WEAPONS OF MASS DESTRUCTION: IS OUR NATION'S MEDICAL COMMUNITY READY?

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGTH CONGRESS

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WEAPONS OF MASS DESTRUCTION: IS OUR NATION'S MEDICAL COMMUNITY READY?

THURSDAY, APRIL 10, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 340, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Bilirakis, Boozman, Filner, and Hooley.

Ex officio present: Representatives Smith and Evans.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. Good morning. Today's hearing of the Oversight and Investigations Subcommittee of the House Veterans' Affairs Committee will come to order.

This hearing will review the progress being made by the Department of Veterans Affairs in implementing Section 3 of Public Law 107–287, entitled The Education and Training Programs on Medical Response to Consequences of Terrorist Activities, which was signed into law this past November. We also want to review the state of readiness of our Nation's medical community to respond to casualties when chemical, biological, or radiological devices are used.

Section 3 of Public Law 107–287 mandates the establishment of an education program to be carried out through the Department of Veterans Affairs. The education and training developed under the program should include a core curriculum to teach medical students how to diagnose and treat casualties that have been exposed to chemical, biological, or radiological agents and toxins.

At the subcommittee's November 14, 2001, hearing, we learned that the Nation's health care providers were not prepared to meet the challenges to diagnose and treat casualties in the event such agents were used. That is why this committee felt it was imperative that such a program be established to disseminate this crucial biomedical training to the Nation's current and future health care professionals.

Since the VA has the infrastructure in place to deliver the continuing education program through its affiliation of 107 medical schools, 163 medical centers, 800 clinics, and over 1,200 educational institutions, and satellite broadcast capabilities, it is log-

ical that the VA be tapped to distribute this information to the entire health care community.

The American Medical Association endorsed MEND for the 21st century when it was introduced, and the American Association of Medical Colleges also supports the concept.

One of the witnesses at the subcommittee's hearing in 2001, Dr. Carlos Omenaca, expressed it this way: "You do not diagnose what you do not think of, and you do not think of that which you do not know about." Dr. Omenaca was the physician who successfully treated the second inhalation anthrax case in Miami, FL. And this doctor is not just an M.D. He is an internist, with a subspecialty in infectious disease.

What we hope to learn today is what progress has been made by our Nation in its ability to respond to casualties resulting from weapons of mass destruction, and what role the Department of Veterans Affairs should have in continuing medical education of health care professionals.

We have a distinguished group of witnesses, and I look forward to hearing their insights on this vitally important issue which affects every one of us.

I'd also note that we have a witness here from HHS. We're concerned about the duplication that may be occurring out there. So we need to figure out what HHS is doing, what VA is doing. Let's not be duplicative, and to make sure that the two major departments are talking.

Let me yield now to Ms. Hooley for comments that she may have.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair. The last Congress passed the Department of Veterans Affairs Emergency Preparedness Act of 2002. At its core was a program to develop and disseminate a series of model education and training programs on the medical response to the consequences of terrorist activities. The language of the bill has its focus on terrorism, but it is clear that some events may not cubby-hole neatly into that category, as it may require some time to determine and attribute intent to the source of an event.

Let me just give you an example. In Oregon a few years ago, we had a group called the Rajneeshees. We had an outbreak of salmonella. They had poisoned the salad bar. We didn't know what it was. Considerable time had passed before we knew it was an act of terrorism.

It is clear that the medical community should not mark time waiting for notice of the cause. Regardless of the springboard for the event—natural cause, accidental cause, intentional cause—the VA Emergency Preparedness Act will better prepare America's medical community to act. This is a needed and necessary outcome.

This hearing is an interim progress check on the efforts to implement the provisions of last year's law. We will also look to the efforts of others to enhance medical preparedness. From the initiatives outlined in Dr. Nelson's statement, it appears that this committee is not the only body to initiate actions to enhance our medical readiness as a reaction to the events of 9/11.

For example, the AMA has created the Center for Disaster Preparedness and Emergency Response. It, too, in part relies on the development of an evidence-based education training model identifying specific needs for physicians and other health care providers.

Additionally, HHS reports that the Health Resources and Service Administration will competitively award 28 million for bioterrorism preparedness and training. I am sure there are many, many other efforts under way by a myriad of organizations to enhance medical readiness.

But my questions are going to be are these efforts coordinated? Are they linked? How are they coordinated? Do they share a common lexicon? Do they all know and train in the five broad categories reported by the multi-agency/medical school panel referred to in the AAMC testimony?

One common solution used by planners planning for the worst case scenario is the need for health care providers from a wide variety of sources to share in the response effort. Are we training these responders along a common track? Are the recognition and response systems integrated?

About 11 years ago, this subcommittee held a hearing on the VA/DOD Hospital System and related issues. Then the worst case scenario planned for by the National Disaster Medical System was an 8.3 earthquake resulting in 100,000 seriously injured people in a matter of minutes. This situation is challenged in our world of potential bioterrorism, where the introduction of either a "boutique" or an "old-world" microorganism into the U.S. population can wreak havoc to millions in but a few weeks.

In either scenario, the medical system will be stressed. A coordinated effort by our caregivers using the same training guidelines and same reporting protocols would work best.

Mr. Chairman, I'm interested in insuring that Section (f) of the Department of Veterans Affairs Emergency Preparedness Act of 2002 regarding the need for close coordination with other outside agencies is given appropriate consideration.

I yield back the remainder of my time.

Mr. BUYER. Ms. Hooley, thank you for your opening statement. And I think it was a valued contribution, the questions that you asked. You're asking, I believe, the right questions, and I compliment you on your opening statement.

I now yield to Mr. Bilirakis. And I'm really pleased he's here, because he's also the chairman of the Health Subcommittee of Commerce, with direct oversight over Health and Human Services. And he, like I am, is very concerned about anything that is duplicative or multiplicious. And I now yield to Mr. Bilirakis.

OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. And I, too, thank you for your foresight in scheduling this hearing. This is Oversight and Investigations. Virtually every committee in the House has one. I would hope that all of them are basically sort of thinking of doing the same sort of thing.

And I know you well enough, Mr. Chairman, to know that, you know, even though this is oversight, this is not a bang-the-VA type of a hearing. The way I look at it more than anything else is, hope-

fully, we will learn what progress has been made, and also what progress has not been made maybe due to the fact that the law is not as helpful as it should be.

And I know that's something that they'll run into an awful lot on chairing the Health Committee on Energy and Commerce is that we can do things to be helpful to the departments and agencies out there. But quite often, more often than not, they don't even contact us to say, "Hey, we need this change in a law or that change in a law," or something of that nature, in order to do our job an awful lot better. So hopefully, this will result probably more in that than anything else.

And I do look forward to working with you, as always, Mr. Chairman. And hopefully, good things will come out of this hearing. Thank you.

Mr. BUYER. Thank you, Mr. Bilirakis.

I ask witnesses to limit their oral testimony to five minutes. Your complete written statement will be made part of the official record. And we are also now joined by the ranking full committee member, Mr. Lane Evans. I appreciate your being here today. And if you have any opening comments you would like to make, I will now yield to you, Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Short and sweet, Mr. Chairman. Today you have brought us together concerning elements of the Federal Medical Response Team. We will receive testimony from those who develop the criteria used to train physicians and other medical professionals.

Accurate recognition of the symptoms and effects of bioterrorism is vital. Coordination for this data among principal agencies is vital.

In the planning stage, these agencies must fully cooperate. We will see today that they have made some good first steps.

Thank you, Mr. Chairman.

Mr. BUYER. Thank you, Mr. Evans. By way of opening, again, we would like to get it right. And just because we step out doesn't mean we always get it right. And immediately after September 11, we had the anthrax scare. We tried to bring collective minds into a room on how we could best get what the military had out, and to have it disseminated across the country.

Looking back on it, perhaps the one person that should have been in that room that wasn't was HHS. But that's sort of the purpose of this hearing. This is a very bipartisan section of the Veterans' Affairs Committee, in which we're all in total agreement. And that's the purpose of this hearing.

So I agree with Mr. Bilirakis. We're just trying to figure out how you're going to implement the law, how are you stepping forward, and how are you communicating with HHS. And we don't want there to be duplicity.

So that's kind of what is the framework, Dr. Roswell, of where we are. And we now recognize Hon. Dr. Robert Roswell, the Under Secretary for Health, Department of Veterans Affairs. He's also accompanied by Dr. Susan Mather, Chief Officer for Public Health

and Environmental Hazards, Veterans Health Administration, Department of Veterans Affairs. Dr. Roswell.

STATEMENT OF ROBERT J. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY SUSAN H. MATHER, M.D., CHIEF OFFICER FOR PUBLIC HEALTH AND ENVIRONMENTAL HAZARDS, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. ROSWELL. Well, thank you, Mr. Chairman. It's, as always, a pleasure to be here, and I also appreciate and salute you for your leadership in exploring this topic.

I do want to begin with an apology. My formal testimony was in error. In the second paragraph of my formal testimony, I indicated that Section 117 of H.R. 5605 had been passed by the House. In fact, that bill was reported by the House. That was a bill that had language restricting the use of appropriated funds for the provisions of what became Public Law 107–287. The final version of that bill, when enacted, in fact, only restricted the use of appropriated funds for Sections 2 and 5 of that bill. The hearing today deals with Section 3.

Implementation of Section 3 of Public Law 107–287, as a result, has progressed more slowly than had been anticipated, due in large part to the uncertainty about the availability of funding in fiscal year 2003 and the use of appropriated funds. However, now that that uncertainty has been clarified, VA is actively pursuing implementation. In fact, VA has developed an implementation plan for Section 3, which we've recently sent to this subcommittee.

Section 3 requires VA to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. These programs are to be modeled after programs established at DOD's Uniformed Services University of the Health Sciences, or USUHS, and must be designated for a wide range of VA health care professionals. The training must address the short-term and the long-term health consequences that may result, including psychological effects.

While the primary mission of the Veterans Health Administration is to provide health care to our Nation's veterans, it also has a mission to provide education and training for health care professionals. VA conducts the largest coordinated education and training effort for health care professions in the Nation. We're currently affiliated with over 107 of our Nation's medical schools, and over half of all physicians practicing in the United States today had a significant portion of their training within a VA setting.

In fiscal year 2002, over 76,000 students received some clinical training through the VA health care system. VA has committed to preparing its health care providers to effectively respond to the challenges of terrorism. We have provided several dozen educational and training opportunities to educate employees in the event of a terrorist attack.

We've developed satellite broadcasts covering biological and chemical warfare issues, and other educational tools and programs for those who may be charged with caring for victims of terrorist events. We've created two war-related illness and injury Centers of

Excellence—one in Washington, the other one in New Jersey. We have developed two Decontamination Training Sites of Excellence—one in Florida, one in Arkansas. We've held national meetings to train professionals on the use of decontamination equipment, which is now being purchased for VA medical centers nationwide.

We've also conducted an international meeting that actually is now in its fifth year. That meeting occurs each year in Florida, and addresses the effects of weapons of mass destruction. It's a broad interagency meeting which includes HHS, NDMS, DOD, as well as VA health care providers.

We've developed pocket cards. Tens of thousands of pocket cards have been distributed, not only to VA staff, but to residents, medical students throughout our facilities dealing specifically in pocket form with the effects of chemical, nuclear, and radiologic sections. And if you open that up, Mr. Chairman, it's a very nice tabular form on the inside that addresses the diagnosis, management, and treatment of the various——

Mr. BUYER. Dr. Roswell? I'm sorry. This is disseminated to whom?

Dr. ROSWELL. This is passed out to VA employees—staff, physicians. But it's also shared with our medical residents. Currently, VA hosts, and funds, over 8,700 medical residency positions. In addition, we have many more medical students who do a portion of their clinical training through VA facilities. And these are made available and, in fact, are very popular with medical students and medical residents who work in VA facilities.

Mr. BUYER. And USUHS helped you with this, or you did it on your own?

Dr. ROSWELL. Much of the information, actually, came from DOD. The Aberdeen, Fort Detrick expertise in this particular area is probably the most significant level of expertise, and we've had excellent cooperation with them.

We also have a Veterans Health Initiative, which is a series of monographs, some of which specifically address this topic. And these monographs are available to VA staff, they're also available on the Web, and they're available on compact disk. The monograph I brought with me today is a Guide to Gulf War Veterans Health, which addresses many of the possible effects of some of the agents that might be used in a terrorist attack. We've also formulated, in concert with DOD, clinical practice guidelines.

I should also point out that when anthrax was suspected in the American Media Relations Building in South Florida, CDC from the Department of Health and Human Services responded quickly. But there was local collaboration with the Department of Veterans Affairs. And based upon CDC recommendations, pharmaceutical agents from the West Palm Beach Medical Center were provided to victims.

The involvement of education and training experts and representatives of the various health care professions in developing these programs is essential. We have already had initial meetings going back to December with USUHS to explore collaborative endeavors, and, in fact, another meeting will take place this afternoon. We further intend to assemble a committee of experts to de-

velop a plan to address priority educational needs through the use of multiple modalities.

Mr. Chairman, as I said, it's a pleasure to be here. Dr. Mather and I would be happy to answer any question you or members of the subcommittee may have.

[The prepared statement of Dr. Roswell, with attachment, appears on p. 49.]

Mr. BUYER. Don't let that little beeper bother you. If you've got more to your statement, please.

Dr. ROSWELL. That's fine.

Mr. BUYER. All right. When you said "clinical practice guidelines," we're very careful when we drafted this legislation not to establish new standards of practice of care. If you do guidelines, are we getting ourselves into this legal question where trial lawyers are going to begin saying this is the beginning of the establishment of a practice of care?

Dr. ROSWELL. I don't think so, Mr. Chairman. Clinical practice guidelines were controversial a decade ago when they were first introduced. Increasingly, they've been accepted. Clinical practice guidelines don't mandate a practice of medicine. Rather, they take the most recent medical evidence and make it available to help in the medical decision-making process. A practice guideline is a nonbinding, non-mandatory way to approach a medical decision, which brings to the clinician at the point of that decision the most relevant medical evidence that may help the decision-making process.

The guidelines we've specifically formulated deal with unexplained symptoms associated with service in the Gulf War, and some of those symptoms that really characterized a number of veterans who served in the Gulf War. And we don't have any compelling reason to believe that we may not see similar symptoms in veterans serving in the current conflict in Iraq. Therefore, we felt it was essential to have that kind of information available to all VA clinicians.

Mr. BUYER. I'm just very careful, because what we're trying to avoid was the entire medical liability questions. And there were even some that were concerned about when the anthrax attack occurred here in DC, whether or not we should give immunity to practicing doctors moving from Virginia to DC, or Maryland to DC, you know, and give them immunity in the case that there was a catastrophic event. And we try to avoid all that. And that's why I'm just being very careful.

On page 5 of your testimony, it states that the VA held a decontamination training course—and you also just mentioned it orally—which included a session on basic emergency hospital decontamination operations. How many decontamination units does the VA have today?

Dr. MATHER. We have about 15 that are really functioning.

Dr. ROSWELL. Yeah. We have a number that are well ahead of the power curve. Our intent is to implement approximately 80 decontamination units nationwide. Probably, as Dr. Mather alluded, 15 are fully equipped and capable today. They include units in Salt Lake City and——

Mr. BUYER. Break it up regionally. If you had an event in a particular place, where could people go for that expertise? Are these 15 spread out regionally?

Dr. ROSWELL. They are.

Dr. MATHER. Washington, DC; Bay Pines; Little Rock, AR; Indianapolis; Salt Lake City; New York; New Orleans; Atlanta. They're spread out.

