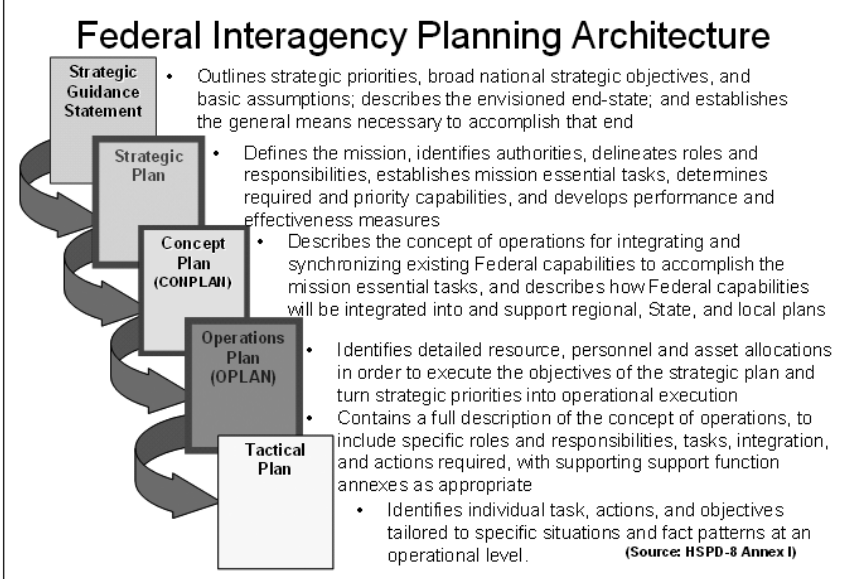
[2] The Federal Response to Hurricane Katrina: Lessons Learned (February, 2006).

[3] The purpose of the Incident Management Planning Team (IMPT) is to support a unified inter-agency planning effort for incidents requiring a coordinated national response. The IMPT will support the development of strategic guidance, concept development, plan development, and plan refinement leading to publication of a series of plans for actual or potential domestic incidents. IMPT Charter, August 21, 2006.

[4] The NPES was aligned with the National Incident Management System (NIMS) and the Department of Defense (DOD) Joint Operations Planning and Execution System (JOPES).

[sic] was The planning process in IPS is based on best practices from planning systems used in civilian and military communities. The IPS calls for several layers of plans, each of which draws upon the plan above it for guidance and direction:



FEDERAL INTERAGENCY PLANNING ARCHITECTURE

Interagency planning is ongoing on the 15 National Planning Scenarios, which were compressed into 8 scenario sets and prioritized by HSC Deputies. On 09 OCT 08, the Homeland Security Council requested that by 20 JAN 08, the IMPT complete the Terrorist Use of Explosives (TUE), Improvised Nuclear Device (IND), and Biological Attack (BIO) Strategic Plans and begin work on the Radiological Dispersal Devices (RDD) and Chemical Attack plans. Currently steady progress is underway to meet this goal; the TUE is completed; the IND is in final adjudication; and the BIO planning process is already underway.

While all interagency plans have not yet been produced under IPS, it is important to note that there is a great deal of planning and preparedness activities that addresses our readiness to address threats. NIMS, NRF and incident annexes provide doctrine and a framework for incident management, and Federal departments and agencies have procedures and plans in place to execute legal and policy responsibilities. As indicated in the chart below, the five biological national planning scenarios have been compressed into two separate scenario sets.

Priority	NRF Scenario Set	National Planning Scenarios
01	Terrorist Use of Explosives (TUE)	Scenario 12: Explosives Attack – Bombing Using Improvised Explosive Device (IED)
02	Nuclear Attack	Scenario 01: Nuclear Detonation – Improvised Nuclear Device (IND)
03	Radiological Attack - RDD	Scenario 11: Radiological Attack – Radiological Dispersal Devices (RDD)
04	Biological Attack – with annexes for different pathogens	Scenario 02: Biological Attack – Aerosol Anthrax Scenario 04: Biological Attack – Pneumonic Plague Scenario 13: Biological Attack – Food Contamination Scenario 14: Biological Attack – Foreign Animal Disease (FAD)
05	Chemical Attack – With annexes for different agents	Scenario 05: Chemical Attack – Blister Agent Scenario 06: Chemical Attack – Toxic Industrial Chemicals (TIC) Scenario 07: Chemical Attack – Nerve Agent Scenario 08: Chemical Attack – Chlorine Tank Explosion
06	Natural Disaster – With annexes for different disasters	Scenario 09: Natural Disaster – Major Earthquake Scenario 10: Natural Disaster – Major Hurricane
07	Cyber Attack	Scenario 15: Cyber Attack
08	Pandemic Influenza	Scenario 03: Biological Disease Outbreak – Pandemic Influenza

IPS PLAN DEVELOPMENT PRIORITY

Question 3b. In particular, have the material threat assessments been completed for pandemic influenza and other biological threat, and what is the status of the plans that addresses the pandemic influenza planning scenario and other biological planning scenarios? Please send us these material threat assessments, as well as the plans based on them. If the plans are not yet complete, please forward the plans in whatever draft state they are in now, and provide their expected deadlines for completion.

Answer. (1) A Material Threat Assessment (MTA) has not been performed on pandemic influenza. The MTA and Material Threat Determination (MTD) process was established per the Project BioShield Act of 2004 (Pub. L. 108–276) to inform medical countermeasure requirements and acquisitions using the Special Reserve Fund for those chemical, biological, radiological, and nuclear agents identified through the MTD/MTA process. Funds to purchase medical countermeasures for pandemic influenza are separate from the Project BioShield Special Reserve Fund and thus pandemic influenza was not included in the MTD/MTA process. MTAs have been completed on the following biological threat agents:

- Botulinum Toxin (Clostridium botulinum);
- Plague (Yersinia pestis);
- Anthrax (Bacillus anthracis);
- Tularemia (Francisella tularensis);
- Typhus (Rickettsia prowazekii);
- Q-fever (Coxiella burnetti);
- Rocky mountain spotted fever (Rickettsia rickettsii);
- Glanders (Burkholderia mallei);
- Melioidosis (Burkholderia pseudomallei); and,
- Viral Hemorrhagic Fevers—Filovirus (Marburg, Ebola); Arenavirus (Junin, Lassa, Machupo, Guanito); Flavivirus (Dengue, Yellow, Kyasanur Forest, Omsk); Bunyavirus (Rift Valley, Crimean-Congo, Hantaan).

These MTAs are classified at the SECRET level and are available upon your request. To date, the anthrax MTA is the first scenario established by the MTA process to be considered in facilitating the Federal Government's planning activities per HSPD–8.

Question 4a. A strategy employed by many departments and agencies for increasing efficiencies for public health and emergency preparedness for emerging biological threats is to better align grants, grant cycles, grant deadlines, etc.

Please describe the roles, responsibilities, and activities of the Grants Coordination Division in the Office of Health Affairs. How much progress has this Division made in better aligning grants, grant cycles, grant deadlines, etc. in this regard?

Question 4b. It is possible for Federal Departments and agencies to issue grants, contracts, and cooperative agreements that extend over more than 1 year at a time. However, many grants, contracts, and cooperative agreements issued by the Department of Homeland Security do not cover multiple years. What do you think of the value and feasibility of multi-year funding for activities that relate to public health security and emergency preparedness for emerging biological threats?

Answer. OHA leads the DHS effort to coordinate preparedness grants that have a health and medical nexus. Efforts are underway to align subject matter expertise in the synchronization of external grant programs (i.e. HHS) and align those efforts to evolving Homeland Security Presidential Directives; National Priorities; Target Capabilities; Emergency Support Functions; and program guidance to enhance national preparedness.

OHA has been intimately engaged with FEMA/GPD in ascertaining health and medical readiness functions through guidance development (State Homeland Security Grant Program (SHSGP)/Urban Area Security Initiative (UASI)/Metropolitan Medical Response System (MMRS)). To that end, OHA has made an increasingly positive impact by providing subject matter expertise in the alignment of grant programs' health and medical capabilities.

Currently, fiscal year 2009 grant guidance is in development and pending release once appropriations are passed. Grant deadlines are typically set through congressional appropriations and remain firm. However, OHA has taken proactive efforts to work with the health and medical community, professional organizations, and internal subject matter experts in the guidance development ahead of appropriation deadlines.

In coordination with the Grant Programs Directorate (GPD) within FEMA, OHA communicates with stakeholders to enhance preparedness efforts with specific attention to health and medical surge capacity, response, and recovery. As a result of the Post Katrina Emergency Management Reform Act of 2006 (PKEMRA), OHA is the principal agent for all health and medical activities that affect our national ability to prevent, prepare for, protect against, and respond to natural disasters, acts of terrorism, and other manmade disasters. In this role, we believe it is critical to ensure that our medical first responders have the resources to respond to catastrophic incidents.

The period of performance for most homeland security grant programs, including MMRS, is currently 36 months and extensions are routinely granted as necessary. There is incredible value to multi-year funding activities. As DHS/FEMA is actively promoting multi-agency as well as multi-jurisdictional capabilities, multi-year funding for these activities is paramount to meet the logistical challenges associated with planning, organization, development, execution, and evaluation.

Activities relating to emerging biologic threats and public health security may benefit from multi-year funding. OHA and FEMA/GPD are working to prioritize grant funding for health and medical capabilities planning.

Question 5. It has been stated that both the Secretary of Homeland Security and the Secretary of Health and Human Services would be co-leaders during an influenza pandemic. You, as well as your respective secretaries, have also stated the same in previous testimony before Congress. Please describe specifically how they will actually lead at the same time. How do you see this working?

Answer. As stated in the National Response Framework, HSPD–5, and other guiding documents, the Secretary of Homeland Security would serve as the leader of the Federal response, coordinating activities of all departments and agencies working through the ESF structure. DHS will work closely with all Federal partners that have responsibilities in preparing for and responding to a pandemic.

The Secretary of the Health and Human Services will fulfill the major responsibility of overseeing the public health and medical response. DHS is responsible for the coordination of the overall Federal response during an influenza pandemic, including implementation of policies that facilitate compliance with recommended social distancing measures, development of a common operating picture for all Federal departments and agencies, and ensuring the integrity of the Nation's infrastructure, domestic security and entry and exit screening for influenza at the borders.

DHS recognizes the key role of HHS in its responsibility to lead the coordination of the public health and medical emergency response activities during a pandemic under Emergency Support Function (ESF) 8, including the deployment and distribution of vaccines, antivirals and other life-saving medical countermeasures from the Strategic National Stockpile. DHS also recognizes the Department of State's role to lead the coordination of international efforts including U.S. engagement in a broad

range of bilateral and multilateral initiatives that build cooperation and capacity to fight the spread of avian influenza and to prepare for a possible pandemic. USDA conducts surveillance for influenza in domestic animals and animal products, monitoring wildlife in coordination with the Department of the Interior, and working to ensure an effective veterinary response to a domestic animal outbreak of highly pathogenic avian influenza.

Question 6. How has the Office of Health Affairs involved other high-level decisionmakers at the Federal, State, territorial, tribal, and local levels in planning efforts? How do you suggest that the processes by which this should occur be improved?