Mr. BUYER. So you laid out the first base regionally, and then you'll expand from there.

Dr. MATHER. Well, many of them had already gone into decon facilities on their own. And what we're doing is try to make sure that every medical center can provide decontamination for mass casualties.

Mr. BUYER. You also mentioned in your testimony that 24 staff from six VA medical centers completed the course. Do these six medical centers have the decontamination units?

Dr. MATHER. They're getting them. They learned to use the equipment when they were in Reno, and the equipment is being delivered to their medical centers, and then they will go home and train the rest of their medical center staff.

Mr. BUYER. Considering the appropriators have been reluctant to provide sufficient funding to implement the Centers for Excellence prescribed by Public Law 107–287, has VA put in a bid or multiple bids to NIH for the research grants related to biological, chemical, or radiological terrorism?

Dr. ROSWELL. VA as a department has not. It's entirely possible that VA investigators have individually submitted grants under that solicitation for funds. But VA as a department has not.

Mr. BUYER. Has VA aggressively promoted its value in providing expertise in homeland defense and bioterrorism training, to HHS and DHS?

Dr. ROSWELL. The answer is yes. We're an active participant in the National Disaster Medical System, the NDMS. We have recently held a Federal Response Partners meeting. We work closely with all agencies. There's very effective communication across departments. And when we've had actual incidents—fortunately, infrequently—VA has been a responder and has participated and worked very effectively with other agencies in south Florida, as I mentioned, as well as in New York and in Washington.

Mr. BUYER. I noted that HHS was developing a duplicative program at a cost of $28 million. I don't understand, because a lot of this has already been developed at Uniformed Services University of Health Sciences. Are you working with them, or trying to figure out the differences here?

Dr. ROSWELL. We've had several meetings with USUHS, including Admiral Zimble, the President of USUHS, and have an ongoing dialogue. I guess in simplest forms, USUHS doesn't have a separate curriculum dealing specifically with weapons of mass destruction. But rather, because of the nature of the medical education and curriculum at that institution, it's integrated into the full medical curriculum.

So we've been working with them to tease out the specific parts that aren't routinely included in medical school curricula around

the Nation, and to make that available to our staff, as well as the trainees who rotate through VA each year.

Mr. BUYER. The last question I have. You said that 76,000 students go through the VA system teaching hospitals. What is the total? Do you know how many students totally are in medical schools in the United States?

(Department of Veterans Affairs response to request from Congressman Buyer follows:)

Congressman Buyer: Total Number of Students in U.S. Medical Schools.

No data are available nationally on the total number of students enrolled by the various health professions except medical schools. The total enrollment in U.S. medical schools in 2001 was 66,253 students. Following is a breakdown of the total number of individual trainees who came to the VA for some or all of the clinical training in 2002.

Department of Veterans Affairs
Office of Academic Affiliations

Health Services Training Major Code Summary for 2002

Training Code and Title		Number of Trainees		
		Paid	Unpaid	Total
01	MEDICAL RESIDENTS	19,168.00	8,628.00	27,796.00
02	SPECIALIZED FELLOWS	151.00	59.00	210.00
03	MEDICAL STUDENTS	0.00	15,982.00	15,982.00
04	DENTAL RESIDENTS	413.00	147.00	560.00
05	DENTAL STUDENTS	0.00	575.00	575.00
06	AUDIOLOGY & SPEECH PATHOLOGY	178.00	412.00	590.00
07	CHAPLAINCY	28.00	134.00	162.00
08	COMMUNITY HEALTH EDUCATION	0.00	5.00	5.00
09	DENTAL AUXILIARIES	0.00	1,462.00	1,462.00
10	DIETETICS	156.00	393.00	549.00
11	HEALTH INFORMATION (MEDICAL	0.00	111.00	111.00
12	HEALTH SERVICES RESEARCH &	6.00	59.00	65.00
13	HOSPITAL LIBRARIAN	0.00	2.00	2.00
14	IMAGING	0.00	1,312.00	1,312.00
15	MEDICAL LABORATORY	0.00	631.00	631.00
16	MEDICAL MEDIA	0.00	3.00	3.00
17	MEDICAL/SURGICAL SUPPORT	0.00	618.00	618.00
18	MENTAL HEALTH	552.00	500.00	1,052.00
19	NURSE ANESTHESIA	47.00	114.00	161.00
20	NURSING—AUXILIARIES	0.00	4,151.00	4,151.00
21	NURSING—PROFESSIONAL	165.00	12,972.00	13,137.00
22	OPTOMETRY	93.00	558.00	651.00
23	PHARMACY	194.00	2,697.00	2,891.00
24	PHYSICIAN ASSISTANT	114.00	848.00	962.00
25	PODIATRY	180.00	534.00	714.00
27	REHABILITATION	204.00	924.00	1,128.00
28	SOCIAL WORK	400.00	206.00	606.00
29	VETERINARY AUXILIARIES	0.00	6.00	6.00
	Fiscal Year: Nationwide Total:	**22,049**	**54,043**	**76,092**

Dr. ROSWELL. I don't have that figure, but I'm sure we can get it and submit it for the record.

Mr. BUYER. All right. I'm just curious.

Dr. ROSWELL. There are over 140 medical schools in the Nation, and the typical class size is approximately 100, I would guess, on average. So with four years of medical school, that would be 400 per school times 140 sites.

Mr. BUYER. I just want to make sure that—I don't know if 76,000 is two-thirds or three-fourths. Or if, in fact, we're not meeting a population, maybe we integrate these activities with HHS.

Dr. ROSWELL. The majority of medical students will rotate through a VA medical center sometime during their training.

Mr. BUYER. I guess we're speaking out of order. Does anybody know? Dr. Nelson? Do you know how many students are enrolled?

Dr. NELSON. I can get the number exactly for you, but figure about 150 per class, four classes per school, 125 medical schools. He's absolutely right. Most of us have a substantial portion of our training at some point in the VA system.

Mr. BUYER. Thank you. Thank you very much. Ms. Hooley, you're now recognized.

Ms. HOOLEY. Thank you, Mr. Chair. A couple questions. I want to start out with and follow up to some other things. You said when you talked about the centers, and you mentioned New York and you mentioned Florida, what's on the west coast?

Dr. ROSWELL. The——

Ms. HOOLEY. I'm going to ask a lot of west coast questions, since that's where I'm from. And I'm very anxious to find out.

Dr. ROSWELL. We don't have a Center of Excellence dealing specifically with terrorism. There is a tremendous amount of capability on the west coast in the VA. Obviously, some of the more prestigious medical schools and academic centers are located in the west coast states, all of which are affiliated with local VA medical centers.

There is a decontamination capability in Salt Lake City that goes back to the time of the Olympics. That's a capability that's well-established that's very close to the west coast.

Dr. MATHER. At this point, I think most of the six that went for training in Reno are from the west coast, but I don't have a list. We can provide you with that, though.

Ms. HOOLEY. Do we anticipate getting a Center of Excellence on the west coast?

Dr. ROSWELL. I don't know that we do. Let me point out that all of the major west coast facilities have been identified to receive an emergency pharmaceutical cache, which would include drugs to sustain operations in the event of a terrorist attack which involved the use of a nuclear, chemical, or biological agent. These are caches that are being deployed nationwide, and high-risk medical centers have already received their caches, including a number of sites up and down the west coast.

Ms. HOOLEY. What kind of—I'm going to follow up on my Chair's questions. What kind of decontamination facilities are available on the west coast? If I was contaminated with something, I would not want to travel to Salt Lake City. It would be a little far for me. I don't know about other people. But what's on the west coast?

Dr. ROSWELL. Well, decontamination has to be a local response.

Ms. HOOLEY. Right.

Dr. ROSWELL. There's no question about it. We are fielding decontamination units at the major west coast VA medical centers, issuing personal protective equipment to allow staff to safely conduct the decontamination process. And as Dr. Mather said, that training is in place. We'll be happy to follow up for the record with

the exact locations, the date of receipt of equipment, and the date of training.

(Department of Veterans Affairs response to request from Congresswoman Hooley follows:)

Congresswoman Hooley: VA Emergency Mass Decontamination Facilities On the West Coast.

The following thirteen facilities in VISNs 20, 21 and 22 on the west coast will have emergency mass decontamination capability this year. Training of the core staff will occur (or has occurred) by the dates indicated. The necessary equipment (portable shower shelters and personal protective equipment) will be delivered shortly after the master contract is signed.

VISN 20

Boise	August 03
Walla Walla	August 03
Portland	August 03
Seattle	August 03
Roseburg	August 03

VISN 21

Sacramento	March 03
San Francisco	March 03
Palo Alto	March 03

VISN 22

Reno	March 03
Los Angeles	March 03
Loma Linda	March 03
Long Beach	July 03
San Diego	August 03

Ms. HOOLEY. There was just a report in the paper that the first health care worker had come down with SARS. What are you doing to make sure your health care workers are protected while caring for patients?

Dr. ROSWELL. First of all, VA is a significant resource. VA has over 1,700 negative pressure isolation rooms, which makes us very well-situated to deal with an infectious illness that requires isolation.

Ms. HOOLEY. Now, before you go on. Are those scattered throughout the country?

Dr. ROSWELL. Yes.

Ms. HOOLEY. Are they on the west coast?

Dr. ROSWELL. Yes, they are.

Ms. HOOLEY. Okay. Just checking.

Dr. ROSWELL. We've actually emphasized the importance of negative pressure isolation rooms for many years, going back realistically to the HIV pandemic in this country. And VA has put a special emphasis on creating standards for negative pressure isolation rooms, which is the exact type of containment room you need to deal with a situation such as SARS.

Ms. HOOLEY. So your health care workers are trained and know what to do in that instance?

Dr. MATHER. We've established a Web site, a VA, both an Intranet and an Internet, Web site with both information on SARS and information for patients about SARS. And we have weekly reminded over the telephone hotline calls that respiratory precautions for anybody who is seen who's febrile, who has traveled to the places in the east, Far East, or who have been in contact with anybody who has traveled or taken care of someone who traveled.

And we've added, because it is unclear whether it's being spread truly by the respiratory route, or also by fomites, that people should wear goggles. And we've checked to see that the hospitals have adequate supplies of goggles, because that's not usually a part of respiratory precautions. Usually, it's just the mask, the respirator.

Ms. HOOLEY. The attachment to your testimony mentions a number of conferences and satellite broadcasts first on WMD training, often including other agencies such as DOD and FEMA. There is a difference between briefing with outside agencies and actual real-time practice with those agencies. What training has VA accomplished or plans to accomplish that goes beyond lectures and tabletop training? What kind of actual real-time training have you done?

Dr. ROSWELL. As I said, we're an active participant in NDMS. We annually participate in the NDMS conference. We have teams that have participated in various exercises that have been interagency. The international meeting I spoke of now in its fifth year that VA hosts each year in Florida. It is not only a didactic meeting that involves these agencies, but each year, it's included in actual hands-on exercise to exercise response capability, decontamination, and triage capability.

We also have sharing agreements with many of the military reserve units at our locations, and actually have been involved in

doing coordinated response exercises with the military as a result of some of those sharing agreements.

Ms. HOOLEY. So you do do the hands-on, I mean, and that's——

Dr. ROSWELL. Yes, ma'am.

Ms. HOOLEY. Dr. Mather.

Dr. MATHER. Each hospital is required to drill twice a year in emergency preparedness as a part of the JCAHO standards. And emergency preparedness, we've always taken an all-hazards approach to emergency preparedness. So in some ways, an earthquake can have the same impact on a community that an explosion has.

So we want our hospitals to be prepared and to know how to exercise their emergency plans, and that's by mandate, they have to drill that twice a year. And often, other groups within the community drill with them.

Ms. HOOLEY. Talking about other groups within the community, how much coordination do you do with other hospitals and health care entities? Are you working with—for example, I will just use Portland, since I know it well—the VA hospital there? Do they coordinate with all the other hospitals and all the other public health care workers for your training exercises? And who takes the lead on those? Help me.

Dr. ROSWELL. I can't answer specifically about Portland. We certainly——

Ms. HOOLEY. But I assume there are some other places you know specifically about.

Dr. ROSWELL. Right. We certainly do that. We encourage that in——

Ms. HOOLEY. How do you encourage it? I mean, what do you do to——

Dr. ROSWELL. Well, we talk to our directors. Weekly, we have a conference call with every medical center director. And as Dr. Mather indicated, recently, we've talked about SARS. But in the past, we've talked about the importance of local disaster planning, the need to coordinate with local health care providers, the EMS system.

The NDMS system is something that we exercise routinely. One of our missions is DOD contingency capability. For example, we would make available up to 6,000 beds within 72 hours, and another 1,000 or 1,500 beyond 72 hours if there were a need from the Department of Defense as a result of casualties coming out of a conflict.

Hopefully, that will never be needed. But if it went beyond that, we would then go to the National Disaster Medical System, which includes non-VA facilities. And we routinely do exercises that actually do bed availability reporting. So there's a lot of activity.

Ms. HOOLEY. What I want to try to get to is you talk to the directors, which is great, and you—whatever the topic of the week is or the day is. Then what do the directors do? I mean, are they actually out? Do they take the lead? Who takes the lead for coordination of all the other health care workers in an area or community?

Dr. ROSWELL. It would vary by locality. We certainly encourage our Directors to take the lead and get involved and identify what resources are available.

Ms. HOOLEY. Do they ever report back to you what they've done, or what they're doing, so you have a——

Dr. ROSWELL. They do. I don't know that we have a systematic report, other than through the way we exercise the NDMS system.

Dr. MATHER. Well, and our EMSHG, the Emergency Management Strategic Health Care Group, has area emergency managers in 34 of our hospitals, and they cover all the hospitals. And they are responsible for getting the Memorandum of Understanding signed with the local hospitals, who will take care of overflow in an emergency. VA doesn't have the lead in the NDMS, but we do have a role in four categories: provision of health care, sheltering, engineering, and I can't remember the fourth one. I think it's acquisitions.

But when FEMA, when the Federal Disaster Plan, is activated, then VA cooperates with FEMA and the other agencies.

Also as an example, with the smallpox vaccination campaign, we've encouraged our medical centers to cooperate with the Health Department. And, in fact, every state has a VA liaison with the State Health Department. And we've vaccinated now, as a part of the Health Department's plans, over 1,000 VA employees prior to getting our own vaccine.

Mr. BUYER. I thank my colleagues. The Chair gave Ms. Hooley great latitude, because we're at the infancy of the implementation of the act. And while I like to focus, yes, on the medical schools, she's jumped into your education to the community professionals. And I think that's extremely important in how that gets coordinated, and that's why the Chair gave great latitude. And I'd more than happily afterwards yield to two other members if you have follow-up questions.

Mr. Bilirakis, you're now recognized.

Mr. BILIRAKIS. Well, thank you, Mr. Chairman. Doctor, let's see, we—of course, Mr. Tolbert and Dr. Nelson and so many others will make up the next two panels, so they will give us many of the answers, I suppose, hopefully. But I would ask you, these have been distributed to all the VA medical personnel, right?

Dr. ROSWELL. Yes.

Mr. BILIRAKIS. Just curiosity. Have you considered furnishing, whether they be the pocket guides or additional information, to any physicians who have already gone through the system? You know, they're not currently medical personnel, they're not currently medical students in the VA health system, but they've already gone through, like my son, as you know, and others.

Dr. ROSWELL. We would currently do that. Interestingly, we recently issued a similar trifold pocket on personal emergency planning, and have had numerous requests for that particular document, and have made those available to non-VA personnel as well. So yes, I mean, we would be happy to do that.

Mr. BILIRAKIS. Well, sir, you have indicated that you have done some coordinating, you have held some—and been involved in some meetings and whatnot with other agencies, heads of other agencies. And we have, of course, Mr. Tolbert here with Homeland Security.

But to what point have they taken the lead in this? I mean, is this basically something where the VA is held responsible to do their own thing, HHS to do their own thing, parts of HHS, CDC

parts, HHS do their own thing, or whatever the case may be there? I mean, is there somebody kind of in charge, as I guess was contemplated by us when we set up the Department of Homeland Security? Is Tom Ridge or somebody in charge there to coordinate all this among—basically, the opening statements on the part of both the Chairman and the Ranking Member emphasize a duplication, hopefully, that there wouldn't be any duplication. Can you respond to that?

And in the process, Doctor, I meant that—and we've known each other a long time. When I said that if there's any suggestions that we can do to—I mean, you've been at this for a while now, and you've been out in the field before that too. So you didn't come in right at the top. You've come up through the ranks, so to speak. So what can we do in the process of your answer here to help, in your opinion, to make this a more efficient, more fluid, if you will, better working system? Go ahead, sir.

Dr. ROSWELL. Thank you, Mr. Bilirakis. Certainly there have been growing pains as we've transitioned functions to DHS. But it's clear that it is a coordinated plan. I think the follow-on panel of witnesses will reaffirm that.

With activation of the Federal Response Plan, there are executive support functions. ESF 8 is health care. That's the one that we have the major role in. Now, the designated lead agent for ESF 8 is, in fact, Health and Human Services. So when the FRP is activated, HHS takes the lead; we fall in and provide support.

The VA system has tremendous capability, because we have over 1,300 locations of care nationwide, over 185,000 health care employees, and we stand ready to support that function. I think that the most important thing we can do is to assure that there's ongoing continuous effective communication.

I have been very impressed in the just over a year I've been in Washington with the level of communication between the departments. I suspect that some of that is new following the events of September 11. But it's a remarkable level of communication between the departments, and I would say that that's something that we need to value, encourage, and continue to facilitate that level of cooperation and communication.

Mr. BILIRAKIS. All right. So it's being done perfectly. You don't need any help from Congress.

Dr. ROSWELL. We always need your help, sir.

Mr. BILIRAKIS. You haven't asked for it, as far as I know, in this regard.

Are these pocket guides going out throughout not just VA system, but through the entire medical personnel system in America?

Dr. MATHER. We've distributed 60,000 so far to VA. We're getting ready to do a second printing, and we have 80,000 requests. Many of those are from health departments or from community facilities, hospitals. Because as VA people move from the VA facility over to the university or to other hospitals, they take them with them. And the holes were so they could put them on a string and hang them in their emergency room by the door. And they've been very popular.

Mr. BILIRAKIS. But have these been directed by Homeland Security?

Dr. MATHER. No.

Mr. BILIRAKIS. No. You've done it on your own. Do you know whether all of the other agencies' departments and whatnot are doing this to try to cover as many of our health care workers in the United States as possible?

Dr. MATHER. I don't know that, no. This seemed to be particularly something that VA physicians and VA health care workers could use. It's brief. It's concise. It doesn't supplant a textbook, but it's something you could have for a ready reference. And so it seemed to meet our needs particularly well. As it turns out, other agencies have thought it met their needs as well.

Dr. ROSWELL. But I do need to point out that the content, in large measure, came directly from DOD, where there is a recognized expertise. So this is not something that we just developed on our own. We went to the best available resources to put it in this format.

Mr. BILIRAKIS. It would be interesting to find out to what extent this is taking place, not only a pocket guide, which looks like it's terrific, but also, you know, information being disseminated. I'll have to ask my son when I see him, whenever I see him, this weekend or whatever, whether he's been notified by anybody what to do.

Thank you, Mr. Chairman.

Mr. BUYER. Well, now we've had two members ask very similar questions. This is part of your fourth mission, specified in the MEND Act, appropriated dollars. And it's wonderful that you get them to your own employees, but part of your job is also in the coordination of the outreach into the community. I don't know why that wasn't done.

Dr. MATHER. And I think the area emergency managers do take them to the hospitals that they are affiliated with through the Memorandum of Understanding as a backup in the NDMS system. So the universities, the medical schools, the teaching hospitals, and the NDMS hospitals are really the locus of our influence.

Dr. ROSWELL. And let me point out, Mr. Chairman, that we have extensive educational capability. We have, actually, 24-by-7 satellite coverage, with four channels of full bandwidth video steerable downlink dishes at every location. And so we have access to a lot of programming that we make available to our staff. But not just to our staff. We routinely invite community providers, military, other personnel in to take advantage of those.

Mr. BUYER. So, Doctors, if the three of us walked into the Portland community, and we wanted to check out all the area hospitals, would they have these?

Dr. MATHER. I don't know. It's possible some of them would.

Mr. BUYER. It's possible. But we don't know.

Dr. MATHER. Those that have a memorandum of understanding with the hospital.

Mr. BUYER. All right. Well, here's the hiccup. From our standpoint, we view it as one of your directives in the law to do. Now, if it's a function that the VA doesn't want to do, believe me, we'll talk to the appropriators, we'll give them money, we'll give it to HHS, and we'll let HHS do it. We just need to figure out who's going to do what. If it's a function that you don't want to do, tell

us. You see what I'm saying? This is great. But I don't know why you wouldn't grab the horns and disseminate it.

Dr. ROSWELL. I was just informed that 80,000 are currently being printed to be delivered to non-VA requesters. So we are doing it.

Mr. BUYER. Okay. Thank you, Dr. Roswell. Dr. Boozman, you're now recognized.

Mr. BOOZMAN. Thank you, Mr. Chairman.

These really are good. I'm an optometrist, an eye doctor, so they really are good. Another way to do these, too, that works real well is to make them where you can stick them? You know, where you've got to pull off, and then they can stick them on a cabinet someplace? And that's just—it really is handy that way. But these are excellent.

I guess the only question I'd have is if you could kind of walk me through, if we had a—say we had a smallpox attack or whatever, you know. Or we suspected that, and, you know, you started seeing some hot spots in this area that way. Do we have a central—does the VA system, does it have a central office that our people would report to that information? Do you see what I'm saying?

In other words, if you started seeing something on the west coast or east coast or whatever, and then maybe, you know, little suspect there, you know, and then maybe something someplace else, or even just in that area, what's the procedure? Do we have a central office where that information goes? And tell me about the guidelines that would happen, and kind of their—maybe their timetable of doing things.

Dr. ROSWELL. Mr. Boozman, the Center for Disease Control, which is a Health and Human Services asset, has the national lead on surveillance and reporting of infectious diseases. All of our staff, all of our personnel comply with all CDC guidelines. So if an incident case comes up, there would be a dual reporting to the CDC, as is required by their regulations, and also through our program offices.

Mr. BOOZMAN. So the VA does have——

Dr. MATHER. Any unusual event, a cluster of cases of something, certainly a skin problem that resembled smallpox, is to be reported immediately through the networks to the Under Secretary for Health's office, and the program people are immediately notified.

Mr. BOOZMAN. So it goes to that office, and then you disseminate it out to the system nationwide?

Dr. MATHER. Yes.

Dr. ROSWELL. Virtually any kind of incident. A couple days ago, we had cloudy water at a facility. It was immediately reported in. We have specific directives out to the field on the types of incidents to be reported. And they're reported electronically. We're always in contact with the field.

But my point is that we're not a maverick here. We actually are working with an interagency approach. And the CDC has the lead, and we work very closely with CDC.

Mr. BOOZMAN. Okay. Thank you.

Ms. HOOLEY. Mr. Chair, if I could just ask a couple quick questions.

Mr. BUYER. Please do. Ms. Hooley is now recognized.

Ms. HOOLEY. Dr. Roswell, is bed capacity a good measure of capacity? Or is there something else that we could use?

Dr. ROSWELL. Bed capacity is one measure of capacity. It's probably not a comprehensive measure of capacity, and it's certainly not the only measure of capacity.

Ms. HOOLEY. What else would you use?

Dr. ROSWELL. Provider staff, the number of physicians, the number of nurses, outpatient visits. One of the things we're actively exploring within the VA is the use of the telephone. For example, if in the greater Portland area, there was an outbreak of smallpox, we believe that the best approach would be to encourage people to stay at home. And I think the concern about their health and well-being is such that they might not stay at home, where they're less likely to contaminate and do harm to other people, unless we had a way to communicate with them.

One of the strengths of the VA system is that we have telephone access, telephone triage available at all of our medical centers. So we're exploring plans about how we might use that telephone infrastructure and that telephone staff to actually manage patients in a home environment if they needed to be quarantined.

So that creates a capacity in the home that goes well beyond our bed capability. If the first time we have an outbreak of smallpox, we immediately hospitalize to quarantine everyone who's a suspected exposure, then it could become very difficult, and it would quickly overwhelm the system.

So we're really looking at non-conventional types of what we call surge capacity to deal with such an eventuality.

Ms. HOOLEY. One last question. This pamphlet—which is very good, and I think it's—I hope you disseminate it to every hospital and every health care worker—is about biological terrorism. Do we have anything—or do you need to do anything with chemicals?

Dr. ROSWELL. There are actually a set of three, ma'am. One deals with biological, the second deals with chemical, the third deals with radiologic, and they're all in the same form.

Ms. HOOLEY. Well, that's wonderful. That answers my question. I only got the biological one, though.

Dr. ROSWELL. We'll be happy to provide the other two for you.

Ms. HOOLEY. All right. Thanks.

Mr. BUYER. Thank you, Ms. Hooley. I want to ask you now to consent to have placed in the record a letter dated May 4, 2003, from myself as Chairman of the Subcommittee on Oversight Investigations to Secretary Principi, along with his March 31, 2003, response to my letter, also with his attachment, which is the implementation plan for Public Law 107–287.

Hearing no objection, it's so entered into the record.

[The provided material follows:]

REPUBLICANS
CHRISTOPHER H. SMITH, NEW JERSEY, CHAIRMAN

DEMOCRATS
LANE EVANS, ILLINOIS, RANKING

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED EIGHTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

March 4, 2003

Honorable Anthony J. Principi
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

On December 9, 2002, I contacted you concerning H. R. 3253, the "Department of Veterans Affairs Emergency Preparedness Act of 2002," that was signed into law by the President on November 7, 2002. Section 3 of this bill establishes an education program to be carried out by the VA modeled upon the education and training curriculum of the Department of Defense's Uniformed Services University of Health Sciences (USUHS). This program would include a curriculum designed to teach current and future health care professionals how to diagnose and treat casualties when exposure to chemical, biological, or radiological agents is suspected.

In my December 9th letter, I requested that the Subcommittee be provided with VA's plan for the implementation of this program. Since this critical program was authorized in the last Congress and funding was made available for FY 2003, we are once again requesting that you apprise the Subcommittee concerning the Department's specific milestone dates and cost estimates to begin the process of implementing this program. In light of the fact that we had specifically asked how the Department planned to fund the program, I was very disappointed that your FY 2004 budget request was silent on this issue. The Committee has included a request that additional funding be authorized in FY 2004 to ensure that this program is fully implemented.

Please provide a response no later than March 15, 2003. If you have any questions, please contact the Subcommittee's Staff Director, Arthur K. Wu, at (202) 225-3569.

Sincerely,

STEVE BUYER
Chairman
Subcommittee on Oversight and Investigations

SB:vtc

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 31, 2003

The Honorable Steve Buyer
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letters of December 11, 2002, and March 4, 2003, regarding section 3 of Public Law 107-287, the Department of Veterans Affairs (VA) Emergency Preparedness Act of 2002. This law directs VA to carry out an education and training program on medical responses to consequences of terrorist activities. VA's education and training programs are to be modeled after those programs of the Department of Defense's Uniformed Services University of Health Sciences (USUHS). Specifically, VA's programs are to train VA staff on how to diagnose and treat people who have been exposed to or injured by weapons of mass destruction. I apologize for the delay in responding to you; however, I understand that the Office of Congressional and Legislative Affairs staff has kept Subcommittee staff informed during the development of this reply.

I am pleased to advise that on December 13, 2002, representatives of the Veterans Health Administration met with Admiral Zimble, President of the USUHS, to explore ways to implement this provision. In that meeting, VA learned that there is no specific DoD curriculum that addresses the diagnosis and treatment of casualties related to weapons of mass destruction. Admiral Zimble provided VA officials with names of the chairs of the departments most involved with this training.

VA has developed an implementation plan and will be meeting with USUHS representatives again to discuss the development of educational tools, materials and programs that would be mutually beneficial to both parties. The implementation plan with projected target dates and cost estimate is enclosed. VA has been involved in WMD training even before September 11, 2001, and the implementation of this additional training as part of already programmed FY2004 training will enhance VA staff ability to diagnose and treat people who have been exposed to or injured by weapons of mass destruction.

Should your staff seek additional information, please have them contact Mr. Doug Dembling, Congressional Relations Officer, at (202) 273-5615. I look forward to working with you and your staff in the upcoming 108th Congress.

Sincerely yours,

Anthony J. Principi

Enclosure

IMPLEMENTATION PLAN FOR PUBLIC LAW 107-287 (HR 3253)

Section # 3: New Program Requirements: Develop model education programs on emergency preparedness. These programs will promote collaboration of resources and development of new initiatives between the Uniformed Services University of Health Sciences, VA Office of Public Health and Environmental Hazards, as well as other health care organizations within federal/state government and the private sector.

Cost: $500,000

Responsible Offices: Office of Public Health and Environmental Hazards (13) and Office of Employee Education (102)

Implementation Plan: Develop curricula in those areas designated in this section	**Target Dates:**
a. **Meet with representatives of the Uniformed Services University of Health Sciences (USUHS) to explore ways to implement this provision. *Completed.***	December 13, 2002
b. **Review current/past EES program content to identify missing components of a comprehensive curriculum**	April 2003
c. **Assemble committee of expert consultants to review materials and make suggestions as to future planning**	May 2003
d. **Prioritize needs from committee experts**	July 2003
e. **Update the program content and components and develop a comprehensive curriculum**	August 2003
f. **Initiate search for other educational products/programs in related areas that correspond to a comprehensive curriculum; assess commercial materials for in house use.**	September 2003
g. **Meet with USUHS representatives to discuss the development of educational tools, materials and programs that would be mutually beneficial to both parties**	September 2003
h. **Develop and/or purchase new educational materials to fill in the gaps for what is needed**	November 2003
i. **Ensure new educational materials can be presented in a variety of formats including but not limited to satellite broadcast, web, print, etc.**	November 2003
j. **Begin nationwide program implementation phase.**	January 2004

Mr. BUYER. Now, if I may ask a question off of the implementation plan. Dr. Roswell, do you have that in front of you?

Dr. ROSWELL. Yes, Mr. Chairman, I do.

Mr. BUYER. I note that you're saying that you'll be able to take this nationwide implementation by January of 2004. You know, when we put this bill—laid this bill out, you said it was going to cost $5 million a year. And so we got the money appropriated. What are you going to do with the other 4.5 million?

Dr. ROSWELL. Mr. Chairman, I believe the $5 million a year figure was primarily for Section 2, which dealt with the creation of——

Mr. BUYER. For the totality.

Dr. ROSWELL. Much of the cost of Public Law 107–287 was in Section 2, the four new centers.