Answer. The Office of Operations Coordination and Planning (OPS) is tasked by the Secretary of the Department of Homeland Security to be the lead for Federal Interagency Strategic Planning. The Deliberate Plans Branch within OPS coordinates these planning activities, with more than 53 Federal departments and agencies participating. Additionally, FEMA is responsible for the development of Concept Plans or CONPLANS that address interagency activities in greater detail. Each Department and Agency is then responsible to develop their own agency specific Operations Plan or OPLAN. Additionally coordination of planning activities with State and local governments happens primarily at the FEMA Region level. It is anticipated that regional plans will also be produced through the IPS.

The Office of Health Affairs (OHA) is a very active partner in all levels of planning at DHS. OHA provides expert advice and works with subject matter experts at the Department of Health and Human Services (HHS), the Department of Agriculture (USDA), and the Environmental Protection Agency (EPA) to ensure that health and medical-related content for these planning efforts has the most current information available.

The required improvement to Federal, State, territorial, tribal and local level planning is being addressed by the adoption of IPS. This system is a major step in the improvement of planning processes across the Federal Government. Additionally FEMA has recently released the interim Comprehensive Preparedness Guide (CPG) 101, "Producing Emergency Plans: A Guide for All-Hazard Operations Planning for State, Territorial, Local, and Tribal Governments" which provides communities with guidance for emergency operations planning. CPG–101 (interim) also describes how the State and local planning process will vertically integrate with the Federal Integrated Planning System. These two planning documents that were developed with the assistance of multiple departments and agencies at all levels of government have vastly improved emergency planning activities across the spectrum of homeland security.

OHA is an integral component in the development of each Federal SGS, Federal Strategic Plans and Federal Concept Plans. Additionally, OHA supported the development of content for the National Planning Scenario No. 2: Biological Attack—Aerosol Anthrax.

Question 7. Do you believe that mobile hospital assets should be deployed during an influenza pandemic? If so, how do you believe that should occur—how would they be most useful?

Answer. The issue of providing care during a pandemic is a matter of surge capacity. Surge care must be delineated from disaster care in that it is not necessarily a space issue, but rather it is limited by available human resources. While it is accurate that there will likely be significant shortages of bed space in which to care for the population, our ability to provide care will be limited by the number of available health care providers. The deployment of mobile medical facilities will assist with the surge only if we are able to staff those beds. This differs from a disaster in that we generally have the ability to mobilize providers from outside of the affected area to bring in to staff a mobile medical facility. In the event of a pandemic all available providers will likely be tied up providing care in their normal institutions. It should also be understood that there will likely be a shortage of available providers due to their inability to report for duty due to illness. As such, we will be potentially facing an overwhelming population of patients seeking care in traditional hospitals while trying to maintain skeleton staffing due to health care provider absence due to illness. Successful mass care during a pandemic will be dependant upon creative use of limited human resources rather than adding mobile beds which may be difficult, if not impossible, to staff.

Question 8. What is the status of the pandemic influenza exercises that were to be incorporated into the National Exercise Program? How many have occurred to date, and how many will occur in the future? What pandemic influenza exercises have you participated in or supported at the Secretary, Assistant Secretary, and Deputy Assistant Secretary levels (please provide dates and brief descriptions)? Are

you satisfied that during these exercises that lessons learned are being adequately communicated and applied to bioterrorism preparedness?

Answer. DHS participated in PLE 1–08, an Assistant Secretary level exercise conducted in Washington, DC on February 20, 2008. Assistant secretaries met to examine the Federal Government response to an influenza pandemic and consider 3 specific modules: Screening of inbound air travelers, distribution of anti-viral medications, Federal Government options if communities fail to implement effective mitigation strategies. The exercise also focused on effective communication strategies during a pandemic. An exercise covering communications coordination during a pandemic was conducted in November 2007. This exercise included the pre-designated National PFO and Regional PFO Pandemic Influenza/Biological Threat Response teams, HHS and representatives from the Homeland Security Council. More exercises for the PFO Pandemic Influenza/Biological Threat Response teams are planned for 2009. DHS has an intradepartmental PI exercise scheduled for Oct 2008 that will primarily cover the specific roles and responsibilities of the DHS component agencies during a pandemic and will review and exercise parts of the DHS pandemic plan and specific DHS component PI plans. DHS is satisfied that lessons learned from all these exercises are being effectively implemented in guiding future policies and programs regarding pandemic and bio-terrorism scenarios.

Question 9. GAO recently released a report on State and local pandemic planning and exercising, and recommended that the Secretaries of the Department of Homeland Security and the Department of Health and Human Services, in coordination with other agencies, convene additional meetings with the States and territories in the five Federal influenza pandemic regions to help them address identified gaps in their pandemic planning. We have heard that previously held meetings were of limited value to both the Federal and non-Federal Governments. Do you think that have additional meetings would be useful? Are you planning on holding additional regional meetings on pandemic influenza, and for what purposes?

Answer. Additional regional workshops will have to be coordinated by DHS and HHS at some time after the current State plan review process has been completed. DHS concurs with HHS, that it would be impractical in the short term because of each department's current involvement in the update of the States' pandemic plans. The current timeline to have all of the updated reviews done, reconciled with States, and analysis of gaps will not likely occur until December 2008 or January 2009 at the earliest. It should be noted that the State plan review effort has also allowed DHS and HHS get a better understanding of what issues the States would like addressed and has provided us with an opportunity to make direct contact with States.

Question 10. There has been a lot of discussion regarding altered standards of care, including in a recent GAO report on medical surge. You have said that the standard care always remains the same, but in the case when resources are limited, the type or amount of care may have to change. Please elaborate. How would you recommend that States and territories address this difficult issue?

Answer. The most common legal definition of standard of care is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances; hence our comment that the standard of care would not change but rather would be evaluated in the context of the situation or circumstances. A mass casualty event involving thousands or tens of thousands, of injured or ill victims will require health care systems to quickly shift from routine operating practices to processes, procedures, and practices that can best support the additional emergent and urgent demand. When feasible, resources (people, equipment, space, supplies, etc.) used to provide certain types of care (e.g. preventive, screening, or elective) may need to be shifted to support the increased demands for emergent and urgent care. Another shift might incorporate the use of non-traditional providers to provide care for those with chronic conditions (e.g. hypertension and diabetes mellitus) that left untended could become urgent or emergent or the "worried well." Examples of this might include:

- Shifting the resources that produce the 183,000,000 visits to physician offices and hospital Out Patient Departments and Emergency Departments for non-illness or non-injury conditions (source: 2006 National Ambulatory Medical Care Survey (NAMCS) and National Hospital Ambulatory Medical Care Survey (NHAMCS)).
- Shifting the resources used to provide the 1,615,100 screening colonoscopies performed annually (source: National Cancer Institute Survey of Colorectal Cancer Screening Practices).
- Having processes in place to effectively optimize the expertise of other non-traditional medical disciplines:

- Approximately 161,000 and 95,000 medical, dental, and ophthalmic laboratory technicians (U.S. Department of Labor, Occupational Outlook Handbook, 2008–09 Edition).
- Approximately 62,000 veterinarians and 71,000 veterinarian technicians and technologists (U.S. Department of Labor, Occupational Outlook Handbook, 2008–09 Edition).

To address this difficult issue, our recommendations to the States and territories would be to:

- Use data-driven processes, specific to the State or territory, to understand their unique set of existing requirements and capabilities.
- Support, facilitate, and fund coordination and collaboration at the community, regional, and inter-State level.
- Provide information to the Department of Health and Human Services to support its role in coordinating public health emergency preparedness and response information.

Question 11. In your position as Assistant Secretary for Health Affairs, it is often not as challenging to partner with another health entity such as the Assistant Secretary for Preparedness and Response at the Department of Health and Human Services, as it is with non-health entities within the Department of Homeland Security itself. How have you overcome these challenges, and what lessons have you learned that you would pass on to those that need to partner across sectors to prepare for emerging biological threats?

Answer. Coordination within the Department of Homeland Security, as well as with other Federal partners is extremely important to ensure a cross-share of information and integration of resources and expertise on both health and non-health issues. A cross-sharing and integration of information and resources is critical because there are overlapping requirements and authorities that must be coordinated in response efforts. Without ongoing collaboration, information is not easily accessible and additional time may be necessary to obtain complete situational awareness. As with many other types of threats, bioterrorism can have wide-ranging consequences and require a multitude of response capabilities and expertise, including health, emergency management, law enforcement, intelligence and critical infrastructure/key resources protection. As such, in the event of a biological attack, many components of DHS would play critical roles in a response.

The Office of Health Affairs (OHA) regularly participates in working groups, strategic planning initiatives, training and exercises and other preparedness and response activities with other Department components to develop coordinated approaches to the various preparedness and response planning initiatives. As an example, the National Biosurveillance Integration Center (NBIC) coordinates and integrates situational awareness information within DHS and with Federal partners. During the recent salmonella saintpaul outbreak, NBIC participated with Federal partners to maintain current situational awareness of the disease outbreak trends. The salmonella saintpaul event is an example of the importance of collaboration by addressing potential issues, including economic effects, international relations, and border screening. In addition, the NBIS Interagency Working Group (NIWG) and sub-working groups meet on a regular basis to participate in biosurveillance conferences to address a broad range of interagency requirements and collaboration issues.

Question 12. Please give us the status of the Department of Homeland Security's own pandemic influenza plan. Has this plan been finalized? If so, when—and how have they been circulated throughout the Department and the Executive branch? Please provide a copy of this plan and any other relevant plans regarding pandemic influenza and other biological threats that the Office of Health Affairs has developed.

Answer. The DHS pandemic influenza (PI) plan will be revised during interagency planning under the IPS. DHS OPS intends to leverage the extensive previous pandemic planning efforts (which include a Federal Pandemic Influenza Concept Plan, a Federal Pandemic Influenza Border Management Plan and a DHS Pandemic Influenza Plan) to expedite the revision of the DHS PI plan. Current estimate for the completion of these revisions is early in 2009.

Question 13. We have a lot of biosurveillance efforts going on throughout the Nation. The National Biosurveillance Integration Center, BioSense, BioFusion, the National Medical Intelligence Center are only a few of the many activities occurring in this arena. In your opinion, how do you think these efforts should be integrated?

Answer. The mission of the National Biosurveillance Integration Center (NBIC) is to provide senior leaders and National Biosurveillance Integration System (NBIS) Member Agencies (NMAs) early cueing and increased situational awareness of biological events across all the biological domains.

NBIS provides a collection backbone that supports cross-domain integration, unique analysis of information, and collaboration between the agencies. Through NBIS, NMAs and participating agencies can provide, share and receive early biological event cueing and bio-situational awareness across all of the biological domains. NBIC serves as the operational hub for this community of member and participating agencies that leverages and integrates the various bio-surveillance efforts in support of the NBIC and NMAs missions. The expectation is that agencies will continue to collect their agency specific information, such as CDC using BioSense, will conduct their own data analysis of this information such as CDC intends to perform within BioPhusion, and then share this information with the NBIC. This is the same functional relationship being established between NBIC and the National Center for Medical Intelligence (NCMI). The NBIC provides the functional capability to collect bio-informational data, integrate those data via collaboration with the member and participating agencies, thus producing various NBIS products to provide early cueing and bio-situational awareness.