Mr. BUYER. Oh, oh, oh, oh. That was specifically prohibited. No monies were appropriated for the medical centers at that point.

Dr. ROSWELL. Oh, I understand. I understand.

Mr. BUYER. But $5 million was specifically appropriated for the MEND Act. For the MEND Act. Five million dollars was specifically appropriated for the MEND Act. Correct? Yeah, it was. And none of those monies of that 5 million per year could be used for the Medical Centers of Excellence.

Dr. ROSWELL. We understand that.

Mr. BUYER. Okay? So what I'm curious about is is what are we doing with the rest of the money? And if you don't have the answer today, please get back in touch with me.

Dr. ROSWELL. Now, let me verify.

Mr. BUYER. Okay? Because maybe you're utilizing it for other expenses, such as these handouts and other things. Just go back and let me know.

Dr. ROSWELL. And the reason there's a substantial—there's a 120 million dollar estimated expenditure in fiscal year 2003 to enhance our emergency preparedness, with the creation of the pharmaceutical caches, the procurement of personal protective equipment, the associated training that comes with that, and the decontamination equipment.

Mr. BUYER. Well, I just need to know what you're doing with the other 4.5 million with regard to the implementation of this act. If this is only costing 500,000——

Dr. ROSWELL. I understand.

Mr. BUYER. Just let me know what's happening.

Now, the position of the administration when it came time for funding the Medical Centers of Excellence, as I understand, the administration was not supportive of that funding to the appropriators. Is that because they're just as concerned about duplication of effort, and that that is something that's going to be coordinated through Homeland Security, and the task will be assigned somewhere else? That's not a leading question. I just don't know.

Dr. ROSWELL. Well, I can't speak for the Secretary, but I believe the concerns centered around the fact that as we speak, we have veterans, tens of thousands of veterans, who are waiting six months or more for needed care. And we believe it would be inappropriate to take medical care dollars appropriated for veterans'

health care and use those to create centers for research in bioterrorism.

Mr. BUYER. Well, that's a rationale. It's either a rationale or an argument. You can take your pick. I'm more concerned from the Federal Government standpoint, if we have the world's best right out here with regard to Fort Detrick, they have every known disease imaginable in the world—virus, toxins, you name it, right? And we don't want to have duplication. So I guess the answer is we don't know what is being directed out of Homeland Security? I mean, are we just going to say, "Okay, we're going to let DOD hold onto this, and we're not going to"——

Dr. ROSWELL. Well, again, I can't speak for DHS. I can point out VA's strengths, which is its vast educational infrastructure, the fact that it's geographically distributed, the fact that it has a huge provider capability, the fact that it has established ongoing active affiliations with 107 of the Nation's medical schools.

Mr. BUYER. All right.

Dr. ROSWELL. And that puts us in a unique position to disseminate information, to share information, and to respond locally to an event.

Mr. BUYER. In my discussions with Chairman Walsh, we recognize that this fourth responsibility to the VA is challenged because of the Category 7's and what they've done in changing the core competency of the VA. So I understand that. But I was able to have him fund this because of the nexus and the necessity. So we'll focus on that at the moment.

Does anyone else have any further questions of Dr. Roswell? Did you have anything, sir, that you wanted to add?

Dr. ROSWELL. Mr. Chairman, I just want to point out that we have spent a substantial amount of money. We believe that our first mission, to provide health care to veterans, must be safeguarded through and continued through the possibility of a local terrorist activity. And that's why we have purchased pharmaceutical caches that will be located at all major medical centers at a cost of several million dollars. In fact, tens of millions of dollars. That's why we purchased the personal protective equipment and the decontamination equipment, to make sure that we can continue to provide health care to veterans.

Mr. BUYER. I understand that. We're trying to figure out how we make this work in providing "Homeland Security" and who will have what responsibility to make sure that we're not duplicative. If the VA steps forward and says, "Congress, I know you wanted to give us this fourth responsibility, and we're really anxious to take it on. However, we're not able to."

You know, and maybe this is best done by HHS. Or maybe it's the can-do spirit. "Yes, sir, we can do this. And we've got the funding. And we're ready to take it on. And we're going to make sure that there's not duplicity in the systems."

Dr. ROSWELL. I view our fourth mission—and I believe I'm correct in my view of this—as a mission which only takes place when designated or requested. There are two types of ways that the fourth mission would be activated. One would be if either the Secretary of Veterans Affairs or the Secretary of Defense initiated the VA DOD contingency plan.

Mr. BUYER. Yeah. But in this case, you've been directed by Congress, right?

Dr. ROSWELL. I understand.

Mr. BILIRAKIS. Mr. Chairman?

Mr. BUYER. Yes, Mr. Bilirakis.

Mr. BILIRAKIS. Well, I think, to me, it sounds like the VA has basically done everything we can expect them to do. I'm not referring to $5 million or expenditures or how that was spent. But I mean in general. Generically, I guess, maybe, is the best way to put it.

But I guess my concern is, again, you know, the duplication and the waste that is taking place.

Mr. BUYER. Right.

Mr. BILIRAKIS. So, you know, maybe it shouldn't be Dr. Roswell. Maybe it should be Mr. Tolbert. I don't know. We have to find out.

I know I was given by Dr. Nelson this quick-reference guide that has been sent out to all of their doctors throughout—I assume they're not all members of the AMA. Doctors that are not even members of the AMA have received this?

Dr. NELSON. Yeah.

Mr. BILIRAKIS. All right. But I guess even though they're not a government office, they've sent it out. The VA has sent out their pocket cards. I wonder if HHS has sent out pocket cards.

Mr. BUYER. Well, we're about to find out.

Mr. BILIRAKIS. I wonder if others, if DOD has sent out pocket cards.

Mr. BUYER. I'm sure they have.

Mr. BILIRAKIS. Wouldn't it be cheaper if they all coordinated, and it was just one card? You know, it would be a hell of a lot less expensive. Things of that nature.

Mr. BUYER. Point well made, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you.

Mr. BUYER. Point well made. All right. Thank you very much, Dr. Roswell. Thank you very much for your testimony.

Dr. ROSWELL. Thank you very much.

Mr. BUYER. You may be excused.

The second panel is Mr. Jerome Hauer, the Acting Assistant Secretary of the Office of Public Health and Emergency Preparedness for the Department of Health and Human Services. Accompanying him is Mr. Eric Tolbert, Director of Preparedness, Emergency Preparedness and Response Directorate, Department of Homeland Security.

Your written testimony will be added into the record, and you're now recognized for five minutes.

STATEMENTS OF JEROME M. HAUER, ACTING ASSISTANT SECRETARY FOR THE OFFICE OF PUBLIC HEALTH EMERGENCY PREPAREDNESS, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND ERIC TOLBERT, DIRECTOR, EMERGENCY PREPAREDNESS AND RESPONSE DIRECTORATE, DEPARTMENT OF HOMELAND SECURITY

STATEMENT OF JEROME M. HAUER

Mr. HAUER. Thank you, Mr. Chairman. It's a pleasure to be here with you today. I will keep my remarks brief, and you have my written testimony.

Mr. BUYER. May I interrupt for just a second?

Mr. HAUER. Sure.

Mr. BUYER. Let me express a satisfaction, Dr. Roswell, for you sticking around for this testimony. This ought to really be helpful. Maybe we can cut through this pretty quick. Thank you.

Mr. HAUER. Parenthetically, we work very closely with Dr. Roswell, and I'll allude to some of that in the testimony. I'd be happy to answer questions on that as well.

The office that I lead is responsible for coordinating and directing the emergency preparedness and response efforts of the HHS agencies, including the Centers for Disease Control and Prevention, the Food and Drug Administration, the Health Resources and Services Administration, and the National Institutes of Health. My office also works closely with CDC and HRSA to insure the effective implementation of the state and local public health and hospital preparedness cooperative agreement programs and HRSA's new continuing education and training and curriculum development program for bioterrorism and other public health emergencies.

As you can see, aspects of HHS missions are closely aligned with the VA's health care mission. As a result of this and as a result of the deliberate efforts by members of both departments, HHS and VA maintain a strong working relationship. Our partnership and health-related emergency preparedness activities has a long history, beginning with extensive collaboration on the creation and management of the National Disaster Medical System, (NDMS). While NDMS is now a part of the Department of Homeland Security, HHS is still collaborating with DHS, DOD, and the VA for its operation.

HHS also retains responsibility for maintenance of the Commission Corps Readiness Force, a group of Public Health Service Commissioned Officers who are prepared to meet emergency requirements anywhere in the country, deployed in groups tailored to the requirements of the emergency. HHS works closely with the VA and other members of the national health infrastructure to insure that our Commissioned Corps officers are recruited, trained, and equipped as a vital agile force capable of meeting emergency health needs.

The VA also provides significant support to HHS's Emergency Support Function 8, as you heard earlier, activities during the disasters through both the contribution of human assets and material resources.

Finally, the VA's assistance has been invaluable to the establishment and maintenance of the HHS-created Strategic National Stockpile.

Our two departments have continued to build a relationship through a variety of other initiatives as well. Recently, HHS concluded a Memorandum of Agreement with the VA to provide vaccine to begin a smallpox inoculation program within the VA hospital system. On a monthly basis, we meet for the Federal Partners meeting, which includes high-level representation from the VA, the Department of Defense, the Federal Emergency Management Agency, and the Department of Homeland Security. Our goal is to ensure continued coordination of health-focused terrorism preparedness initiatives throughout the Federal Government.

Together, HHS and the VA are aggressively seeking to improve our Nation's preparedness for public health emergencies. We have also integrated our efforts at the state and local levels. The CDC and HRSA cooperative agreement programs mandate VA representation on the state bioterrorism preparedness and hospital preparedness advisory committees. I'm pleased to report that the states have taken this recommendation seriously, and are collaborating with regional VA representatives in developing surge capacity and acute community response plans.

I hope I've been able to provide you with a clear picture of the strength of our existing relationship with the VA.

I would now like to take the opportunity to highlight the role of the VA as a critical resource for the education of our Nation's health care professionals. It is in this capacity that I see a great deal of potential in terms of ensuring that our physicians, nurses, paramedics, and other health providers are prepared to meet the challenges of caring for victims of biological, chemical, and radiological attack.

HHS has been working vigorously with health professionals, schools, and associations to develop appropriate training materials and curriculum objectives for the treatment of victims of radiological, chemical, and biological agents. The CDC and HRSA cooperative agreements have portions that focus on education and training for public health and hospital-based providers, and HRSA will competitively award $28 million in fiscal year 2003 to academic health centers and other health professional training entities for this purpose.

As HHS works to establish these programs, it is essential to identify opportunities for collaboration and coordination with other partners. VA maintains a concentration of expertise in the treatment of biological and chemical casualties, and is therefore a considerable resource for supporting specialized education in this field.

Furthermore, as training sites for the majority of health professionals, VA facilities play a prominent role in the early stages of medical training. Building on our existing relationship, HHS and VA will work together to further the integration of high-quality terrorism preparedness training into the education of our Nation's health care providers.

VA's contributions to terrorism preparedness do not end with the establishment of robust training and education programs. It is also important to recognize in the case of chemical or biological attack,

or other sizable emergency, VA has served and will continue to serve as a community resource for both veterans and, when necessary, non-veterans.

Also, I alluded to earlier, HHS views VA resources broadly during an emergency. And VA has readily responded to our request for assistance. HHS's continued partnership with VA will benefit our states and communities by strengthening the skills of our front line health providers and by expanding the depth of resources that can be called upon to respond to any type of emergency.

At this time, I'd be happy to answer any questions. I appreciate the opportunity to be with you today, and I appreciate the time. Thank you, Mr. Chairman.

Mr. BUYER. Thank you.

[The prepared statement of Mr. Hauer appears on p. 55.]

Mr. BUYER. And the Chair does stand corrected. I said, Mr. Tolbert, that you were accompanying Mr. Hauer. I do apologize. You're here in your own right for the Department of Homeland Security. Mr. Tolbert, you're now recognized.

STATEMENT OF ERIC TOLBERT

Mr. TOLBERT. Thank you, Mr. Chairman and members of the subcommittee. I'm pleased to be here today to discuss the disaster response activities of the Department of Homeland Security, including our close working relationship with the Department of Veterans Affairs. My name is Eric Tolbert, and I am the Director of the Response Division for the Emergency Preparedness and Response Directorate of the Department of Homeland Security.

During the time I served as director of the North Carolina State Emergency Management Agency just one year ago, I managed numerous disasters, including the costliest disaster in our state's history, Hurricane Floyd. Thankfully, we didn't have a large number of casualties caused by that disaster. But I can tell you, having been on the front line, I was very comforted to know that there was a robust federal capability, a well-coordinated capability, that was there to support the health and medical system in North Carolina. So I know firsthand the importance of the health and medical community in responding to disasters.

And as a former first responder, I know how vital it is to coordinate the training and planning for all contingencies, including those that would require medical response to these new specialized events involving chemical, biological, nuclear, and radiological events.

The Emergency Response and Preparedness Directorate of the Department of Homeland Security, the mission that we have is to lead the Nation to prepare for, mitigate the effects of, respond to, and recover from major domestic disasters, both national and manmade, including acts of terrorism. These are the same core responsibilities that guided FEMA, the Federal Emergency Management Agency, as an independent agency.

To attain the requirements of our medical responsibilities, two vital health and medical response programs were transferred from the Department of Health and Human Services into the Department of Homeland Security. First, the Office of Emergency Response, which includes the administration of the National Disaster

Medical System, and two, the material assets and operation and control of the Strategic National Stockpile.

I'd first like to talk about the NDMS, which you've already heard from the VA a little bit about this program. The NDMS, or National Disaster Medical System, is a partnership between the Department of Homeland Security and the Department of Defense, Department of Veterans Affairs, and the Department of Health and Human Services. We also have a lot of state and local government participation, as well as private sector participation, in this key system.

The system includes three major mission components, including direct medical care, patient evacuation, and the non-federal hospital bed system, and was created as a national medical response system to supplement state and local medical resources during disasters and emergencies; secondly, to evacuate patients to designated locations throughout the United States for casualties that cannot be managed locally; and last, to support the military and VA health care systems during an overseas conventional conflict.

Let me talk about the teams that are a major part of this system. Over 8,000 private sector medical and support personnel become federal employees when called to federal service. These individuals, volunteers who leave their private sector jobs, are organized into 90 specialized teams.

I would add that some of these employees are also federal employees, I learned recently, at the national conference that we held, including Veterans' Affairs employees who do this as a second and additional duty to their regular job. These specialized teams provide field medical care. They're also capable of providing or supplementing in-hospital care. They provide and support patient evacuation, mental health assistance, victim identification, and mortuary services.

We also have four specialized teams, one in the west, one central, and two in the east, which are specially trained and equipped to provide decontamination and treatment of patients impacted by weapons of mass destruction. I would add that these teams' pharmaceutical support comes from and is managed by the Veterans' Affairs Department.

In addition to the domestic mission, NDMS is a partner in the military contingency program. This system is available to provide medical care in hospitals in over 2,000 private, non-federal hospitals across the United States should a military conflict overwhelm the DOD and VA health care systems.

On the hospital and the evacuation side, the VA and Department of Defense maintain 62 Federal Coordinating Centers. These centers manage patient evacuation for those who cannot be cared for in the actual disaster area, and maintain a nationwide network of voluntary, pre-identified, non-federal acute care hospitals who provide definitive care for the victims of domestic disasters and military contingencies.