For example, during the recent salmonella event, the NBIC provided inter-agency information integration, sharing, and awareness in support of the Food and Drug Administration (FDA). Additionally, the NBIC team is working closely with the CDC as it develops the National Bio-Surveillance Strategy for Human Health and serves to facilitate the interagency and cross-domain collaboration for this important strategy effort.

As mandated in Public Law, the various biosurveillance and intelligence data streams should be integrated leveraging the NBIS with the NBIC providing the keystone.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO REAR ADMIRAL W. CRAIG VANDERWAGEN, MD, ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Question 1. We know that you have considered the possibility and impact of bioterrorism and an event such as pandemic influenza occurring simultaneously or one right after another. This being the case, some have suggested that medical and public health resources should be held in reserve to address additional events. Do you think this is even possible? How do you believe the multiplicative threat can and should be handled?

Answer. Response was not provided at the time of publication.

Question 2. Beginning in fiscal year 2009, the Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006 requires the Secretary of the Department of Health and Human Services to withhold some grant and cooperative agreement funding where a State has failed to develop an influenza pandemic plan that is consistent certain criteria, benchmarks, and standards established by the Department of Health and Human Services. Have the criteria, benchmarks, and standards been established by the Department of Health and Human Services? If so, when? What is the status of the Departmental review of State plans required by PAHPA to ensure that certain criteria are being met?

Answer. Response was not provided at the time of publication.

Question 3a. A strategy employed by many departments and agencies for increasing efficiencies for public health and emergency preparedness for emerging biological threats is to better align grants, grant cycles, grant deadlines, etc.

Please describe the roles, responsibilities, and activities of those grant-making agencies and offices at the headquarters level of the Department of Health and Human Services, and at its subordinate agencies regarding grants alignment with those put out by other departments and agencies. How much progress has the Department of Health and Human Services made in better aligning grants, grant cycles, grant deadlines, etc. in this regard?

Answer. Response was not provided at the time of publication.

Question 3b. It is possible for Federal departments and agencies to issue grants, contracts, and cooperative agreements that extend over more than 1 year at a time. However, many grants, contracts, and cooperative agreements issued by the Department of Health and Human Services and its subordinate agencies do not cover multiple years. What do you think of the value and feasibility of multi-year funding for activities that relate to public health security and emergency preparedness for emerging biological threats?

Answer. Response was not provided at the time of publication.

Question 4. It has been stated that both the Secretary of Homeland Security, and the Secretary of Health and Human Services would be co-leaders during an influenza pandemic. You, as well as your respective secretaries, have also stated the

same in previous testimony before Congress. Please describe how they will actually lead at the same time. How do you see this working?

Answer. Response was not provided at the time of publication.

Question 5. How have you involved other high level decisionmakers at the Federal, State, territorial, tribal, and local levels personally in planning efforts? How would you improve the processes by which this should occur?

Answer. Response was not provided at the time of publication.

Question 6. Do you believe that mobile hospital assets should be deployed during an influenza pandemic? If so, how do you believe that should occur—how would they be most useful?

Answer. Response was not provided at the time of publication.

Question 7. The Assistant Secretary for Preparedness and Response has a unit that deals with exercises. Previous, your office reached out to the Department of Homeland Security regarding the use of the Lessons Learned Information Sharing system. Is the Department of Health and Human Services using the system yet? How are personnel in your office working with those in the Office of Health Affairs, the National Exercise Program, etc., to combine efforts and data?

Answer. Response was not provided at the time of publication.

Question 8. GAO recently released a report on State and local pandemic planning and exercising, and recommended that the secretaries of DHS and HHS, in coordination with other agencies, convene additional meetings with the States and territories in the five Federal influenza pandemic regions to help them address identified gaps in their pandemic planning. We have heard that previously-held meetings were of limited value to both the Federal and non-Federal governments. Do you think that have additional meetings would be useful? Are you planning on holding additional regional meetings on pandemic influenza, and for what purposes?

Answer. Response was not provided at the time of publication.

Question 9. There has been a lot of discussion regarding altered standards of care, including in a recent GAO report on medical surge. In this report, GAO recommended that the Department of Health and Human Services establish a clearinghouse for States and territories to share information regarding their current approaches to addressing this issue of altered standards of care. According to GAO, the Department of Health and Human Services was silent on that recommendation, although the Department did agree with GAO's findings. Why was the Department of Health and Human Services silent on that recommendation? How would you recommend that States and territories address this difficult issue?

Answer. Response was not provided at the time of publication.

Question 10. Please provide information regarding the consensus meeting run by the Department of Health and Human Services in Indianapolis regarding medical surge requirements.

Answer. Response was not provided at the time of publication.

Question 11. What has the Department of Health and Human Services done to examine what happened to the hospitals in the Gulf Coast during Hurricane Katrina, and how the Department of Homeland Security communicated that information to hospitals throughout the country?

Answer. Response was not provided at the time of publication.

Question 12. What types of assistance has the office of the Assistant Secretary for Preparedness and Response offered or is it planning to provide to the States, territories, tribes, and localities to help them in planning, exercising, and general preparedness for an influenza pandemic? Has the office of the Assistant Secretary for Preparedness and Response systematically asked the States, territories, tribes, and localities what type of assistance would be most helpful to them? If so, what did they say and what has been done to address their needs?

Answer. Response was not provided at the time of publication.

Question 13. Since pandemic-specific funding to the States and certain localities will be ending this year, and pandemic "fatigue" is setting, are you concerned about how the States, territories, tribes, and localities will maintain continuity in their pandemic preparedness? If so, is the Department of Health and Human Services taking any specific actions to help maintain this focus into the next administration and over the long-term?

Answer. Response was not provided at the time of publication.

Question 14. Are there any plans to provide additional pandemic-specific funding to the States and certain localities for pandemic efforts?

Answer. Response was not provided at the time of publication.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO DR. DANIEL M. SOSIN, DIRECTOR, BIOSURVEILLANCE COORDINATION UNIT, AND ASSOCIATE DIRECTOR FOR SCIENCE, COORDINATING OFFICE FOR TERRORISM PREPAREDNESS AND EMERGENCY RESPONSE, CENTERS FOR DISEASE CONTROL AND PREVENTION

Question 1. We have a lot of biosurveillance efforts going on throughout the Nation. The National Biosurveillance Integration Center, BioSense, BioFusion, the National Medical Intelligence Center are only a few of the many activities occurring in this arena. In your opinion, how do you think these efforts should be integrated?

Answer. The United States is confronted by an array of threats with natural, accidental and intentional origins. Numerous domestic and global biosurveillance capabilities exist across the human, plant, animal and environmental domains; these capabilities are distributed across levels of government and the private sector but are inadequately coordinated. Integrating biosurveillance capabilities requires investment in:

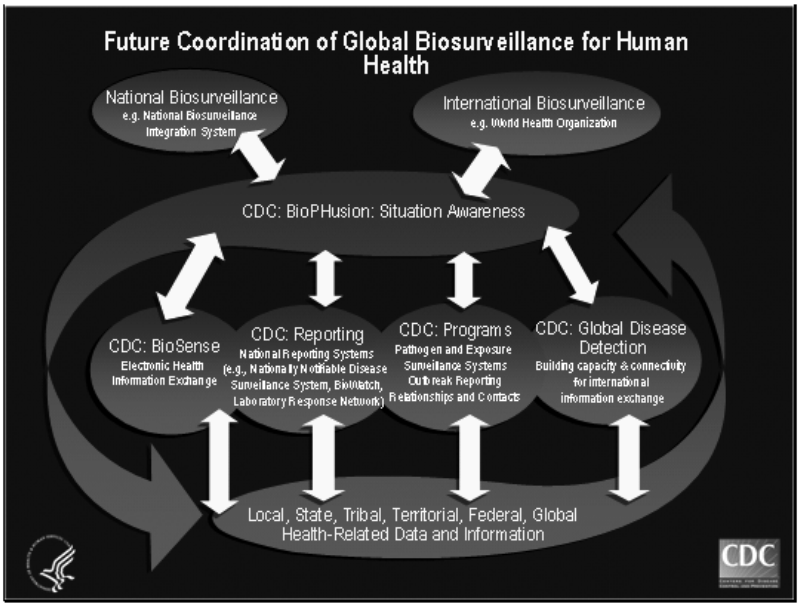
- A comprehensive Nation-wide focus embracing centralized and collaborative planning and achievable standards while allowing decentralized execution at all levels of government;
- Enabling existing systems and people to connect across multiple platforms—a single infrastructure is not a viable option;
- Building transparent communication and information-sharing systems that balance interests of stakeholders at all levels of government and distribute and receive information for decisionmakers simply and comprehensively.

Ultimately, biosurveillance addresses the management of an information supply chain for the control of acute health events of national interest through early detection and characterization for intervention.

The National Biosurveillance Integration System (NBIS) has been established to integrate biosurveillance information from all available sources, including public and private entities and NBIS member agencies. NBIS is chartered to analyze the information, from a national/homeland security perspective, and to share and disseminate information and finished products to senior governmental leaders and contributing partner agencies. HSPD–21 directs the Centers for Disease Control and Prevention (CDC) to collect, assess, and share human health biosurveillance information with all levels of government and with the private sector. Similarly, other domain-specific agencies collect, process, and share biosurveillance information that is gathered from a broad array of domestic and global biosurveillance information sources across a range of biological domains, including food, wildlife, and domestic animals.

NBIS provides a single point within the Federal Government for the integration of these agency-specific biosurveillance reporting streams. NBIS also provides the capability for the acquisition, integration, assessment, and sharing of biosurveillance-related data from intelligence, nongovernment, and other open source reporting systems across each of the domains, as well as those within the public health, food and agriculture, chemical, energy, transportation, and financial infrastructures. The National Biosurveillance Integration Center (NBIC), housed within DHS, provides NBIS community members with a unique environment for interagency cross-domain event cueing and situational awareness.

The following graphic depicts the life cycle of biosurveillance for human health for CDC. The various health and health-related data and information resources from State, local, tribal, and territorial jurisdictions, and other national, Federal, and international biosurveillance entities are reflected at the base of the graphic. These resources may feed data through biosurveillance systems (e.g., BioSense) or through programs and people in search of information to guide actions. In the ideal State, each of these entry points to the agency is tightly linked for information exchange with the others and the BioPHusion program serves both to integrate information from the multiple streams and to improve cross-agency networking for information exchange. Fused information products, including electronic health data from direct clinical connections such as BioSense, national surveillance systems like NNDSS and LRN, and condition-specific surveillance conducted by prevention and control programs, are disseminated by BioPHusion back to providers to close the information loop and to customers of human health biosurveillance at the national and global levels (e.g., NBIS, WHO).