Lastly, I'd like to talk about the Strategic National Stockpile, which also the operational control and assets were transferred to the Department of Homeland Security. It's primarily comprised of 12 "push packages" of pharmaceuticals, medical supplies and equipment that are strategically located around the country to pro-

vide rapid response to emergencies with life-saving drugs and equipment. The stockpile also includes a vendor-managed inventory that can be deployed should a major health or medical event occur. DHS is now responsible for determining when and where the stockpile should be deployed. We do that in collaboration with the health care agencies.

HHS will continue to manage the contents of the stockpile with the VA's continued assistance. And I would add, this is critical assistance. And I'm convinced it's saving the government a lot of money because of the buying power of the cooperative federal agencies in actually purchasing the pharmaceuticals, drug rotation, and inventory management.

In addition, we also work with the VA on a number of other things, including routine exercises, as well as training missions. We'll continue to work with the VA in those particular areas. And one new area of interest is the Noble Training Center, which also was just transferred to the Department of Homeland Security from Health and Human Services. We'll continue to collaborate and to carve out the niche in the agencies that can provide the needs for the medical care community.

Mr. Chairman, that concludes my prepared remarks, and I'll be pleased to answer any questions you may have.

[The prepared statement of Mr. Tolbert appears on p. 59.]

Mr. BUYER. Thank you, Mr. Tolbert.

We're going to stand in recess for two minutes. Our recorder has something he has to take care of real quick, and he's going to come right back.

[Recess.]

Mr. BUYER. What I'm trying to do is to sort this out. The MEND Act was passed by Congress prior to—we've got several things happening at once. We've got the Homeland Security Department up, we've got the MEND Act going, everybody's moving out doing different things, and now we're trying to figure out—you've got a tough job, Mr. Tolbert. Because we want to figure out where we're not duplicating services, okay?

And so if you've got different departments and agencies and people doing different things. You know, we created this Department of Homeland Security so we can sort of turn to you. And then you then turn to different departments and agencies to then work out Memorandums of Understanding. Get these MOUs worked out. And that's kind of where I'm thinking we're headed on this one.

HHS testifies you're to "develop appropriate training materials and curriculum objectives for the treatment of victims of chemical and biological agents." Then I look over here for the MEND Act. "They're to support training and equipment of state and local health care professionals to deal with the growing threat of chemical, biological, radiological, and nuclear terrorism."

I mean, they have their charge. You've got your charge. And what I do recognize about private institutions, whether they be health care providers or hospitals or whatever, you make a grant available, they're going to go for the money.

So our responsibility is to the taxpayer to make sure the system is clean and effective. So I don't want us to go, "Well, we're going to have different hospitals making particular grants that are en-

dorsed by this Senator or this Member of Congress to take care of their particular hospital, and—because this is the best."

Well, wait a minute. We want to develop a system here for the country that makes sense, and the reason for this hearing is exactly to bring clarity to this.

So when Dr. Roswell testifies and says that we've been meeting, and you testify and say you've been working vigorously with other health care professionals, are you working vigorously with the VA too?

Mr. TOLBERT. We are, as a matter of fact.

Mr. BUYER. And are you headed toward, perhaps, an MOU.

Mr. TOLBERT. In fact, we have another MOU that we're working on with the VA right now on some of these issues that is in the hands of both their deputy secretary and our deputy secretary for review. Let me——

Mr. BUYER. Let me ask this question.

Mr. TOLBERT. Sure.

Mr. BUYER. Hold that thought. Has HHS worked with the Uniformed Services University of Health Science?

Mr. TOLBERT. Oh, yes. As a matter of fact, we work with them quite regularly. The cadre—what we have done with them, and what I have tried to do, is pull the expertise out of there and tried to export that.

USUHS has excellent capabilities. They have expertise in the chem, bio, and nuclear and RAD area. But the number of students they train is the student body that goes into the uniformed services.

Mr. BUYER. Have you already made contact or coordination with these medical schools across the country?

Mr. TOLBERT. Yes. We have been talking with the Association of Medical Schools, American Association of Medical Schools, American Association of Schools of Public Health.

As a matter of fact, very recently, we just funded a grant to the American Association of Schools of Public Health to help develop a uniform curricula that could go out to all the schools of public health. We are looking at doing something similar with medical schools.

Mr. BUYER. We're going to do something a little different here.

Mr. TOLBERT. Okay.

Mr. BUYER. Dr. Roswell, will you come up to this open chair and have a seat? I think this will help every one of us. Because what we have here is we've got the VA under the MEND Act with the directive to go out there and to make contact through your teaching hospitals to do the very same thing that HHS is doing. And we've got Homeland Security that's supposed to be the oversight. Okay?

Dr. Roswell, who's now part of Panel 2, were you aware of what HHS has been doing with regard to their contacts of medical schools, which would also include your teaching hospitals?

Dr. ROSWELL. Yes, we are.

Mr. BUYER. And has that been coordinated?

Dr. ROSWELL. Mr. Hauer mentioned the Federal Partners Meeting. That's been a superb way to coordinate activities.

When Mr. Bilirakis asked me what can Congress do, you know, I think were it not for that kind of communication that the Federal

Partners Meeting allows, among other types of interactions between the three departments—four, actually, because DOD is very much involved, then I would have some real reservations about our ability to effectively coordinate.

I don't think that congressional action is needed, because I think that there is, in my experience, an unprecedented spirit of cooperation, collaboration between the departments. And there truly is a concerted effort to seek a common goal of making sure that this Nation is prepared for any eventuality.

Mr. BUYER. Thank you, Doctor. Mr. Tolbert, I'm just going to do a supposition, and then solicit your comment. Would this work better that rather than we, Congress, giving this directive to the VA that you're going to do this particular act, and HHS is going to do what they're going to do because Mr. Bilirakis and others have got them doing these things, should we turn to the Homeland Security?

And you say, "Well, the VA has a nexus, but the nexus is not part of the whole. The whole is really covered by HHS to all teaching hospitals, and that maybe we should let HHS take a lead and have an MOU with the VA with regard to their nexus. And you let us know what that costs, and then we begin to fund the parcel." Is that where this is going?

Mr. TOLBERT. Mr. Chairman, I think there's already a natural evolution, because the doctrine was established—the division of responsibilities was established over 10 years ago in the Federal Response Plan. With the Department of Health and Human Services being the lead agency, it's still a collaborative effort. And there are support agencies, including the VA.

So there has been a natural division of responsibilities, and we're now evolving into a National Response Plan, which will attempt to, for the first time, combine the various—the four major federal plans that exist for contingencies into a single document.

But all of those rely upon HHS as the lead agency for the health and medical component in a disaster operation, with the support of all the other federal agencies. So they lead and guide that effort.

Mr. BUYER. All right. I'm going to yield to Ms. Hooley. But the bottom line that what we care about here, is making sure this is effective, cost effective, and that those students out there and the providers get the knowledge that they need. Okay? Timely.

Ms. Hooley?

Ms. HOOLEY. I'm just going to follow up with that. I'm going to ask a question. I've got a small community hospital. You know, it's a good hospital. They do a great job. But if they wanted to know how they deal with a disaster, and how do they respond to a disaster, or biological terrorism, or chemical terrorism, who would they call? Who would they go to?

Mr. HAUER. When it comes to responding to hospital preparedness for——

Ms. HOOLEY. Yeah. They're trying to prepare all their medical steps. Who would they call?

Mr. HAUER. There are several issues. One is hospital preparedness for any kind of multi-casualty incident; and then more specifically, hospital preparedness for recognizing and treating chemical and biological issues. All of that is on CDC's web site right now.

We have done a very aggressive outreach through the American Hospital Association.

We have been working very aggressively with the states. The first year's grant money (fiscal year 2002), *125* million for hospitals, has been sent out. And as part of the program, there was a requirement for regional planning. And within that, there was a requirement for training and exercises at the local level. So that——

Ms. HOOLEY. Has that been done now?

Mr. HAUER. It is being done.

Ms. HOOLEY. It is being done. It's completed?

Mr. HAUER. It is being done. We are sending an additional $498 million out for hospital preparedness this year. That money will go for some of the things you heard Dr. Roswell talk about: personal protective equipment, for decon equipment, and for special air handling systems within the hospital.

One of the things we're trying to emphasize—because as the Chairman said, we, too, do not want to see duplicative equipment and resources—we are trying to emphasize a regional approach. Not every hospital needs decon equipment. Not every hospital needs the same level of equipment and care. What they need to do is recognize that they've got certain kinds of patients and be able to refer them.

More importantly, we need a better pre-hospital system in this country. And we are working very aggressively on pre-hospital care, so that patients are triaged to appropriate health care settings so that they don't bring contaminated patients to a hospital that is not adequately equipped.

Ms. HOOLEY. A quick other question for you. What's been your participation with the VA and the exercise of Liberty Shield, and what did each agency do, and what were the outcomes?

Mr. HAUER. As we went through the planning process for Liberty Shield, we had numerous meetings with the VA, because one of the biggest issues we have to confront is hospital surge capacity. A lot of that surge capacity and a lot of the staffing capability is available to us through the VA.

So we worked closely. We looked at the potential number of beds that were available. In the event something were to occur, either domestically or a massive incident overseas, and we had to move people back to this country, the VA and HHS now meet on a regular basis at the very senior levels of the organization and focus on these kinds of issues regularly.

Ms. HOOLEY. In regards to the monthly Federal Partners Meetings, which includes high-level representation from the VA, what does the VA achieve from these meetings, and can you provide some examples of the outcomes, Dr. Roswell?

Dr. ROSWELL. The Federal Partners Meeting, again, from my perspective—though I've worked in Washington in the past, I've only been here this time a little over a year—it's been a wonderful opportunity for me to get to know people like Mr. Hauer and Mr. Tolbert to establish communications, to discuss activities.

One of the concerns, for example, that particularly sticks in my mind that came up at a Federal Partners Meeting had to do with how the NDMS could simultaneously be counted on to respond to

both of its missions. Because it has a DOD contingency mission, as well as a regional domestic emergency response mission.

And one of the scenarios which was actually—you know, it came up in the discussion. It was something I'd worried about. Through the Federal Partners Meeting, we actually learned that there was a tabletop exercise designed to explore that very thing. And I then followed up on that exercise and got a much better understanding of exactly how we would deal with those kind of contingencies.

But it's the opportunity to network, to develop communication channels, to explore various eventualities. Because I think the best-laid plans can't deal with every possible eventuality. And when we face those eventualities, we have to have the contacts and the personal relations.

Ms. HOOLEY. Clearly, you got something out of it. My question is were there any—can you give me an example of a specific outcome that caused you to take some action, other than just—I mean, lots of meetings we go to are really wonderful for knowledge, but did it make you do something other than——

Dr. ROSWELL. A classic example is the MOU that Mr. Hauer talked about with HHS making vaccine available to VA. Our smallpox vaccination program for VA employees was a specific action that was activated out of that type of interface.

Mr. HAUER. If I might just follow on. Two actions that came out of the meeting are: the smallpox program. We are very dependent and look to the VA in the event of an incident in this country. And now that they have people who are vaccinated and trained to be vaccinators as part of the infrastructure and can now help respond to a smallpox outbreak.

More importantly, as part of the tabletop that Dr. Roswell was alluding to, we found this issue as we were planning for Liberty Shield. The same beds were going to be called on for potentially injured soldiers that would be brought back to this country, as well as a second incident occurring here in the United States. We would have the same demands on the same beds.

So we began to look at our planning for capacity and for alternate capacity so that we were not double counting beds. We actually, as part of the partnership we've had with the VA, we're learning a lot together that historically has not been done in this country.

Mr. BUYER. Thank you, Ms. Hooley.

Mr. Bilirakis, you're now recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Mr. Secretary—Secretary Hauer—how long has your office been—well, was it just created recently as a result of the——

Mr. HAUER. Yes.

Mr. BILIRAKIS. Okay. So it's a relatively new office.

Mr. HAUER. It is new.

Mr. BILIRAKIS. You're an acting secretary, aren't you?

Mr. HAUER. Yes. My office is new. I was on board as the director of the office before the President signed the bill in July of last year.

Mr. BILIRAKIS. Well, in your testimony, you stated that CDC and Health Resources and Services, HRSA, as we call it, are developing training for public health providers. Now, once these training programs are fully developed—how far along are they, by the way?

Mr. HAUER. It depends on which one it is. We're doing a whole host of them. We're doing them for pre-hospital care providers. We're doing them for nurse practitioners. We're doing them for physicians.

Mr. BILIRAKIS. Some are completed?

Mr. HAUER. They are. Some are further along than others, yes. We have training programs for public health providers. Those are ongoing. We have terrible shortages in this country of public health providers.

Mr. BILIRAKIS. God knows I know that.

Mr. HAUER. Particularly epidemiologists. And we are working aggressively to try and engage——

Mr. BILIRAKIS. Well, let me ask someone. Once these programs are fully developed—and I would hope that as they are developed that they would be put into play rather than wait until they're all done—who determines—I guess Mr. Tolbert—who determines who should disseminate these programs, who should put them into play and whatnot? Homeland Security does that, I presume, right?

Mr. TOLBERT. Specific training programs?

Mr. BILIRAKIS. Well, they apparently are developing—"they" being HHS—developing the programs themselves. But in terms of how those programs are going to be used, who determines how they're going to be used? In other words, who disseminates that information? Who decides?

Mr. HAUER. We roll them out as soon as they're ready.

Mr. BILIRAKIS. All right. You roll them out to whom?

Mr. HAUER. If we develop a program for pre-hospital care providers. We've been working with the American Association of Emergency Physicians. We've been working with the Emergency Nurses Association. As programs are developed for specific audiences that are tailored for that community, we get them done, and we don't wait to do other programs. We roll those out immediately.

Mr. BILIRAKIS. Why, that certainly makes sense, and I'm happy to hear that. But I guess are any of those programs going to be made available to everybody? For instance, if the VA decides to use those programs?

Mr. HAUER. Absolutely. Any program that we have developed is available for everybody and anybody. We try and put it on line.

Mr. BILIRAKIS. I guess I just keep getting back to it. And Mr. Tolbert—all of you, really. Our lives have been changed tremendously since September 11th of 2001. There's no question about that. We used to—Dr. Roswell, we used to tussle on Agent Orange, and we'd just go on and on, the Persian Gulf Syndromes, and so many other things—health care, claims, et cetera, et cetera. And we still have all that, and in health care, we still have all the other problems.

But on top of that now, we have bioterrorism. So it's made our jobs that much tougher. And Mr. Tolbert, I would suggest yours is probably tougher than anybody's. So, you know, with all due respect, I raise these points on duplication of effort and coordination and things of that nature.

You're making decision s as a very important part of Director of Preparedness for Homeland Security. You're making decisions, and you're, I guess, sharing those decisions, disseminating or making

sure that information like we just talked about is disseminated to whoever it should be disseminated to. Are you getting all the cooperation that you should have from all these other departments and agencies and offices and whatnot?

Mr. TOLBERT. Yes, sir, there is tremendous cooperation. In fact, some days, I feel like we're on the speaker circuit together, because we work so closely together trying to insure that we're not duplicating the effort.

I think a critical element in the fusion, though, that's often left out is the state level partners that we all utilize. Most governors—or all governors—have established a Homeland Security advisor, which now is becoming the fusion point. Typically, that——

Mr. BILIRAKIS. That's working out well? You're getting cooperation from all those people?

Mr. TOLBERT. Exactly. And as part of the ongoing grant programs, what's actually happened—it worked very well—is that we required for any advisory committees in developing strategic plans for the utilization of our various grant programs, we even had redundancy to insure that the right players were at the table. The HHS programs required that the emergency manager or the Homeland Security advisor be a participant. And we required that the health director be a participant on the grant program.