The life-cycle of collection management, analysis, interpretation, and dissemination requires multiple systems and reciprocal relationships with all levels of government. Key functions of CDC's biosurveillance management depicted in this graphic are noted below:

- *Human health*.—CDC is responsible for leading biosurveillance efforts for human health and providing a common operating picture for human health to national and international biosurveillance organizations.
- *Reciprocal relationships*.—CDC receives and disseminates information to local, State, tribal, territorial, Federal and global entities. Mutual benefit must be achieved wherein national visibility and multi-sectoral context enhances information value.
- *Horizontal relationships*.—Key biosurveillance activities at CDC work collaboratively to integrate subject matter expertise and information gathered from surveillance systems.

Just as CDC's BioPHusion activity utilizes information from across formal and informal sources to combine and communicate this information for situation awareness for human health, the National Center for Medical Intelligence (NCMI), is a DOD/DIA organization serving to fuse classified medical intelligence. NCMI produces medical intelligence assessments, forecasts and databases on foreign military and civilian health care including worldwide infectious disease risks and global environmental health risks. CDC maintains public health liaison staff with the NCMI and the National Biosurveillance Integration Center (NBIC).

CDC is a consumer of credible and coherent medical intelligence and not a source of this type of information. Through CDC's Office of Security and Emergency Preparedness (OSEP) information from the intelligence community is identified, acquired, and channeled appropriately to components of CDC that will benefit from the information.

The primary objective of BioSense is to create a real-time picture of the health of Americans as seen through the lens of America's acute health care system, allowing decisionmakers to assess how well that system is performing in response to the challenges posed by an acute health emergency, to characterize evolving threats, to plan responses to threats and assess their impact. The information gathered through BioSense can provide complementary information to CDC programs, such as the Nationally Notifiable Disease Surveillance System or the National Healthcare Safety Network, and contributes to the daily situation awareness report produced by the BioPHusion Program.

Question 2. Please describe the two CDC programs—BioSense and BioFusion. How are they similar and how do they differ? How do or will these programs inter-

face and provide inputs into other agencies' programs, such as the National Medical Intelligence Center, the National Biosurveillance Integration Center, etc.?

Answer. The need to develop and share critical information for decisionmaking within public health has increased markedly over the last few years. The ability to share this information, however, has decreased due to the proliferation of multiple data systems and fragmented knowledge exchange. CDC's BioPHusion program was formed in order to exploit the agency's unique information repositories and health-related subject matter capabilities and to allow the routine collection, monitoring, and synthesis of hundreds of disparate information sources to create actionable knowledge. BioPHusion, an analytic unit, merges information from a variety of sources, such as other Federal agency, media-related, non-governmental organizations and social network sources, and draws on these multiple data streams to produce an integrated view of health threats and events—in effect, the daily situational awareness needed for public health action. Since August 2008, BioPHusion has produced a preliminary daily public health situation awareness report.

BioSense, a surveillance data system, collects de-identified health record level data from enrolled hospitals and health information exchanges across the Nation to identify anomalies in patterns of hospital visits and detect outbreaks of disease and maintain public health situation awareness.

BioSense will include:

- Sensitive and timely detection of PH events through monitoring of electronic data streams from emergency departments, primary care, poison control centers, and other data sources;
- Regional coordination of investigation of aberrancies in real-time data and response through data sharing and electronic communications;
- Electronic death notification and monitoring;
- Electronic case reporting and investigation;
- Tracking of outbreaks and forecasting of size, magnitude and location of future spread of disease;
- Support of innovation, research and development to improve the Nation's real time biosurveillance capabilities and work force capacity development.

Data received in the BioSense system are available simultaneously to State and local health departments, participating hospitals and CDC through a web-based application that is accessed through the CDC Secure Data Network. The BioSense application has over 800 users in 124 State and local public health jurisdictions. BioSense receives real-time data from over 570 non-Federal hospitals and batched data from over 1,200 DoD and Veteran Affairs medical facilities. BioPHusion receives information about the anomalies in patterns of health visits detected by BioSense and incorporates this information into a common picture that contains information from other CDC surveillance systems and sources, such as news reports about disease outbreaks.

CDC maintains public health liaison staff with other agencies' programs such as the National Center for Medical Intelligence (NCMI), formerly called the Armed Forces Medical Intelligence Center, and the National Biosurveillance Integration Center (NBIC). CDC liaisons sit in different programmatic areas of CDC but serve as CDC-wide resources for interfacing with the programs of other agencies. In this emerging and evolving role as a liaison, experts have provided epidemiologic expertise in the interpretation and analysis of health-related information for the NBIS daily report, served as a resource to DHS on the status of CDC surveillance systems, and consulted on medical and medical policy issues to prevent or address the exposure of Department of State employees and their families stationed overseas to infectious diseases, to name just a few examples.

Question 3. We know that assays for avian influenza were put through the Laboratory Response Network for Bioterrorism (LRN). Why was this done, considering avian influenza is not an agent of biological terrorism? What other assays for non-bioterrorism agents have been put through the LRN? Is it the intention of CDC to put more assays for disease agents that are not agents of biological terrorism through this Network? Please explain the reasoning for these decisions.

Answer. Assays for avian influenza were put through the LRN because of the need by the Department of Health and Human Service (HHS), DoD and Homeland Security Council to have a standardized assay deployed as soon as possible in support of coordinated preparedness and integrated response plans. The LRN was used because of its:

- Dual mission (i.e., high priority bioterrorism threat agents as well as other high priority biological threats to public health mandated by emergency preparedness or rapid response needs);

- Efficacy of using the established LRN national and international infrastructure asset to ensure standardization of detection and response communications (i.e. notification and lab result reporting);
- Unique capability of CDC collaborators to develop a high quality test, expeditiously deploy the test reagents with controls and ensure performance readiness through an ongoing proficiency testing program.

Planning to rapidly identify an emerging influenza pandemic is a public health priority and is a principle goal necessary for successful implementation of programs to mitigate a pandemic's impact. In a pandemic, all aspects of society will be affected, such as the public's health and economy, in addition to the possible security implications of widespread illness and work absenteeism in the population. Capacity for rapid detection of new pandemic strains in the LRN laboratories, with one or more laboratories in each State, is a critical component of U.S. pandemic planning. The LRN was also used for emergency response to SARS Coronavirus. CDC will include more assays for disease agents that are not agents of biological terrorism through the network only when emergency preparedness and response exigencies require it.

Question 4. What can the Federal Government do to assist State, territorial, tribal, and local public health personnel strengthen and coordinate biosurveillance for emerging biological threats (including emerging and re-emerging infectious diseases, as well as bioterrorism) at those levels? How do you see information from localities throughout the country rolling up into a cohesive real-time disease surveillance picture?

Answer. There will always be a need for hypothesis-driven analysis, human insights, and judgment in situational awareness activities. Professionals from diverse disciplines provide a range of skills necessary for the components of a biosurveillance system to work effectively to protect the Nation's health. Current and projected shortages in work force skills and capacities in addition to a dearth of trained workers and the inability of government to provide competitive salaries and benefits present serious challenges.

A focus on the public health work force is part of CDC's mission; efforts to sustain and enhance biosurveillance capacity at the State, territorial, tribal and local levels must include support and funding for CDC's biosurveillance work force initiatives. These initiatives include:

- Developing public health workers who serve all levels of government through fellowships and training programs;
- Defining the biosurveillance-related competencies and integrating into health curricula;
- Placing CDC staff in the field to build biosurveillance capacity at the State, local, tribal and territorial levels; and
- Collaborating with partners to improve links between the Nation's public health and clinical health care systems.

The solutions to these challenges must create job opportunities and viable career paths for health professionals. A comprehensive Federal approach will ensure a prepared, diverse, and sustainable health work force—with the right number, mix, and disciplines—capable of meeting the challenges ahead, such as enhancing timely reporting from clinical settings to health departments and helping to ensure that information from localities can roll up into a cohesive, real-time disease-surveillance picture.

Additional strategies for enhancing the exchange of disease surveillance information include the following:

- *Electronic Health Information Exchange*.—While biosurveillance encompasses many types of data, health care data provide the most specific and direct representation of the health of communities. The electronic health data-sharing environment should allow appropriate access to health information when it is needed, automated analyses that support notifiable disease detection and outbreak cues, the ability to query systems for addition investigation when warranted, and feedback loops to validate findings and enact countermeasures. Access to data will be increased through the development of regional cooperatives, linkages with health information exchanges and enhancing incentives for clinical providers to transmit data to public health. Regional cooperatives will also promote data sharing among States. Support for these systems, combined with investments for a trained and competent work force having outbreak detection and response skills, will enhance real-time disease surveillance for rapid identification of emerging threats.
- *Electronic Laboratory Information Exchange*.—The public health laboratory remains an important agent for improvement in public health practice. Rapid assays and genotypic/phenotypic characterization have allowed public health ex-

perts to identify subtle threats and respond more quickly, efficiently, and effectively than has ever been possible before. Increasing the connectivity of laboratories (public health, clinical, and research) and their analysts through standards and technology will also yield rapid and significant benefits in improved biosurveillance.

- *Unstructured Data and Data Mining*.—Material obtained from media, Internet, and informal communication sources is showing promise as a valuable complement to more direct measures of population health and is an underutilized resource. Successful methods have been developed for aggregating and analyzing these unstructured data so that they can be incorporated today as a complementary health security resource for detecting potential incidents that warrant investigation. Significant opportunities to improve these data through rigorous research and experience should be leveraged.
- *Integrated Biosurveillance Information*.—A commitment is needed to develop tools, methods, and analyst capabilities, to appropriately integrate information from multiple sources, and to create more actionable information than is otherwise available from individual sources and current information products. The fusion model should address notification protocols and effective communication of findings.
- *Global Disease Detection and Collaboration*.—Visibility of emerging health threats around the world is contingent on the local capability to detect and investigate and our connection to the health work force. Developing international capability through work force and infrastructure improvements will increase global health awareness and our connection to it.

Question 5. Please describe how you envision epidemiological investigations taking place when hospitals and other health care establishments are completely overwhelmed by a biological threat that sweeps the Nation, since we know that they will not have time for to use standard reporting mechanisms. What will CDC be able to do to help? How will we be able to get an accurate picture of what is happening with the disease?

Answer. In the unfortunate circumstances of a significant biological event sweeping across the country, CDC will lead and support epidemiological investigation and response at all levels of government by focusing on the following activities:

- *Preparedness*.—As much as possible, CDC is working to automate aspects of health information exchange. This is an evolutionary process and we will have more automated electronic resources next year than we have this year and more still in 5 years. Our preparedness goal is to prioritize and expedite the implementation of automated resources and lessen the burden of a pandemic when it arrives. The national planning effort of the National Biosurveillance Strategy for Human Health is helping to identify the priority targets for investment across the Nation and program initiatives such as those sponsored by the Office of the National Coordinator for Health Information Technology, HHS (e.g., National Health Information Network) and the National Center for Public Health Informatics, CDC, HHS (e.g., BioSense) expedite implementation.
- *Adaptation*.—When collection cannot be automated, CDC will adapt and scale back information requirements to those that are most vital for saving lives and protecting health. For instance, confirming a case at the onset of a pandemic will require more specificity and rigorous validation, but as a confirmed pandemic evolves the requirements can be simplified (e.g., influenza-like illness counts).
- *Investigation*.—CDC will bring more public health expertise directly to the clinical community. CDC will provide support to State and local jurisdictions through the services of the epidemiologic work force, such as members of the Epidemic Intelligence Service and the Career Epidemiology Field Officers. Through the provision of a surge work force, CDC staff will assist with the information gathering, identification of outbreaks, and inform the response planning and implementation.
- *Response Management*.—CDC will serve a central role in supporting the management of complex, distributed health systems. CDC will utilize existing programs and relationships with governmental entities to receive and disseminate information. Key systems such as the Health Alert Network (HAN) and Epidemic Information Exchange (Epi-X) provide CDC two tools to disseminate information quickly to decisionmakers. HAN includes a web-based connectivity and rapid communications capability among CDC and local and State health departments and health care providers. HAN has demonstrated effectiveness for communicating urgent public health messages to the health care community. Epi-X provides secure web-based communication regarding outbreak and other acute or emerging health events among public health officials from CDC, State,

and local health departments, and the military. Additionally, CDC will apply information technology tools to the management of the response as appropriate.
- *Gathering Health-related Information*.—Information sources outside the clinical community will provide complementary information. CDC will also have experts in the field conducting various assessment activities, including environmental monitoring and tracking patterns in vector-borne diseases.

Through the implementation of these complementary efforts, decisionmakers will be able to ascertain an accurate picture of the health event.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO DR. DAVID R. GIFFORD, DIRECTOR OF HEALTH, DEPARTMENT OF HEALTH, STATE OF RHODE ISLAND

Question 1. One of the emerging biological threats of current interest is Methicillin-resistant *Staphylococcus Aureus* (MRSA). We understand that we now have both institutional and community-based MRSA here in Rhode Island. Describe the steps you have taken to address this threat. What resources and guidance do you need to help you combat this threat?

Answer. MRSA is a growing threat in communities and in health care settings, and it represents an enormous health and economic impact in the United States. It is estimated that MRSA is responsible for 19,000 deaths per year; 4.5 out of every 100 hospital visits results in an infection and one study estimated that each infection costs an additional $37,000 per hospital stay.

State health departments need increased funding to combat health care-acquired infections and decrease this burden. Increased resources would enable States to:
- fund programs to educate health care practitioners on methods to decrease antimicrobial resistance and implement better infection control measures;
- conduct surveillance; and,
- investigate and respond to outbreaks in hospitals, schools, and other settings.

In Rhode Island, we have been focusing on MRSA for the past couple of years which has included the following:
- In collaboration with hospital infection control professionals we facilitated the development of infection control best practice guidelines and standards for hospitals. These 2001 published guidelines have received national acclaim and have been a model for other States to adapt. The guidelines were published in the national trade journal in 2002: Arnold MS, Dempsey JM, Fishman, M, McAuley PJ, Tibert C, Vallande NC. The Best Hospital Practices For Controlling Methicillin-Resistant Staphylococcus Aureus: On the Cutting Edge. Infect Control Hosp Epidemiol 2002;3(2):69–76. They are currently being implemented in Rhode Island. Individual hospitals track their performance with success with implementing guidelines. When uncontrolled outbreaks in hospitals occur they are reportable to the Health Dept. None have been reported. Recent surveys indicate hospital acquired MRSA rates in Rhode Island are stable and nor growing.
- In collaboration with representatives from nursing home (long-term care) infection control professionals we have developed guidelines for the management of MRSA in Rhode Island nursing homes (attached). The LTC surveyors use these guidelines to review for deficiencies at LTC.
- In 2005 we sent an informational advisory on community acquired MRSA to all Rhode Island physicians (content is current and valid): See *http://www.health.ri.gov/disease/communicable/providers_mrsa060705.php*.
- We maintain a 24-hour on-call system to provide expert consultation, assess needs and make recommendations to institutions, facilities and professionals related to prevention and control measures, as well as public risk assessment and risk communications for various MRSA-related issues, especially clusters—outbreaks or sustained transmission. We provide such consultations on average once a month.
- We have an active collaboration with the Rhode Island Dept. of Corrections and have provided on-site consultations and review of prevention and control measures at the ACI (adult correctional institution).
- Our public health nurses are available to provide information and guidance to members of the public by phone (222–2577) daily. The office receives at least one or two calls a day on this subject.
- We maintain an informational web page on the subject: *http://www.health.ri.gov/topics/mrsa.php*.

Question 2. In your opinion, has bioterrorism preparedness been integrated with pandemic influenza preparedness? How have you been able to integrate these activities into the existing framework in Rhode Island for public health emergencies that

occur more frequently or currently? Can you give us a few examples of how you have done that in Rhode Island?

Answer. The bioterrorism Cooperative Agreement activities have prepared us well to meeting the planning challenges for pandemic flu head-on. In Rhode Island, the Cooperative Agreements led to the development of public health adopting the ICS structure, the construction of a Departmental Operations Center (DOC), the strengthening of disease outbreak protocols, and successful real-life responses to incidents that required isolation, mass vaccinations, medication distribution, medical surge, strong interagency interoperable communication, and large public information campaigns. For example, we were able to apply these new resources and training to situations related to:

- a case of active TB in Central Falls high school resulting in over 500 students and teachers getting TB skin tests on a single day;
- distribution of Hepatitis A vaccine to over 500 restaurant workers as a result of exposure from a co-worker; and,
- closing of three school districts from a community outbreak of *Mycoplasma Pneumonia*, which included the distribution of antibiotics over the New Year's Day weekend to nearly 300 families.

Question 3. What is your opinion of Federal regional offices of all types? Do you think that regionalization is a good model for Rhode Island?

Answer. Regional collaborations and standing relationships clearly enhance multi-jurisdictional communications, planning and response capabilities. This is especially true as it pertains to mutual aid, whether it is between individual States or through a national system such as the Emergency Management Assistance Compact of which Rhode Island is a member.

Traditionally, federally organized regional planning and coordination emanated from the Office of the Regional Health Administrator of the Department of Health and Human Services (we are in Region I which is headquartered in Boston). In recent years, and driven in large part by our shared mission to better prepare for public health emergencies, there has been a growing Federal presence in the regions not only as part of HHS (e.g. Regional Emergency Coordinators) but also from the Department of Homeland Security, such as the pandemic influenza pre-designated Principal Federal Official. Conceptually, this construct has great merit in that it provides direct linkages between States and key Federal agencies and a ready resource to support States without having to go directly to agency headquarters as long as they are informed and empowered to provide the necessary assistance and support.

The recent consolidation and standardization of policy, program design and oversight to central Federal agencies has changed the role of Federal Regional Offices. The challenge is to manage the growing pains by clearly defining roles, responsibilities, and agency "lanes"; maintain open communications; and establish lines of reporting, to name a few. In the Northeast, with small States and frequent cross-border issues, efforts to coordinate regional activities and responses will be helpful. However, the current regional leadership could be more active in facilitating these discussions across State lines.

Question 4a. DHS and HHS recently led a series of five workshops for States in the five Federal influenza pandemic regions primarily to discuss the current update of State and territorial pandemic plans. A Regional Principal Federal Official (PFO) and Federal Coordinating Officer (FCO) for pandemic influenza are pre-designated for each of these five pandemic regions.

What was your impression of the DHS/HHS led workshop held in January 2007 for pandemic Region A? Did you find it helpful in planning for a pandemic? Should more regional meetings of State and Federal officials be held on pandemic influenza? How could they be made more useful?

Answer. A half-day regional briefing was conducted to discuss the draft State Pandemic Influenza Operational Planning Guidance. It provided an opportunity for a cursory high-level discussion on the expected process for plan development and submission. Having the draft guidance well in advance of the meeting would have provided an opportunity for more substantive discussion on many of the key planning elements. We did appreciate the opportunity to submit follow-up comments and questions as the guidance was being finalized. Many of the States' concerns and comments were considered, making the final version more useful.

Additionally, I think that regional meetings are helpful to bring together State teams to interact and learn from each other. However, many of the regional meetings do not provide enough opportunity for interaction and learning from our counterparts. Regional meetings that principally utilize PowerPoint presentations to convey information either by experts or by teams does not provide the opportunity for more meaningful interaction between State team members. I think regional meet-

ings should be held but need to spend less time on transfer of factual issues more on regional planning between State teams.

Question 4b. How has the regional PFO assisted with your pandemic preparedness efforts?

Answer. The regional PFO has reached out to us to ask about our current process and has offered to bring State teams together.

Question 5. What additional resources are needed for you to address emerging biological threats—including pandemic influenza, bioterrorism, etc.?

Answer. Every year CDC State and local preparedness grant funding is reduced. States need a sustained commitment of Federal funds to recruit and retain highly qualified public health professionals to continue preparedness exercises, planning and other important activities. Reductions in the ASPR hospital preparedness grants are a major concern to State health officials.

Emerging biological threats are also addressed through Epidemiology and Laboratory Capacity grants, which require continued support. For example:

- CDC funding for Epidemiology and Laboratory Capacity decreased since 2002 from $78.5 million to $61 million in 2007.
- Epidemiology and Laboratory Capacity (ELC) is a funding mechanism intended to address emerging threats by enhancing investigation/surveillance capabilities and laboratory capacity at State and local health departments.
- CDC's West Nile, Antimicrobial Resistance, Influenza and Emerging Infections programs also support work at the State and local level.
- ELC funding is declining because of budget cuts at CDC making it harder for State and local health departments to respond to new disease threats.

Emerging biological threats are also addressed through Emerging Infections Programs, which require continued support. For example:

- There are 10 Emerging Infections Programs throughout the Nation that collaborate among public health, academia and clinical institutions to provide rapid and flexible response to emerging disease threats.
- Although Rhode Island is not an EIP site, these programs provide vital surveillance information about food-borne infectious diseases, information about Creutzfeldt-Jakob disease, and collected the data for the most recent study on the burden of MRSA in the United States.

Question 6. What problems do you face in spending Federal dollars? Is the Rhode Island State Budget cycle in synch with those of the Federal Departments and agencies?

Answer. The Rhode Island State Budget cycle is not in synch with Federal grant years, which makes contracting more difficult, as well as having to close grants and the State budget 6 weeks apart. Also, each State has to follow its purchasing rules even for Federal funds. Thus, spending funds takes some time. Delays in the release of Federal Cooperative Agreement guidances, awards, and redirect request approvals therefore often hinder the timely spending of Federal funds at the State level.

The other problem facing Rhode Island and many other States are hiring or spending freezes due to State budget issues as well as FTE caps. These "freezes" and CAPs are usually applied to all sources of funding including Federal sources. This then makes expending Federal funds in a defined budget cycle difficult.

In addition, the fiscal year 2009 Hospital Preparedness report language and CDC State and local grant preparedness language proposed by the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies that provides funding for "a full year of grants rather than 9 months and 3 weeks of grants as proposed by the administration" would be helpful.

Question 7. Please provide your perspective on training and exercising. Do you believe your organization is training the way it fights (i.e., the way it would need to in order to respond to biological threats)?

Answer. I could not agree more with the concept of "training the way you fight". Nationally, State health agencies participated in more than 700 exercises of all types in 2007 and many more took place at the local level. Exercises require significant time and effort to plan and execute. Most States faced at least one major emergency response in 2007, and only 11 percent of States had no major emergency that required their response.