So we've insured—we've put all the safeguards in place to insure that there's fusion at the state level. They have the opportunity to select from the menu of programs and to apply those strategically as they see fit based on——

Mr. BILIRAKIS. You haven't run into any glitches that you feel possibly that maybe—you know, the Homeland Security law was quite a package, and obviously, we probably didn't do everything right. You haven't run into any glitches in all this business that maybe could be altered if we maybe took another look at Homeland Security law?

Mr. TOLBERT. I would rely more as a former consumer of the services of federal agencies. I saw, really, very limited overlap. The training curriculum, the planning guidance, and really, the value in the VA that I as a state director viewed was that they were there as a training resource and as an exercise resource. So in Durham and Fayetteville and Asheville, they were an integral part of the training and exercises for the community. It's a community system first that responds to the event, regardless of cost.

Mr. BILIRAKIS. Well, Mr. Chairman, just curiosity. Mr. Tolbert mentioned—I think it was Mr. Tolbert—mentioned about the purchasing of drugs, the stockpiling, if you will, of drugs. Is that being—are those being purchased the way the VA purchases drugs? They are.

Mr. TOLBERT. Yes.

Mr. BILIRAKIS. They're taking advantage, then, of your system in terms of——

Dr. ROSWELL. We actually use our National Acquisition Center in Chicago to make those procurements and buy off the FSS supply schedule. So it's very efficient.

Mr. BILIRAKIS. That's great. Thank you.

Mr. HAUER. And the VA has been housing some of the drugs for the HHS, now DHS, Strategic National Stockpile for a number of

years. So that relationship has been ongoing and has been quite effective and efficient.

Mr. TOLBERT. As well as the pharmaceutical caches for the specialized medical teams for responding to a WMD event.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. That's a great question and testimony. Thank you. Mr. Boozman? Dr. Boozman?

Mr. BOOZMAN. I guess all of us have—you know, kind of in following up, I guess all of us have concern about the duplication. As Homeland Security, do you have the authority, then, to coordinate this stuff? I know you talked about cooperation.

Mr. TOLBERT. We have the authority through this contingent plan to now develop the National Response Plan. And the National Response Plan aligns and assigns the federal agencies to perform emergency missions, including the preparation for implementing those emergency missions. So that's a pretty well-defined doctrine that will not change very much in this new evolution to a National Response Plan.

On a more strategic level, the secretaries of our departments collaborate very frequently in the strategic view of what America needs—support—to achieve in this whole Homeland Security arena.

So yes, we do have a lead responsibility strategically as well as operationally for alignment and assignment for emergency and future disasters.

Mr. BOOZMAN. So the meetings are set up in a formal way, and you would be the person that initiates that, or——

Mr. TOLBERT. We rely primarily on the Federal Coordinating Committee on this health element. The health and medical element is one of 12 emergency support functions that the department has the responsibility to manage and oversee. This is one element. And we use the coordinating committee as that primary coordinating body.

Mr. HAUER. Whenever we host a meeting or they host a meeting, if we host a medical planning meeting, there is always representation from DHS at the meeting to ensure that there's a coordinated effort.

Mr. BOOZMAN. So if we saw duplication a year from now, you know, as you get this thing done, it would be the Coordinating Committee that we'd talk to? Or would you be—I guess what I'm ultimately asking is who's the guy that's responsible?

Mr. TOLBERT. We would ultimately have the responsibility to insure no duplication.

Mr. BOOZMAN. Okay. Thank you.

Mr. BUYER. I think this question is pretty important on authority. You know, we created your department, but now you're having to coordinate under a strategic plan with two agencies—or one department, one agency—that aren't under your control. Or even authority, or even direct lines of command. So I'm really pleased. I want to compliment you for having your discussions like you're doing.

Mr. TOLBERT. Mr. Buyer, if I could add to that. The Homeland Security Presidential Directive Number 5, however, does establish the Secretary of Homeland Security as being the primary federal

agent for coordinating federal response. So that further supplements the Federal Response Plan and the evolving National Response Plan in delineating roles and responsibilities. So the secretary ultimately is accountable for the alignment and assignment of emergency duties.

Mr. BUYER. I'm just tickled to death that we've got all three of you here at the table, and I also have Chairman Bilirakis here.

When HHS wanted to buy out all of the drugs and stockpile them, and you used the best price practice of the VA, who bought those?

Mr. TOLBERT. The majority of the drugs in the Strategic National Stockpile were purchased through contracts through the VA.

Mr. BUYER. Did you reimburse the VA?

Mr. TOLBERT. Yes. It's all done on a—we buy it through them. We reimburse them.

Mr. BUYER. All right. Because I remember you, Chairman, putting money in for the purchase.

Mr. BILIRAKIS. Well, are all——

Mr. BUYER. Mr. Bilirakis, I yield to you.

Mr. BILIRAKIS. Are all the costs—thank you, Mr. Chairman. Are all the costs reimbursed, Dr. Roswell?

Dr. ROSWELL. Mr. Bilirakis, all of the costs to acquire and manage the inventory of the national stockpile are fully reimbursed by HHS. There is——

Mr. BUYER. To include warehousing.

Mr. BILIRAKIS. All the handling and——

Dr. ROSWELL. But let me point out that we have additional pharmaceutical caches. In fact, over a hundred are being procured that are strictly for VA use. The idea would be that if there were a local event—for example, in Bay Pines, FL, they already have a pharmaceutical cache in place that would allow them to treat up to 2,000 patients a day for two days, which would safeguard the employees and the patients they might see until the national stockpile could be deployed to respond to an incident in that location.

So that, of course, comes out of the medical care appropriation for VA.

Mr. BILIRAKIS. Right.

Mr. HAUER. And there are certain drugs that we do not buy through the VA. There are certain antivirals that we don't buy through the VA and certain vaccines we don't buy through the VA. The new smallpox vaccine went through a direct procurement. But on a lot of the antibiotics—ciprofloxacin, doxycycline—and most recently, we have enhanced the stockpile with a larger cadre of respirators, we did that working through our partners at the VA.

Mr. BILIRAKIS. Who writes the check when these drugs are purchased?

Mr. HAUER. The VA purchases it.

Mr. BILIRAKIS. The VA writes the check?

Mr. HAUER. And we do a reimbursement.

Mr. BILIRAKIS. And you do a reimbursement.

Mr. HAUER. Yes.

Mr. BILIRAKIS. Now, they're stockpiled, they're warehoused, they're handled, everything else that goes along with it. The VA does that?

Mr. HAUER. Not all of it.

Mr. BILIRAKIS. Not all of it.

Mr. HAUER. The VA does some of it, but——

Mr. BILIRAKIS. But to the extent of what they do, are they reimbursed for that?

Mr. HAUER. Absolutely. The warehousing——

Mr. BILIRAKIS. Dr. Roswell, this is your opportunity, if you——

Dr. ROSWELL. We're very pleased with the relationship.

Mr. BILIRAKIS. All right. Thank you.

Mr. BUYER. I think I'm getting close. So our goal is the collaboration of effort and resources. And that is going to be coordinated. That's your responsibility, Mr. Tolbert.

Mr. TOLBERT. Strategically. Yes, sir.

Mr. BUYER. Strategically, as you are in your working group. Your implementation plan that you've given us, I think, will evolve, based on testimonies here today, and that Dr. Roswell and Mr. Hauer, you're going to need to coordinate as to how the two of you are going to work together to get the curriculums and what you want to the teaching hospitals. VA covers their nexus. You cover the remainder. And then the two of you will also work in cooperation on how the medical providers get their educations.

Mr. HAUER. Right.

Mr. BUYER. That's kind of where we're moving to, right? While you do this, please stay in touch with the staff of the VA, in case we have to make any changes legislatively. Let us know what your MOUs, Memorandums of Understanding, are. And please also let Mr. Bilirakis's staff on the Health Subcommittee of Commerce also know, okay?

Mr. HAUER. If I might make one comment, Mr. Chairman. I think that the one thing I would like to emphasize is some overlap in our efforts is actually going to be quite helpful. It's one thing to take a card and try and distribute it. We just did a mailing to 3.5 million health care providers on smallpox in this country. It's another thing to actually get out to the community hospitals and do the hands-on training. And I think the more channels we have to get out and do that, the more productive we're going to be.

The one caveat is there needs to be consistent training in what we're doing. We can't be doing something as far as training protocols that is different than the VA.

Mr. BUYER. Right. And you may have the responsibility by directorate from the President. But you know what? There's a private industry out there that can't wait for you.

Mr. HAUER. Right. Absolutely.

Mr. BUYER. They can't wait. Because they've got trial lawyers nipping at their heels. So they have to sort of take the lead at the local level. So you've got different states out there doing different things. You may have heard the Indiana Medical Association got their own Web site.

Mr. HAUER. Right.

Mr. BUYER. And you might have a practitioner in a particular place comes up with something. They're not calling Homeland Security first. They're probably calling their expert in infectious disease that taught them something in a medical school.

Mr. HAUER. But one of our——

Mr. BUYER. Please——

Mr. HAUER. I'm sorry.

Mr. BUYER. No. I know that sometimes the Federal Government, we all like to get in the same room. But please open yourself up. We're going to hear testimony from the American Medical Association, but include these teaching—these hospitals and——

Mr. HAUER. Absolutely. One of our challenges, is trying to engage some of the smaller community hospitals, because, they don't see the need. That—Petersburg, IN, you know, if I were to go back down to Petersburg, IN, I'm not sure that the hospital in Pike County would be as interested in this. But if I went to Evansville, I'd have no trouble getting the hospitals down there engaged. And that's been our challenge.

Mr. BUYER. Right. Mr. Hauer, all this is going to go by a state plan.

Mr. HAUER. Right. Absolutely.

Mr. BUYER. Because you've directed the governors to come up with a plan. We've funded the plan. And, you know, it prevents Members of Congress from doing stuff for a particular hospital that might be in their own back yard.

Mr. HAUER. Understood. Thank you.

Mr. BUYER. Okay. I feel good. Is everybody on the same wavelength? All right. Thank you very much. Thank you very much for your testimony. The panel is excused. Very productive.

We also have now have our third panel. Welcome, Dr. John Nelson, who is secretary-treasurer of the board of trustees for the American Medical Association; accompanied by Dr. James J. James, Director, Center for Disaster Medicine and Emergency Response, American Medical Association; and Dr. Jordan J. Cohen, President, American Association of Medical Colleges. Also testifying will be Col. Maria Morgan, Deputy Adjutant General, New Jersey National Guard.

Here also sitting at the table is Chairman Chris Smith of the full committee of the House Veterans' Affairs Committee. And he's here to introduce one of the witnesses. Mr. Chairman, you're now recognized.

Mr. SMITH. Thank you very much, Mr. Chairman. First of all, I want to thank you for holding this very important oversight hearing, and to all of our witnesses for their testimony. It's very timely. And, you know, I listened just to the tail end of the previous speaker, and Dr. Hauer talked about the importance of consistency.

The genesis of Public Law 107–287, the Medical Preparedness Act, came right out of the anthrax crisis that we had in my district in Hamilton Township. And I attended a number of those meetings, was a part of, at least in an oversight capacity, although it didn't stifle me in terms of speaking up where I thought it was appropriate.

But I was amazed, in all candor, Mr. Chairman, how frequently not only were the recommendations from CDC changing like the weather, whether it be Cipro or doxycycline, whether or not the regimen was a set number of days, who was exposed, where the dissemination points would be.

And the ultimate indignity was that the hospital, Robert Wood Johnson Medical Center, which stepped up to the plate, provided

the venue by which the doxycycline, and before that, the Cipro, was disseminated, did not get payment for an excess of half a year for outlays that they had, out of the goodness of their heart. They weren't designated by the postal authorities to do this. But, you know, we had to threaten a line item in Treasury-Postal to get the U.S. Postal Service to fork up the money and fork over the money to this hospital. Just underscored that there was a tremendous amount of chaos.

That led to this bill. We held, as you know, a series of hearings to see what was being done under the auspices of the VA to work the issue in advance in a Manhattan-type process to ensure that if it hits again, whether it be sarin, VX, nerve gas, anthrax, you name it, smallpox, that we would have a protocol and a prescribed regimen that would be followed to care for our soldiers and/or those people who might be malaffected in our communities.

I was not impressed by what was on the table and ready to go when this hit a couple of years ago in New Jersey. And, you know, hopefully, these bioterror, chemical, and radiological Centers of Excellence will at least move the ball along at least somewhat. As you know, Mr. Chairman, we were hit in the omnibus appropriations bill with a very hostile hold on Section 117, which, as I talked to various members of the Appropriations Committee, they didn't have a clue it was even in there, which begged the question how did it get there.

Thankfully, that's being lifted today, or tomorrow, when the appropriations supplemental comes up, Section 117, and its impact will be lifted so that these centers can go forward.

And I just wanted to say that as a little bit of a backdrop, Mr. Chairman, that what we do here does make a difference. And you asked the questions about overlap. Hopefully, all of that squares out as we move forward. But it seems to me that these centers will provide a very vital contribution to what is not unthinkable anymore, and that is the use of chemical, biological, or radiological weapons against our men and women in uniform.

And hopefully, none of that is manifested in Iraq. But you never know. That war continues. And we've got to get these centers up and running.

But I do have the privilege, Mr. Chairman, of introducing a very distinguished guest, Col. Maria Morgan, one of our witnesses today. And I thank you for inviting her to be here.

Col. Morgan was appointed by New Jersey Governor McGreevy as our state's deputy adjutant general on March 1, 2002. She previously served as the commander of the 108th Medical Squadron at McGuire Air Force Base in New Jersey.

Maria Morgan was born in Trenton, NJ, which I've had the honor of representing for all 23 years as a Member of Congress. She attended the College of New Jersey, where she received a degree in nursing. She also earned her master's from Central Michigan University, and a certification in community health nursing from the American Nurses' Credentialing Center in 1990.

Col. Morgan began her military career in 1980, when she was commissioned as a first lieutenant in the 108th Tactical Fighter Wing in the Air National Guard. Her responsibilities as a clinical

nurse included immunizations and infection control, and she has participated in multiple overseas deployments.

My colleagues should know that she is a frequent lecturer at both the state and national level on various health issues, such as bioterrorism, health care reform, and health care policy development. As an active member of the Military Surgeons of the U.S., Col. Morgan has made numerous presentations at MSUS on bioterrorism, immunization, standardized medical readiness training systems, and managing health care in the deployed field locations.

Last, but not least, Col. Morgan has published several articles in New Jersey medicine, primarily on anthrax and bioterrorism. I've had the opportunity to work with Col. Morgan over the last several months and last year on weapons of mass destruction preparedness issues, and I can personally vouch for her hard work, very, very fine knowledge on these issues, and extreme dedication to this issue.

And regrettably, I can't stay with you, Mr. Chairman. The President of Romania is in my office right now, so I've got to get back. But I want to thank you for having this hearing, and again, to our witnesses for their testimony.

Mr. BUYER. Thank you, Mr. Chairman. Just let the President of Romania know that we're very supportive of New Europe. (Laughter.)

Thank you, Mr. Chairman.

Well, with that, Col. Morgan, we'll let you open.