We at the Rhode Island Dept. of Health have a low threshold to utilize ICS for many real-life incidents facing the Department. This helps us both better respond to these incidents but also serves as a real-life training opportunity for both primary and secondary staff within the Department. We have found that this is more helpful than some of the simulation exercises. Nonetheless, more mock exercises would also be helpful, especially when the simulations are treated not as exercise but a real-life response.

In addition to training and exercising, States learn how to improve their systems through response to real-life events. These events offer opportunities for program improvement that are comparable to exercises. For example, in 2006, the Rhode Island Department of Health exercised the same capabilities that would be needed in a bioterrorism incident by successfully delivering antibiotics to 275 families following a mycoplasma outbreak.

Question 8. The best preparation for public health emergencies involves public health workers who plan and exercise their plans for emergency response jointly with local elected officials, police and fire departments, emergency managers, the National Guard, hospitals, physicians, schools, businesses, and other community partners. Please describe how this has occurred in Rhode Island regarding emerging biological threats like pandemic influenza and bioterrorism.

Answer. While all response planning in the State requires joint planning with partners and the Rhode Island Department of Health serves as the ESF–8 lead for State-wide planning, many of the Cooperative Agreement requirements have facilitated this process. Because Rhode Island has no local health departments, in order to meet the requirements of the SNS/CRI program, the Rhode Island Department of Health engages in contracts with each municipality in the State for SNS/CRI planning. This program has been the source of a tremendous amount of relationship building with emergency management directors, and police, fire, and EMS staff. This has proven to be a successful venture when real-life events occur and these plans must be called into action because the relationships and planning foundations are already in place.

In addition, because the Rhode Island Department of Health acts as both a local and State health department for all jurisdictions in the State, it would become quickly overwhelmed in a pandemic situation. In order to appropriately plan for a pandemic, ten acute care hospitals have been deputized to serve as local health departments within the State during a pandemic, allowing them the authority to direct all public health and medical activities within their regions. Each of these healthcare service regions has a planning committee, comprised of hospitals, health centers, first responders, and community partners to address the utilization of medical and non-medical assets within the region.

Question 9a. Recently, GAO released a report on the status of State and local planning and exercising for an influenza pandemic. GAO found that while all 50 States have developed an influenza pandemic plan in accordance with Federal pandemic funding requirements, a review conducted by the Department of Health and Human Services concluded that these plans had "many major gaps" in 16 of 22 priority areas, such as the policy process for school closures and communications, community containment and medical surge capacity. GAO also found that all States and localities that had received pandemic funds met the requirements to conduct a pandemic exercise to test their plans. We know updated plans were due in July for a second round of reviews led by the Department of Health and Human Services.

What is the current status of planning and exercising for an influenza pandemic in Rhode Island?

Answer. As referenced in your question, every State and territory was recently required to submit comprehensive details of their Pandemic Influenza Operations Plans for U.S. Government review. The Federal planning guidance was released on March 11 and identified three strategic goals:

(1) Ensuring Continuity of Operation of State Agencies and Continuity of State Government;

(2) Protect Citizens; and,

(3) Sustain/Support 17 Critical Infrastructure and Key Resource Sectors.

It contained over 400 operating objectives and sub-objectives to be in one way covered or addressed in the State Plans. Rhode Island filed its submission on time. The plan was more detailed and advanced compared to the first round of plan reviews referenced in the question, and we await the preliminary assessment that we believe will be available in the next couple of months.

Question 9b. What were the identified gaps in Rhode Island's pandemic plan from the HHS-led interagency review conducted in 2007? How did you address those gaps in the current update to your State plan and how do you plan to address them in the future?

Answer. For Rhode Island, the HHS-related issues, which required an additional response, were in the areas of COOP and Community Containment. While HEALTH still awaits feedback on these resubmissions, the requirements for the 2008 State Pan Flu Operations Plan led to further development of the Department's COOP and has helped facilitate COOP planning State-wide, since many of the gaps in the Department's plan were due to lack of policy decisions at a higher level than individual departments. This process is ongoing.

HEALTH's Community Containment plan was modified to include the guidance from "Community Strategy for Pandemic Influenza Mitigation". HEALTH is currently working to continue improvement on this plan through work with the Department of Education, and is also preparing a regional survey that would develop triggers for the region as to when certain non-pharmaceutical interventions should be implemented.

Question 9c. Please describe the pandemic exercises that Rhode Island has held or participated in and whether any changes were made to the State's pandemic planning as a result of these exercises. Do you plan to hold any pandemic exercises in the future at the State and/or local levels? If yes, please describe the exercises you have planned.

Answer. Five of the ten health care service regions have conducted functional and/or full-scale alternate care site exercises. The remaining five regions will conduct their alternate care site exercises within the current grant year. In order to fully examine the capacity to track and provide vaccine during a pandemic, three municipalities conducted combined CRI/CRA POD exercises utilizing seasonal flu vaccine during the last flu season. State-wide tabletop exercises on antiviral distribution and community containment have been conducted.

Question 10a. While the Federal Government has provided pandemic influenza guidance to the non-Federal public and private sectors, non-Federal officials have told GAO that they would welcome additional guidance from the Federal Government in a number of areas to help better plan and exercise for pandemic influenza.

What Federal assistance have you asked for, or do you need, to address the identified gaps in Rhode Island's pandemic plan?

Answer. Rhode Island has asked for clearer guidance and additional planning support regarding Public Health COOP, prioritization of antivirals during a pandemic (and whether or not antivirals can/should be used for prophylaxis vs. treatment), the use of masks, triggers for the use of non-pharmaceutical interventions, especially school closures and social distancing.

Question 10b. What other planning guidance do you need?

Answer. There are three guidance documents currently in Federal clearance, which, when released, will provide important planning assistance to the States. The pending documents are:

- *Proposed Guidance on Antiviral Drug Prophylaxis during an Influenza Pandemic;*
- *Proposed Considerations for Antiviral Drug Stockpiling by Employers in Preparation for an Influenza Pandemic;* and,
- *Proposed Guidance on Workplace Stockpiling of Respirators and Facemasks for Pandemic Influenza.*

There has been a strong emphasis on planning for stockpiling, distribution and administration of pharmaceutical countermeasures for pandemic flu (vaccines and antivirals). While these interventions are an important defense against a pandemic threat, States would benefit from additional focus on non-pharmaceutical countermeasures. The document released in February 2007, Interim Pre-Pandemic Planning Guidance: Community Strategy for Pandemic Influenza Mitigation in the United States, was an excellent starting point for planning in this area. States would benefit from further discussion on some key points such as school closures and social distancing, and the intricacies of avoiding unintended consequences from these control measures. Examples include optimal methods for providing meals when schools are closed to children who depend on subsidized school lunch programs and providing guidance to the public on home care of sick individuals (when to seek care, proper infection control practices, etc.).

It should be noted, however, that sustained funding to support State pandemic planning will be necessary to operationalize existing and new guidance documents.

Question 11. According to the Implementation Plan for the National Strategy for Pandemic Influenza, "State, local, and tribal law enforcement agencies should coordinate with appropriate medical facilities and countermeasure distribution centers in their jurisdictions to coordinate security matters, within 6 months" of when the Plan was released—so the deadline would have been October 2005. To your knowledge, has this coordination taken place? If so, how, and if not, how would you recommend this happen?

Answer. Yes, we have done some coordination has taken place but the process is ongoing. Rhode Island plans and responds in accordance with the National Response Framework's Emergency Support Function (ESF) structure. The State Police lead ESF–13 and provide assistance in planning with local law enforcement agencies. Through the SNS/CRI program, the Rhode Island Department of Health has engaged in contracts with each municipality in the State for SNS/CRI planning. The security issues faced at the local level are addressed by the State Police in coordina-

tion with HEALTH. Currently, plans are available for 37 of the State's 39 municipalities. These plans would be used in coordination with the health care service regions' plans for countermeasure distribution.

Each of these health care service regions has a planning committee, comprised of hospitals, health centers, first responders, and community partners to address the utilization of medical and non-medical assets within the region.

Question 12. The Implementation Plan for the National Strategy for Pandemic Influenza provided this task, "All Federal, State, local, tribal, and private sector medical facilities should ensure that protocols for transporting influenza specimens to appropriate reference laboratories are in place within 3 months"—which would have been July 2006. Are these protocols in place in Rhode Island? What challenges did you face in executing this task?

Answer. Yes, these protocols are in place. We have an established courier system to deliver influenza specimens to the State Health Laboratory, which is the only reference laboratory in the State. Given the small geographic area involved and the concentration of the majority of facilities submitting specimens in relatively close proximity to the lab, there have not been any particular challenges associated with implementing this plan.

Question 13. What is your opinion of the decision to centralize Disaster Medical Assistance Team assets in your region? What problems do you see with this approach; especially in the context of a biological threat that sweeps the entire region?

Answer. The National Disaster Medical System (NDMS) and one of its components parts, DMAT, is a cornerstone of our country's mass casualty system. The public health community supported the decision to return management and oversight responsibilities of the NDMS to the Department Health and Human Services and commends HHS's efforts to systematically identify and address gaps. Regarding centralization, the challenge is to strike the careful balance between bringing about material management and human capital efficiencies that may come about with centralized services with the assurance of State partnership and ready availability of the assets when needed. We cannot afford unintended consequences that could possibly delay response time and effectiveness.

Rhode Island has a particularly strong DMAT and the regionalization has stripped the RI–1 DMAT of independent funding, causing them to lose the space that NDMS paid to have refurbished as a warehouse, training, and administrative space. The RI–1 DMAT was deployed in two teams during the recent hurricanes and was faced with the inability to utilize their own cache, which was designed, organized, and trained with to meet the needs of the team specifically. These changes impact not only the RI–1 DMAT's ability to respond efficiently and effectively in a Federal deployment, but also in their ability to provide medical assets within the State during a local/State emergency.

Question 14. It is clear that we need to increase efficiencies in public health preparedness. How do you suggest that be done?

Answer. Within Rhode Island efficiency can be gained through continued efforts to support the intrastate regional team models. Rhode Island has organized a robust hazardous materials and decontamination team capability. Additionally, Rhode Island has used this same model to support law enforcement WMD tactical teams, Urban Search and Rescue and Disaster Medical Response resources. The in-State regionalization provides an efficient platform for use of grant funds, it provides for standardized equipment and model training programs while avoiding duplication of effort across multiple jurisdictions.

Question 15. Do you think that the Federal Regional Planning/Coordinating Committee meetings are useful? If not, why not?

Answer. Conceptually, yes, but they have yet to be executed in a manner that allows for useful collaboration throughout the region.

Question 16. As you know, public health has been identified as one of the critical infrastructures of our Nation. Have you been included in the planning undertaken by the Department of Homeland Security to protect the public health infrastructure? From what you know about this work, how does it affect what you are trying to accomplish in your position? What more do you think needs to be done in this regard, especially in advance of an influenza pandemic?

Answer.