STATEMENTS OF COL. MARIA MORGAN, DEPUTY ADJUTANT GENERAL, NEW JERSEY NATIONAL GUARD; JOHN C. NELSON, M.D., SECRETARY-TREASURER OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY JAMES J. JAMES, M.D., DIRECTOR, CENTER FOR DISASTER MEDICINE AND EMERGENCY RESPONSE, AMERICAN MEDICAL ASSOCIATION; AND JORDAN J. COHEN, M.D., PRESIDENT, AMERICAN ASSOCIATION OF MEDICAL COLLEGES

STATEMENT OF COL. MARIA MORGAN

Col. MORGAN. Mr. Chairman, members of the committee, thank you for the opportunity to be here today. I'm here to testify about the New Jersey National Guard's role in disaster preparedness and response to a WMD event in New Jersey.

As you know, the National Guard has a dual mission, both state and federal. Federally, we have always responded to presidential call-ups and rotated routinely through federal taskings. In the state, the National Guard has traditionally provided military support to civil authorities for natural disasters. This support is initiated in most states when the Governor activates the National Guard. And in New Jersey, the process of deployment occurs through the State Office of Emergency Management, which is operated by the New Jersey State Police.

The role of the National Guard and state support changed dramatically on September 11, and has expanded considerably. New Jersey National Guard has multiple roles for response, in prevention preparedness response mitigation in the State of New Jersey

Emergency Operations Plan, but most importantly, in mass care security and decon.

Any assessment of whether New Jersey is thoroughly prepared to handle a future WMD incident would be incomplete without a discussion of the important role of WMD civil support teams.

The committee should be aware that, like Indiana and Oregon, New Jersey failed to obtain a federally-funded WMD civil support team, a CST-Heavy, from the Department of Defense. We did, however, field the team from our traditional light force, which we call a Civil Support Team Light. The Civil Support Team Heavy, though, has capabilities in nuclear, biological, and chemical technical expertise.

The differences between a light and a heavy team are significant. For instance, the members of a CST-Light are traditional members with full-time civilian jobs that would delay response. The light team also does not have the assets of a fully-funded, federally-designated team, including a mobile communications van, and most importantly, a mobile laboratory with on-site chemical and biological analysis capability.

In October 2001, further complicating the events of September 11, as you heard from the congressman, anthrax attacks were launched, and the hub was determined to be postal locations in New Jersey. The National Guard assisted with gathering samples for analysis at several locations. Hundreds of residents were affected, postal operations compromised, and nationwide, 23 confirmed cases of anthrax infection.

At the time, the ability to manage the anthrax cases by the state's health system and the CDC was called into question. In addition, the New Jersey State Laboratory was overwhelmed with the task of sampling. An increase in the laboratory designation for the University of Medicine and Dentistry of New Jersey as a backup lab was immediately sought so that UMDNJ could begin to assist. Since then, the New Jersey State Health Department has formed partnerships with the private sector in order to be better able to respond to the next potential event, regardless of the type. The state has continued to pursue the needed expansion of the state lab.

The VA medical care system has an important role in helping to move our Nation further down the path of medical preparedness to handle these events. For instance, the VA provides an enormous amount of medical training to our Nation's physicians and nurses, as you have heard all morning. And, in fact, a large percentage of all practicing doctors and nurses today received a portion of their training at a VA medical center. Therefore, it makes logical sense for the VA to be a key engine for disseminating standardized information on WMD treatment protocols and standards of care.

For these reasons, I believe it is important for Congress and the administration to rapidly implement Public Law 107–287, authored by Chairman Smith and enacted by this committee last year, which calls for the creation of at least four medical emergency preparedness centers within the Department of Veterans Affairs, medical centers to research and develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of weapons of mass destruction; to provide edu-

cation, training, and advice to health care professionals; and provide laboratory, epidemiological, medical, and other appropriate assistance to federal, state, and local health care agencies and personnel involved in or responding to a disaster or emergency.

An additional need for preparedness in education has been identified at our 85 licensed acute care hospitals in New Jersey. And an additional issue for all hospitals nationwide in analyzing their capacity should be the nursing shortage issue. It is our feeling that the more we do to augment our resources and improve our processes such as with the VA Program, positive outcomes will result. Maximizing our resources also includes obtaining a CST-Heavy.

New Jersey's alert level remains at orange with the rest of the country. But our continuing security missions on our northern borders, we again requested a WMD Civil Support Team to be stationed in New Jersey, pre-positioned for ready response mirroring that of New York State.

The New York National Guard CST-Heavy has been forward deployed in anticipation of a WMD attack. We made that request in the last couple of weeks. It was again denied, as was the request for a team in 2001.

Thank you again for this opportunity. That concludes my presentation, or my testimony, and I'd be happy to answer any questions.

Also, Chairman Buyer, I bring regards from our adjutant general in New Jersey, Brig. Gen, Glen Reith, who I believe was a classmate of yours.

[The prepared statement of Colonel Morgan appears on p. 65.]

STATEMENT OF JOHN C. NELSON

Dr. NELSON. Thank you, Mr. Chairman. I am John C. Nelson, M.D. I am the Secretary-Treasurer of the Board of Trustees of the American Medical Association, but more importantly, a practicing obstetrician and gynecologist in Salt Lake City, UT, having obtained part of my training in Portland, OR. I also am a proud veteran of Vietnam conflict, sir. I appreciate being here today.

Obviously, after 9/11, a lot of things changed, and now we have a new potential terror on the home front—casualties in the emergency room resulting from weapons of mass destruction, in addition to the regular catastrophic events.

Just like President Bush's determination to bring terrorists to justice, medicine's effort now to insure that physicians are prepared to respond to disasters must be multi-faceted, broad-based, and implemented with the long-term approach in mind. The American Medical Association is prepared to meet this challenge. However, we cannot do it alone. We need the support of Congress and the Federal Government, as well as other private organizations. The last panel certainly drew attention to that.

Our testimony today, folks, is on three key issues. First, is the medical community better prepared to respond to casualties resulting from unconventional weapons or catastrophic events today? Second, where are the current gaps and what remains to be done? And finally, what can the AMA—how can we collaborate with the DVA to further educate and prepare the medical community?

First, is the medical community prepared to respond to mass casualties from disasters? Yes. Firmly, yes. Today, physicians are far

better informed about the clinical aspects of bioterrorism and other attacks, as well as where to get such information. The AMA and the CDC Web sites attest to this.

Fortunately, the AMA was at the forefront of identifying disaster preparedness as a priority many years before 9/11.

For example, our Council on Scientific Affairs devoted at least five reports and countless activities on how physicians can be more involved and better prepared. After the tragedy of 9/11, the AMA contacted federal agencies such as HHS and CDC to offer our assistance.

AMA and CDC co-sponsored weekly video telecasts on bioterrorism. We also developed a comprehensive Web site on terrorism and disaster response and prepared and distributed educational materials. And you should have received this CD-ROM, which is excellent—I recommend it to you—and some other pamphlets which you have seen. These activities are ongoing. We also have been closely involved in the development and the implementation of the administration's smallpox vaccination program.

We're proud to say the AMA has established a Center for Disaster Preparedness and Emergency Response, and I'm very pleased that the director of this new center, former Army General Dr. James James, is here with me today. Dr. James is developing a comprehensive medical and public health program to respond to bioterrorism and other disasters.

The center is working with several prominent universities to develop courses and training materials for health professionals and the responder community. One such course, the Basic Disaster Life Support, is almost ready for publication, and will be available for all physicians, perhaps on the Web.

But where are the gaps in our preparedness? The public health infrastructure is still weaker than it should be. Practicing physicians in the public health community need to work together more effectively. We had a saying in Washington years ago, "The buck stops here." Well, now it's "The bug." It doesn't stop there. It stops here, inside our chest. And unfortunately, those bugs do not know bureaucratic lines, and state lines, and jurisdictions.

We have got to find a way simply to work together publicly, privately, and in every single way. Therefore, the next step is to prepare a physician work force that has the practical skills to respond competently to disasters and participate in their local networks. The disaster scene is not a suitable classroom. This gives a great opportunity to work with the DVA and other federal agencies. We need a strong public-private collaboration, obviously.

Our role as a convener at the AMA suggests that we must do four things. First, we need an evidence-based medical curriculum; second, informational resources on disaster medicine and the medical response to terrorism; third, we need model community medical response plans, with testing and evaluation of those plans, not just something on the shelf; and finally, physician efforts in support of community health and safety, disease reporting and communication.

Our national defense medical system also must be strengthened. Many practicing physicians are part of this system, affiliated, for instance, with a hospital that's directly connected to a DVA or a

DOD facility. The DVA and DOD facility may, in fact, be the organizing entity in their region. These are natural alliances for medical education and should be fostered. These facilities could also play a critical role in providing surge capacity, which must include not only beds, but personnel, laboratories, and the like.

And we have got, Mr. Chairman, to get this to the local level, the most local of all levels, the private practitioner's office, where the patients will often come, not necessarily to a VA or other hospital.

We thank you for the opportunity of testifying today, and we'd be happy to answer questions at the appropriate time.

[The prepared statement of Dr. Nelson appears on p. 69.]

STATEMENT OF JORDAN J. COHEN

Dr. COHEN. Thank you, Mr. Chairman, members of the subcommittee, for inviting me—it says here "this morning"—this afternoon to be with you.

I'm Jordan Cohen, President of the Association of American Medical Colleges. AAMC represents the Nation's 126 medical schools, some 400 major teaching hospitals, and health systems.

Mr. BUYER. Dr. Cohen, can you pause a second?

Dr. COHEN. Sure.

Mr. BUYER. We have three votes. So that would be a 15 and two fives. So I'll ask my colleagues what you want to do. We can go ahead and take his testimony and submit questions to them. Or we can say, "Hey, go to lunch," and I'll come back.

Ms. HOOLEY. I would prefer just to submit questions.

Mr. BUYER. Submit questions? All right. Dr. Cohen? Go ahead, Dr. Cohen.

Dr. COHEN. As I said, the 400 major teaching hospitals in our association include over 70 VA medical centers. We also represent 92 academic and scientific societies, which represent nearly 100,000 medical school faculty. And we also represent the medical students and residents.

When I came before the subcommittee in November 2001, I testified primarily about plans for the association's First Contact, First Response Initiative. I'd like to take the opportunity today to update the committee on that initiative and what I think are really quite great strides that the medical education community has made over the past 18 months in improving the level of training and knowledge of medical students, residents, and physicians to prepare them for possible biological, chemical, and radiological threats.

Shortly after I testified November of 2001, the AAMC did convene a meeting of representatives of medical specialty, medical education, nursing, public health, and scientific organizations, including the VA, to help us identify and develop educational and informational resources to aid physicians and residents who are likely to be the first to encounter victims of chemical or biological or radiological attacks.

Designated the First Contact, First Response Initiative, the meeting provided an opportunity to discuss the development of educational resources to assure that residents and practicing physicians learn the essentials of the medical conditions that may be caused by terrorist activities. At the meeting, the specialists, societies, and organizations affirmed their commitment to developing

and maintaining ways to distribute, especially by the Web, educational material for use by all interested parties. Centers for Disease Control and Prevention also agreed to assist by providing the educational materials that they were developing, about which you heard earlier.

Since that initial meeting, the AAMC has monitored the development of new resources and provided this information to our constituents as appropriate.

In my earlier statement, I also mentioned our plan to convene a panel of experts to provide guidance to medical schools on the relevant content that should be included in the medical school curriculum. This is an educational model that the association has used with great success in the past on issues such as population, health, and medical informatics.

The group we convened included experts in medical education, as well as in preparedness for weapons of mass destruction. We had representatives from schools of medicine, nursing, public health, the CDC, the Uniformed Services University of the Health Sciences, and the group was asked to respond to two questions. What should medical students learn about bioterrorism; i.e., what are the appropriate learning objectives? And what kind of educational experiences would allow students to achieve those learning objectives?

The panel reached the general consensus that responses to bioterrorism events should be considered in the context of any threat—biological, chemical, physical, or radiological—that may result in mass casualties. The experts agreed that it would not be productive to have medical students memorize the characteristics of all potential agents, but rather, that education should focus on general concepts, such as classes of agents and the various mechanisms of injury.

Importantly, the panel noted that future physicians should understand the appropriate roles and responsibilities they will play during a WMD event, how to coordinate with the public health system in particular. The group identified approximately 30 discreet learning objectives in which medical students should be able to demonstrate knowledge and skills. Those objectives were divided into five broad categories: basic sciences; clinical sciences; public health system interventions; public health roles and responsibilities; and finally, professional ethics.

The panelists agreed that these objectives should be integrated across all four years of the medical school through a combination of didactic and experiential learning exercises. Several strategies were outlined to achieve these objectives, including standardized patients, disaster drills, on-line study modules, and additional elective opportunities.

Mr. BUYER. Dr. Cohen?

Dr. COHEN. Yes.

Mr. BUYER. Thank you.

Dr. COHEN. You're quite welcome.

Mr. BUYER. I have two minutes to sprint to the Capitol. I'm not 19 anymore.

Dr. COHEN. You can make it.

[The prepared statement of Dr. Cohen appears on p. 81.]

Mr. BUYER. I want to thank you for coming. I want you to knock on that door of those meetings that they're having and get in. If you're not getting in, let me know. Mr. Bilirakis and I should get you in and get you involved, so we don't have this duplicative effort.

You're on the front line. You've got the liability; they don't. And, you know, you've gone out, and you've gotten a 26-year veteran here, Gen. James. Who's funding that center?

Dr. NELSON. The American Medical Association.

Mr. BUYER. Yeah. See, I don't know. We need to think here and streamline. But I recognize that you're on the front line, and you can't wait for the government. You've got to move forward. And I saw in your testimony, you've got the 23 medical schools.

But let's just make sure that what the Federal Government is doing with regard to curricula is in agreement with what you also believe as medical experts in the field.

So if you can't gain that access, you let me know. But please make that effort to gain that access to those meetings so we can collaborate.

Dr. NELSON. We need to get rid of all the barriers.

Mr. BUYER. That's where we are. Let's be seamless.

Dr. COHEN. Right.

Mr. BUYER. Agreement?

Dr. COHEN. Thank you very much.

Dr. NELSON. Thank you.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

APPENDIX

Statement of
The Honorable Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
on
VA's Progress in Developing a Medical Education and Training Program on the Medical Responses to the Consequences of Terrorist Activity

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April 10, 2003

Mr. Chairman, I am pleased to be here to testify before the Subcommittee on the progress in the development of the medical education and training program mandated by section 3 of Public Law 107-287, the Department of Veterans Affairs Emergency Preparedness Act of 2002. With me today is Dr. Susan Mather, VA's Chief Officer for Public Health and Environmental Hazards.

Implementation of section 3 of Public Law 107-287 has progressed more slowly than had been anticipated, due in large part to the uncertainty concerning language in VA's FY 2003 appropriations bill. Section 117 of H.R. 5605, as passed by the House, included language that would have prohibited the use of FY 2003 appropriations for implementation of all provisions of H.R. 3253, which was subsequently signed into law as Public Law 107-287. However, the final language enacted on February 20, 2003, prohibited the use of funds provided for FY 2003 for implementation of only sections 2 and 5 of Public Law 107-287. Accordingly, VA is now actively pursuing implementation of section 3, as well as the other, "non-prohibited" provisions.

Section 3 requires VA to carry out a program to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. That section further requires these programs to be modeled after programs established at DoD's Uniformed Services University of the Health Sciences (USUHS). At a minimum, these programs shall include emergency preparedness training for health care professionals. They must also include, among other things, (1) training in the recognition of chemical, biological, radiological, incendiary, or other explosive agents, weapons, or devices that may be used in terrorist activities; and (2) identification of potential symptoms related to use of those agents, weapons, or devices. The training would also be required to address short-term and long-term health consequences, including psychological effects that may result from exposure to such agents and the appropriate treatment of those health consequences. The programs must be designed for a wide range of VA health care professionals in a variety of fields.