- Homeland Security Presidential Directive 7 (HSPD–7) and the National Infrastructure Protection Plan (NIPP) provide the overarching framework for a structured partnership between Government and the private sector for protection of Critical Infrastructure and Key Resources (CI/KR).
- The Healthcare and Public Health (HPH) Government Coordinating Council (GCC) brings together Federal, State, local, tribal and territorial interests to identify and develop collaborative strategies that advance critical infrastructure

protection. The overall vision of the HPH Sector is to prevent or minimize damage to, or destruction of, the Nation's health care and public health infrastructure.
  - The private sector members comprise the Healthcare and Public Health Sector Coordinating Council (SCC), while the public sector comprises the GCC. The lead for the HPH Sector is the Department of Health and Human Services (HHS), serving as the Sector-Specific Agency (SSA).
  - Current State health agencies serving on the GCC on behalf of ASTHO: the Alaska Department of Health and Social Services, Michigan Department of Community Health, and the Washington State Department of Health. Members from these State health agencies provide the State perspective on issues related to health care and public health in relation to CI/KR. These members also sit on workgroups associated with the GCC to identify core metrics to measure critical infrastructure and key resource capabilities as well as research and development initiatives. Participation is mainly through conference calls either on a monthly or quarterly basis, and possibly one in-person meeting.
- Goals of the Sector specific to Public Health include Workforce Sustainability, Physical Security, Cyber Security, and Service Continuity.
- Path Forward: Moving forward, the Healthcare and Public Health Sector will focus on:
  - Assessing procedures for collecting, validating and updating CI/KR protection and preparedness-related data to assure that the processes are cost-effective, meet HSPD–7 needs, and are not burdensome.
  - Identifying a process for coordinating with other sectors to implement cross-sector programs.
  - Developing a methodology to measure and assess the effectiveness of the HPH Sector's preparedness and response capabilities to various threat scenarios or real events.

Unfortunately, due to staffing shortages, the Rhode Island Emergency Management Agency does not currently have an individual supporting DHS's Critical Infrastructure/Key Resources planning. While public health is invited to the planning and response table, we have yet to begin working with our partners who manage the State's Homeland Security Grant on the steps to be taken to protect the public health infrastructure.

Question 17. From the public health perspective, there are certain similarities and differences between disasters and pandemics. Can you describe a few of both, and talk about the implications you see for Federal support from both DHS and HHS?

Answer. Pandemics are widespread epidemics affecting large populations throughout the world. Disasters (such as hurricanes or release of an infectious agent in a jurisdiction) and pandemics have impacts on health, critical infrastructure, the economy, and (potentially) national security. In most localized disasters, resources can be redirected from non-affected areas to affected areas, including first responders (through mechanisms such as EMAC), countermeasures and medical supplies, and other infrastructure-related support. The availability of this support enhances the response and often speeds up the recovery process.

A pandemic is a worldwide outbreak of an infectious disease that will have broader and potentially longer term impacts on health, critical infrastructure, the economy, and national security. In the case of an influenza pandemic, all jurisdictions will be affected within a relatively short time frame making it difficult to share resources. As a result, systems will become progressively overwhelmed for longer periods of time. There may also be increased absenteeism, from critical infrastructure and response-related jobs, due to fear of the virus or the need to care for a loved one who cannot obtain care in a traditional medical setting. The Federal Government has been clear that States and local areas should not anticipate receiving Federal support during a pandemic, as it is not possible to provide support to all States at the same time.

It is important for DHS and HHS to provide sustained funding to States to build response capabilities, conduct exercises and then refine pandemic influenza and all-hazards preparedness plans. These capabilities will enable States to better respond on their own when a pandemic strikes.

DHS and HHS should also provide guidance on whether and how reimbursement may be available through the Stafford Act for infectious disease-related response activities.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO MAJOR GENERAL ROBERT T. BRAY, ADJUTANT GENERAL, STATE OF RHODE ISLAND; COMMANDING GENERAL, RHODE ISLAND NATIONAL GUARD; DIRECTOR, RHODE ISLAND EMERGENCY MANAGEMENT; AND HOMELAND SECURITY ADVISOR, STATE OF RHODE ISLAND

Question 1. As a military officer, you are well aware of the military approach to planning. Given all of your experience with operating in the civilian context, though, you are also well aware that most civilians, including the Federal Government, do not use the military approach. What advice would you give your civilian counterparts? How have you been able to get other civilian agencies here in the State to come on board?

Answer. The Military Decision Making Process (MDMP) provides a formal, interactive and dynamic way to generate feasible, acceptable and supportable courses of action to solve problems, but it is not unlike other methods used by other entities. When developing a plan to adequately accomplish a goal or solve a problem, the process matters more than the model used. An effective planning model must contain processes that facilitate the examination of all factors that will or may affect an organization's attempt to solve a problem.

The Rhode Island Emergency Management Agency (RIEMA) offers and conducts numerous courses on the Incident Command System (ICS) to educate responders and response agencies on the methodology for an organized and coordinated response to emergencies. Additionally, RIEMA engages agencies and stakeholders through participation in numerous committee meetings. Education and consensus building is our primary tool for gaining cooperation and coordination toward integrated emergency management.

Question 2. Describe the challenges of being triple-hatted as the Adjutant General, EMA Director, and Homeland Security Director. How do you think holding these and other positions simultaneously has helped you to address threats to the State and its citizens?

Answer. There are many challenges associated with being triple-hatted but they are not uncharacteristic of a chief executive's position. In Rhode Island form fits function due to the inter- and intra-agency connection, as well as the common strategic nature of emergency management. In order to effectively meet these challenges, it is essential to have a competent staff and a solid adherence to core organizational competencies relating to span of control, chain of command, and unity of command.

The ability of the Adjutant General as a federally recognized General Officer of the United States military to function in several authoritative statuses (Title 32, Title 10, State Active Duty, and as a State employee) provides and allows for bridging requirements and institutions in the interest of responsive emergency management. An Adjutant General with Emergency Management experience may be the only official who can effectively communicate strategically with Federal agencies such as, USNORTHCOM, USARMYNORTH, NGB, DHS, and FEMA.

Question 3. Not every State has incorporated the National Guard, emergency management, and homeland security to the extent that you have here in Rhode Island. Please explain how this works in the State of Rhode Island. Is this something that you would recommend all States doing? If so, why, and if not, why not?

Answer. The incorporation of the agencies is statutory according to Rhode Island State law. Approximately 12 other States incorporated the responsibility for these agencies under their Adjutant General. While many Federal laws apply to provide a measure of continuity, the uniqueness of each State's laws provides significant diversity. Integration of the agencies for emergency response, which includes training, planning, and preparation, is what may be most unique. It has been my initiative to merge agency capabilities as much as regulations will allow. The challenges to that initiative have been internal personalities and turf, labor laws, Federal regulations and not surprisingly, paradigms. Integration of capabilities between the agencies make sense corporately, reduces duplication of effort, increases efficiency, maximizes resources and streamlines the process of delivering limited resources in a timely manner, where and when they are needed. Consequently, I highly recommend incorporation as an organizational format. Essential, however is the need for statutory authority as well as responsibility. The incorporated agency must have the statutory authority to affect and ensure coordination, cooperation, and compliance within the agency as well as among the multiple agencies and jurisdictions receiving support.

Question 4. Do you believe that the Rhode Island Emergency Management Agency has enough funding to cover planning efforts? How much more funding do you think is necessary? What other planning resources do you need?

Answer. The RIEMA does not have sufficient funds to accomplish its statutory obligations because of the Federal grant process and State budget deficit. The FMA/DHS grant application process and format does not adequately provide for a uniquely governed State, like Rhode Island, to promote its hazards and infrastructure to compete for funding. Additionally, the percentage share of the grant funding that the State is eligible for limits the agencies' performance. Second, the budget deficit in Rhode Island limits the amount of funds available to the agencies. Therefore, support for both the dollar and "in-kind" funding required to match and fully utilize Federal grant dollars is limited.

Question 5. What additional resources are needed for you to address emerging biological threats—including pandemic influenza, bioterrorism, etc.?

Answer. Effectively addressing emerging threats within the full spectrum of CBRNE, including biological threats, requires adequate situational awareness (SA) and the ability to work within a common operating picture (COP). In order to obtain SA and COP, personnel, funding, knowledge, authority, equipment, and logistical support are essential. The best way to address emerging biological threats is to prevent them from happening. A proactive approach requires an inter-agency fusion cell, intelligence, communication, a well-trained staff capable of processing SA into a COP which facilitates mitigation. In order for Rhode Island to achieve that level of capability, the RIEMA needs additional trained personnel, better two-way intelligence sharing between State and Federal agencies, statutory enforcement authority for local inter-agency cooperation, and the equipment and statutory authority to support a joint inter-agency coordination center.

Question 6. What problems do you face in spending Federal dollars? Is the Rhode Island State Budget cycle in synch with those of the Federal Departments and agencies?

Answer. There are two primary problems in spending Federal dollars. The first is the ability of the municipalities supported by RIEMA to both appropriately spend their grant funds and execute their grant funds in a timely manner. Some local agencies have limited accounting ability to execute large sums of Federal grant dollars within the specified time once a project is approved limit. The second problem is the ability to produce either the dollar or in-kind State match, given both the nature of the State budget and the unique local government dependence upon State support. The State of Rhode Island's budget cycle differs from the Federal Government's by beginning on July 1 instead of October 1.

Question 7. How has the State Fusion Center assisted in State efforts to address emerging biological threats?

Answer. The State Fusion Center works well with other law enforcement agencies, local and Federal, to address potential or emerging threats. The State Fusion Cell coordinates and communicates across State lines for SA. The State Fusion Center is law enforcement-centric.

Question 8. Please provide your perspective on training and exercising. Do you believe your organization is training the way it fights (i.e., the way it would need to in order to respond to biological threats)?

Answer. There are several levels of competency for emergency response and degrees with each of them. The RIEMA provides training and exercises, as well as support to local and Federal agencies in the conduct of training and exercises. The RIEMA supports a robust training and exercise regimen, which is necessary to accommodate new initiatives, as well as to train a constantly rotating response force. First responders are very competent at the tactical level.

Question 9. The best preparation for public health emergencies involves public health workers who plan and exercise their plans for emergency response jointly with local elected officials, police and fire departments, emergency managers, the National Guard, hospitals, physicians, schools, businesses, and other community partners. Please describe how this has occurred in Rhode Island regarding emerging biological threats like pandemic influenza and bioterrorism.

Answer. The Rhode Island Department of Health serves as the State lead agency for all matter of emergency planning relating to threats that may result in a public health emergency. Most notable is their membership in the Emergency Management Advisory Committee. Dr Gifford and I co-chaired the recent State multi-agency effort to complete the State's Pandemic Influenza plan, which focused on the continuity of government through the COOP site. The State Health Department has involved all public and private health agencies in National Incident Management System Incident Command training. They are a model agency for preparation and support.

Question 10a. Recently, GAO released a report on the status of State and local planning and exercising for an influenza pandemic. GAO found that while all 50 States have developed an influenza pandemic plan in accordance with Federal pan-

demic funding requirements, a review conducted by the Department of Health and Human Services concluded that these plans had "many major gaps" in 16 of 22 priority areas, such as the policy process for school closures and communications, community containment and medical surge capacity. GAO also found that all States and localities that had received pandemic funds met the requirements to conduct a pandemic exercise to test their plans. We know updated plans were due in July for a second round of reviews led by the Department of Health and Human Services.

What is the current status of planning and exercising for an influenza pandemic in Rhode Island?

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

Question 10b. What were the identified gaps in Rhode Island's pandemic plan from the HHS-led interagency review conducted in 2007? How did you address those gaps in the current update to your State plan and how do you plan to address them in the future?

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

Question 10c. Please describe the pandemic exercises that Rhode Island has held or participated in and whether any changes were made to the State's pandemic planning as a result of these exercises. Do you plan to hold any pandemic exercises in the future at the State and/or local levels? If yes, please describe the exercises you have planned.

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

Question 11a. While the Federal Government has provided pandemic influenza guidance to the non-Federal public and private sectors, non-Federal officials have told GAO that they would welcome additional guidance from the Federal Government in a number of areas to help better plan and exercise for pandemic influenza.

What Federal assistance have you asked for, or do you need, to address the identified gaps in Rhode Island's pandemic plan?

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

Question 11b. What other planning guidance do you need?

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. There-

fore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

Question 12. According to the Implementation Plan for the National Strategy for Pandemic Influenza, "State, local, and tribal law enforcement agencies should coordinate with appropriate medical facilities and countermeasure distribution centers in their jurisdictions to coordinate security matters, within 6 months" of when the Plan was released—so the deadline would have been October 2005. To your knowledge, has this coordination taken place? If so, how, and if not, how would you recommend this happen?

Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

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Answer. The Office of the Adjutant General, including the Rhode Island Emergency Management Agency and the Rhode Island National Guard is the lead coordinating agency for emergency planning, preparation and response to emergencies and disasters of all types in the State of Rhode Island. With respect to the remaining questions, the Adjutant General is not the subject matter expert or lead technical agency. The Rhode Island Department of Health is the primary subject matter expert for matters of health, including the DMAT and the Pandemic Influenza. Therefore the remaining questions are respectfully deferred to the Rhode Island Department of Health.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO MR. THOMAS J. KILDAY, JR., HOMELAND SECURITY PROGRAM MANAGER, RHODE ISLAND EMERGENCY MANAGEMENT AGENCY

Question 1. What is your opinion of Federal regional offices of all types? Do you think that regionalization is a good model for Rhode Island?

Answer. In my opinion the Federal Regional offices provide a valuable link for Rhode Island Emergency Management Agency and other State agencies to seek advice, work on planning issues and coordinate grant activities. A regional office understands the local challenges unique to the region in question rather than viewing each State as just another State from the national level. Additionally, the regional office understands the Federal policies and the State polices for their constituent States; this knowledge allows the regional offices to help States interpret policy. Often the regional office serves as a mediator on issues that require further clarification with the Federal offices. The only gap lies in the area of funding and planning actions. Currently the funding is provided at the Federal, State, and local level. There is not a mechanism to ensure regionally based program funding and these programs are often the first programs cut during a budget crunch or a department re-organization. During my time serving the State I have personally seen the Federal regional model bear the effects of budget constraints and reorganization.

Question 2a. DHS and HHS recently led a series of five workshops for States in the five Federal influenza pandemic regions primarily to discuss the current update of State and Territorial pandemic plans. A Regional Principal Federal Official (PFO) and Federal Coordinating Officer (FCO) for pandemic influenza are pre-designated for each of these five pandemic regions.

What was your impression of the DHS/HHS led workshop held in January 2007 for pandemic Region A? Did you find it helpful in planning for a pandemic? Should more regional meetings of State and Federal officials be held on pandemic influenza? How could they be made more useful?

Question 2b. How has the regional PFO assisted with your pandemic preparedness efforts?

Answer. The answer to question No. 2 part A & B will be provided by Dr. Gifford from the Rhode Island Department of Health. Rhode Island Emergency Management has partnered with Rhode Island Health Department on pandemic planning over the years and has collaborated on the answers to the pandemic questions related to this testimony.

Question 3. How would you recommend that entities within the Federal Government better align and coordinate the grants that they put out to the States and territories?

Answer. The Federal Government could improve the grant process by aligning programs and requirements across Federal departments and agencies. In Rhode Island we establish stakeholder committees to facilitate the planning and grant processes to ensure alignment with programs ongoing in the State. This coordination is required within the grant guidance for each Federal program whether it is a DHS or DHHS program. I find it interesting the States are required to plan with intra- and inter-State stakeholders although we often find that this is not the case with the Federal departments. There are conflicting timelines, program requirements and duplication of programs across a number of Federal agencies often with extremely compressed timelines.

Question 4. Given the decision to centralize the DMAT in the region, what do you think needs to be done? Do you think that the State needs to develop its own disaster medical assistance assets?

Answer. I feel that this decision by the ASPR validates Rhode Island's decision more than 5 years ago to go forward with plans to build a cache of response equipment and capacity to stand up a Field Hospital and other response capabilities independent of the team's Federal Cache. With more than 200 RI DMAT members, and more than 400 Medical Reserve Corps members, the RI DMAT Team has depth in every position on the team. They have demonstrated many times that they can deploy assets on both Federal deployments and calls for assistance from Rhode Island public health and emergency management officials for in-State needs. The team now has a substantial cache of equipment and mechanisms in place to train and deploy credential-verified volunteer health care providers and support personnel to respond to extraordinary medical needs. Other States that have come to depend upon the National Disaster Medical System (NDMS) DMAT teams should look to Rhode Island's model in this area.

Question 5. How do you think decisions will be made when medical professionals are in the National Guard, and would need to be called up for Guard service and medical service simultaneously?

Answer. The question may be moot in the sense that when the National Guard deploys any of its assets, the members have no choice when it comes to deploying. They are obligated to go. This has resulted in medical personnel shortages in every State as National Guard and Reservists have been deployed to the wars in Iraq and Afghanistan. Health care providers at many levels are already in short supply, and their deployment will only make adequate staffing more difficult. Recruiting health care providers for volunteer service from non-acute care facilities is one answer as to how to fill vacancies left by deployments of the Guard and Reserve. The Medical Reserve Corps is an ideal organization to provide this recruitment and training, as has been demonstrated in Rhode Island.

Question 6. Is there funding provided to the Rhode Island EMA to do critical infrastructure and/or continuity of operations planning?

Answer. Critical infrastructure planning in Rhode Island is considered one of the responsibilities of the Homeland Security Program Manager and other staff. There is not anyone specifically tasked to work on critical infrastructure planning at this time. The funding is provided in part through the Department of Homeland Security grant program funds that Rhode Island receives. Ideally Rhode Island would have a single individual working on critical infrastructure planning and Continuity of Operations Planning but budget constraints and resource allocation has not allowed this to happen. There are programs such as the Buffer Zone Protection Program that provide funding to support critical infrastructure efforts although this funding goes directly to the critical infrastructure owner to provide for protective measures against attacks.

Question 7. What do you think can be done to increase efficiencies in emergency preparedness?

Answer. Within Rhode Island efficiency can be gained through continued efforts to support the intra-State regional team models. Rhode Island has organized a robust hazardous materials and decontamination team capability. Additionally, Rhode Island has used this same model to support law enforcement WMD tactical teams, Urban Search and Rescue and Disaster Medical Response resources. The in-State regionalization provides an efficient platform for use of grant funds, it provides for standardized equipment and model training programs while avoiding duplication of effort across multiple jurisdictions.

QUESTIONS FROM CHAIRMAN JAMES R. LANGEVIN TO PETER T. GINAITT, DIRECTOR, EMERGENCY PREPAREDNESS, LIFESPAN HOSPITAL NETWORK

Question 1. What is your opinion of Federal regional offices of all types? Do you think that regionalization is a good model for Rhode Island?

Answer. Response was not provided at the time of publication.

Question 2a. DHS and HHS recently led a series of five workshops for States in the five Federal influenza pandemic regions primarily to discuss the current update of State and territorial pandemic plans. A Regional Principal Federal Official (PFO) and Federal Coordinating Officer (FCO) for pandemic influenza are pre-designated for each of these five pandemic regions.

What was your impression of the DHS/HHS led workshop held in January 2007 for pandemic Region A? Did you find it helpful in planning for a pandemic? Should more regional meetings of State and Federal officials be held on pandemic influenza? How could they be made more useful?

Answer. Response was not provided at the time of publication.

Question 2b. How has the regional PFO assisted with your pandemic preparedness efforts?

Answer. Response was not provided at the time of publication.

Question 3. We understand that a decision has been made that for mass casualties, the hospitals will take over the Convention Center. What happens when this private sector entity wants and needs its asset back to start their business enterprise again?

Answer. Response was not provided at the time of publication.

Question 4. Please give us your perspective on altered standards of care. How do you recommend that the necessary discussions take place and difficult decisions be made—in the State of Rhode Island and throughout the Nation?

Answer. Response was not provided at the time of publication.

Question 5. What additional guidance do you think the Federal Government still needs to provide to the States and territories—regarding altered standards of care, pandemic influenza, emerging biological threats, bioterrorism, etc.?

Answer. Response was not provided at the time of publication.

Question 6. What additional resources are needed for the hospital network in Rhode Island to address emerging biological threats—including pandemic influenza, bioterrorism, etc.?

Answer. Response was not provided at the time of publication.

Question 7. What problems does the hospital network in Rhode Island face in spending Federal dollars? Is the Rhode Island State budget cycle in synch with those of the Federal departments and agencies?

Answer. Response was not provided at the time of publication.

Question 8. Please provide your perspective on training and exercising. Do you believe your organization is training the way it fights (i.e., the way it would need to in order to respond to biological threats)?

Answer. Response was not provided at the time of publication.

Question 9. The best preparation for public health emergencies involves public health workers who plan and exercise their plans for emergency response jointly with local elected officials, police and fire departments, emergency managers, the National Guard, hospitals, physicians, schools, businesses, and other community partners. Please describe how this has occurred in Rhode Island regarding emerging biological threats like pandemic influenza and bioterrorism.

Answer. Response was not provided at the time of publication.

Question 10. According to the Implementation Plan for the National Strategy for Pandemic Influenza, "State, local, and tribal law enforcement agencies should coordinate with appropriate medical facilities and countermeasure distribution centers in their jurisdictions to coordinate security matters, within 6 months" of when the Plan was released—so the deadline would have been October 2005. To your knowledge, has this coordination taken place? If so, how, and if not, how would you recommend this happen?

Answer. Response was not provided at the time of publication.

Question 11. The Implementation Plan for the National Strategy for Pandemic Influenza states that, "All health care facilities should develop, test, and be prepared to implement infection control campaigns for pandemic influenza, within 6 months" of when the Plan was released—so the deadline was October 2006. Hospitals and other health care facilities in Rhode Island are more than familiar with infection control measures. Can you describe the specific challenges in identifying and implementing infection control measures for pandemic influenza?

Answer. Response was not provided at the time of publication.

Question 12. What is your opinion of the decision to centralize Disaster Medical Assistance Team assets in your region? What problems do you see with this approach, especially in the context of a biological threat that sweeps the entire region? Or will having those assets centralized help with a widespread biological event? If so, how?

Answer. Response was not provided at the time of publication.

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