While the primary mission of the Veterans Health Administration (VHA) is to provide health care to our nation's veterans, it also has a mission to provide education and training for health care professionals. VHA conducts the largest coordinated education and training effort for health care professionals in the nation. In this regard, VHA has affiliations with 107 medical schools and over 1,200 educational institutions. In FY 2002, over 76,000 students received clinical training in VA facilities. VHA provides educational services that are customer-based, accessible, performance measured, cost-effective and lead to the accomplishment of VA's organizational goals and objectives – providing high-quality health care and services to our nation's veterans.

Mr. Chairman, VA has committed to preparing its field administrators and health care providers to effectively respond and manage the challenges of terrorism, and we have made great strides to prepare VA employees for terrorism and emergency related crises. We have provided several educational and training opportunities to educate employees in the event of another terrorist attack. We have developed satellite broadcasts covering biological and chemical

warfare issues and other educational tools and programs for those who may be charged to render care for victims of terrorist incidents. We have collaborated with the Department of Defense on several joint educational initiatives. We also have the capability, through our education infrastructure, to share the programs that we produce with others. A listing of national initiatives that have been made available to VA employees is included on the Attachment to this statement.

As the Congress has recognized, it is critical that education and training programs be designed for a wide range of health care professionals. To that end, the involvement of education and training experts and representatives of health care professions at all levels is essential in developing a comprehensive education response. We have already had preliminary meetings with representatives from USUHS to explore collaborative endeavors. VA has also developed an implementation plan, which we recently sent to the Subcommittee, and we will be meeting with USUHS representatives again to discuss the development of educational tools, materials, and programs that would be mutually beneficial to both parties. We further intend to assemble a committee of experts to develop a plan to address priority educational needs through the use of multiple modalities consistent with section 3 of Public Law 107-287.

Mr. Chairman, this concludes my statement. Dr. Mather and I will be happy to respond to any questions that you or other members of the Subcommittee might have.

Attachment

The following highlights a few of the programs and initiatives VA has developed since September 11, 2001, to provide emergency and terrorist related training to employees:

1) VA's Employee Education Service (EES) sponsored or co-sponsored 195 hours of instruction on biological, chemical and radiological agents that have a high probability of being used as weapons of mass destruction. One hundred ninety-two hours of this instruction was targeted to clinical staff and three hours to administrative.

2) Eighty-five hours of instruction addressing response to use of Weapons of Mass Destruction (WMD) has been provided to an estimated 10,000 staff using distance-learning technology.

3) One hundred-ten hours of training have been provided to approximately 4,400 staff in face-to-face training sessions. This includes two WMD conferences conducted in VISN 8 co-sponsored by the University of South Florida Division of Continuing Education in 2002 and 2003 with participants from federal, state, local and international groups. This also includes participants in two National Disaster Medical System National Conferences involving VA, DoD, FEMA and HHS staff.

4) Eleven satellite broadcasts on chemical and biological agents have been provided. Three of these utilized programming developed in whole or in part by the Department of Defense (DOD). These programs are rebroadcast at different times of the day so that all employees have the opportunity to view them. These programs are also taped and re-used in locally developed training programs. An additional three broadcasts, scheduled for May, July and August, are being jointly developed by EES, the Department of Army Medical Research Institute of Infectious Diseases, and the VA Emergency Management Strategic Healthcare Group.

5) An inaugural VA Decontamination Training Course was held March 10-14, 2003 in Reno, Nevada. This weeklong session offered three days of basic emergency hospital decontamination operations, and two days of a train-the-trainer program that gives trainees important skills to take back to their facility. Twenty-four staff from six VA medical centers completed the course. Subsequent training courses will be held at the Little Rock, AK, and Bay Pines, FL, VA medical centers.

6) Last week, VA broadcast two satellite programs designed to address management of possible casualties of the current war with Iraq. In addition, web-based materials will be made available to VA clinicians addressing both the physical and mental health aspects of war injuries. Issues of biological attacks will be included, since the skills required to treat these types of injuries in combat casualties are, in most cases, identical to those needed to respond to a terrorist attack.

7) A number of products, web courses and training are in the VA Learning Catalog or currently under development. This training resource is available to all VA facilities and VA employees in all locations.

8) VHA has developed laminated pocket cards to assist providers in managing patients with diseases possibly related to biological, chemical and radiological exposure in the context of terrorism. The cards give providers proper information for better treatment of patients who have been exposed to these agents. These are now available through the facility education contact and on the web. Sixty thousand cards were produced at the first production and the requests for them have exceeded our supply. Another order has been placed for immediate delivery to supplement the first one bringing the total of new requests to over 83,000. These pocket cards have reached not only a VA audience, but DOD, other federal agencies as well as states and local agencies involved in the response to WMD

9) Last year EES began the development of continuing medical education programs which focus on the unique needs of those enlisted men and

women who have served in areas of high risk (Veterans Health Initiative). Currently there are 10 of these modules all of which also relate to caring for those who may be affected by weapons of mass destruction. To keep abreast of current events in the Middle East, new VHI programs are under development which address Traumatic Brain Injury, and Post Deployment Health Care: Biologic Warfare Agents. Other programs will be developed as topics emerge from the battlefront and further potential uses of weapons of mass destruction are identified.

Testimony
Before the Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
United States House of Representatives

Weapons of Mass Destruction: Is Our Nation's Medical Community Ready?

Statement of

Jerome M. Hauer, M.H.S.

Acting Assistant Secretary for Public Health Emergency Preparedness
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 am
on Thursday, April 10, 2003

Thank you, Mr. Chairman and members of the committee for the opportunity to be here today to comment on the Department of Veterans' Affairs program to develop medical education and training for consequences of terrorist activities.

My name is Jerome Hauer. I am the Acting Assistant Secretary for Public Health Emergency Preparedness within the Department of Health and Human Services. The Office that I lead is responsible for coordinating and directing the emergency preparedness and response efforts of the HHS agencies, including the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH), in the case of a public health emergency. My office also works closely with CDC and HRSA to ensure the effective implementation of the state and local public health and hospital preparedness cooperative agreement programs and HRSA's new continuing education/training and curriculum development program for bioterrorism and other public health emergencies.

As you can see, aspects of the mission of the Department of Health and Human Services are closely aligned with the VA's healthcare mission. As a result of this and as a result of deliberate efforts by members of both Departments to maintain open lines of communication, HHS continues to benefit significantly from a strong working relationship with VA. One example of our collaboration is VA's support of HHS's Emergency Support Function 8 activities during disasters, through the contribution of

both human and material resources. VA's assistance has also been invaluable to the creation and ongoing maintenance of the Strategic National Stockpile.

Our two Departments have continued to build a relationship through a variety of other initiatives as well. On a monthly basis, we meet together for the Federal Partners Meeting which includes high level representation from VA, the Department of Defense, and the Federal Emergency Management Agency. Our goal is to ensure continued coordination, throughout the Federal government, of health-focused terrorism preparedness initiatives throughout the federal government. We also participate with VA and other Federal agencies in joint activities such as Liberty Shield, a Department of Homeland Security initiative that has increased our preparedness for terrorism during the conflict in Iraq. HHS and VA continue to coordinate the monitoring of human health in the U.S. as part of this effort.

VA should be recognized for its long-standing commitment to the provision of expert hospital and outpatient care for veterans. I would like to take this opportunity to highlight the role of VA as a critical resource for the education of our nation's health care professionals. It is in this capacity that I see a great deal of potential in terms of ensuring that our physicians, nurses, paramedics and other health providers are prepared to meet the challenges of caring for victims of a biological or chemical attack.

HHS has been working vigorously with health professional schools and associations to develop appropriate training materials and curriculum objectives for the treatment of victims of chemical and biological agents. The CDC and HRSA cooperative agreement programs have portions that focus on education and training for

public health and hospital-based providers, and HRSA will competitively award $28 million in FY2003 to academic health centers and other health professions training entities for bioterrorism preparedness education and training. As HHS works to establish these programs, it is essential to identify opportunities for collaboration and coordination with other partners. VA maintains a concentration of expertise in the treatment of biological and chemical agent casualties and is therefore a considerable resource for supporting specialized education in this field. Furthermore, as training sites for the majority of health professions schools, VA facilities play a prominent role in the earliest stages of medical training. Building on our existing relationship, HHS and VA can work together to further the integration of high-quality terrorism preparedness training into the education of our nation's health care providers.

VA's contributions to terrorism preparedness do not end with the establishment of robust training and education programs. It is also important to recognize that in the case of a biological or chemical terrorism attack, or other sizable emergency, VA has served, and will continue to serve as a *community* resource, for both veterans and, when necessary for non-veterans. As I alluded to earlier, HHS views VA resources broadly during an emergency, and VA has reliably responded to our requests for assistance. HHS's continued partnership with VA will benefit our states and communities by strengthening the skills of our front line health care providers and by expanding the depth of resources that can be called upon to respond to an emergency.

At this time, I would be happy to answer any questions you may have.

STATEMENT OF

ERIC TOLBERT

DIRECTOR, RESPONSE DIVISION
EMERGENCY PREPAREDNESS AND RESPONSE DIRECTORATE
DEPARTMENT OF HOMELAND SECURITY

BEFORE THE

OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 10, 2003

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the Department of Homeland Security (DHS) disaster response activities, including our close working relationship with the Department of Veterans Affairs (VA). My name is Eric Tolbert, and I am the Director of the Response Division of the Emergency Preparedness and Response Directorate of DHS.

Two vital health and medical response programs were transferred from the Department of Health and Human Services (HHS) into the Department of Homeland Security (DHS)– the Office of Emergency Response, including the National Disaster Medical System, and the Strategic National Stockpile.

The Department of Homeland Security manages the National Disaster Medical System (NDMS) and coordinates much of the federal health, medical, and mental health response to major emergencies, federally declared disasters and terrorist incidents. DHS also is responsible for the federal health and medical response to domestic terrorist incidents involving weapons of mass destruction (WMD).

National Disaster Medical System

Started in 1984, NDMS is now a partnership between DHS and the Departments of Defense, Veterans Affairs and Health and Human Services, state and local governments, and the private sector. The System includes three major components: direct medical care, patient evacuation and the non-federal hospital bed system. NDMS was created as a nationwide medical response system to:

- Supplement state and local medical resources during disasters and emergencies;
- Evacuate patients to designated locations throughout the United States for casualties that cannot be managed locally; and
- Support the military and VA health care systems during an overseas conventional conflict.

NDMS comprises over 8,000 private sector medical and support personnel organized into approximately 90 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, National Medical Response Teams for WMD response, Veterinary Medical Assistance Teams, Mental Health Teams, International Medical/Surgical Response Teams, and other specialty teams across the nation. These volunteers leave their private sector jobs and become federal employees when called to service.

NDMS meets the national need for the medical component of the National Response Plan, including medical care, in-hospital care, patient evacuation, mental health assistance, victim identification and mortuary services. NDMS is also a partner in the military contingency program, and can be activated directly by the Assistant Secretary of Defense for Health Affairs. In the event of a military conflict that overwhelms the DOD and VA health care systems, NDMS will be available to provide medical care and hospital beds in over 2,000 private (non-federal) hospitals across the U.S.

Federal Coordinating Centers

VA and DOD work closely with our office, by maintaining a system of sixty-two Federal Coordinating Centers (FCCs). These facilities, located in major metropolitan areas, manage the day-to-day planning and operations in one or more assigned geographic NDMS Patient Reception Areas. The FCC's are responsible for the management of patient evacuation for those who cannot be cared for in a disaster area.

FCC's maintain a nationwide network of voluntary, pre-identified, non-federal acute care hospitals to provide definitive care for the victims of domestic disasters or a military contingency that exceeds the medical care capability of the affected local, state, or Federal medical system.

NDMS Activities and Operations

After a natural disaster or terrorist event, NDMS, through its Disaster Medical Assistance Teams (DMATs) provides medical care in austere conditions, including pre-hospital, ambulatory and in-patient care, medical transportation, patient evacuation, and other medical duties as required. Fully operational DMATs, which must be self-sustaining for up to 72 hours, deploy with standardized equipment, pharmaceuticals and supplies in a disaster area. The International Medical/Surgical Response Team (IMSURT) can rapidly deploy to sites overseas to provide on scene surgical as well as medical care in support of Department of State missions.

In 1996, the DHHS Office of Emergency Response (OER) was charged with assisting the National Transportation Safety Board (NTSB) in the aftermath of airline and other transportation disasters. Other assistance includes providing Disaster Mortuary Operational Response Teams (DMORTs) to work with local medical examiners in the identification of victims, provision of mortuary services, and assistance to the families of the victims. 10 DMORTs are located throughout the U.S and an additional DMORT was created to be able to deal with contaminated victims of a WMD event. The teams have deployed with NTSB a number of times, and have also assisted individual states and localities, most recently in Rhode Island after the nightclub fire.

National Security and WMD Activities

Beginning with the 1996 Summer Olympic Games, OER has participated in a number of national special security events that have the potential for a terrorist attack. The National Medical Response Teams (NMRTs) have deployed with the FBI, DOD, Secret Service, U.S. Capitol Police and other law enforcement groups to Presidential State of the Union Addresses, Republican and Democratic national conventions, Presidential inauguration events, world summits, and other high profile events. Three of the four NMRTs were created from DMATs that were given additional training and provided specialized personal protective and other specialized equipment, appropriate pharmaceuticals, and mass decontamination capability to deploy to areas where a terrorist

event has occurred and be able to immediately begin to decontaminate and treat victims. A fourth NMRT is permanently stationed in the Washington, DC metropolitan area. VA is an active partner in this effort, by maintaining the NMRT pharmaceutical caches and ensuring that they are ready to deploy at a moment's notice.

Strategic National Stockpile

Begun in 1999, the Stockpile includes pharmaceuticals, antidotes, antibiotics and other medical supplies to treat victims of a biological or chemical attack. The stockpile is composed of 12 "push packages" of pharmaceuticals, medical supplies and equipment strategically located around the country to provide rapid response to emergencies with life-saving drugs and equipment. The stockpile also includes a "vendor managed inventory" that can be deployed, should a major biological event occur. DHS is now responsible for determining when and where the stockpile should be deployed. HHS will continue to manage the contents of the stockpile, with VA's continued assistance in pharmaceutical purchases, drug rotation and inventory management.

VA Partnerships

As I've mentioned, VA is an active partner in all NDMS activities, through NDMS management activities, deployment to disaster areas of medical, management and support staff, assistance in OER's operational center, and active management of NDMS' Federal Coordinating Centers. Together, we conduct training exercises, as well as organize and manage an annual NDMS training conference.

Since 1997, VA has provided invaluable expertise and service in managing and maintaining the WMD pharmaceutical caches. Based on DHS' threat based assessments, VA purchases the pharmaceuticals and medical supplies, maintains an active inventory, provides climate controlled space, rotates and replaces stock as required, and deploys the inventory when called upon by DHS.

We hope that we will also be active partners in the development of the education

and training programs on the medical responses to the consequences of terrorist activities. One of the HHS programs that transferred to DHS was the Noble Training Center (NTC) located in Anniston, Alabama. NTC was the base hospital at Fort McClellan that was transferred by Congress to HHS for use as a WMD medical training facility. DHS will work with VA at NTC to establish a coordinated medical training approach to train medical staff in a hospital setting.

Conclusion

The mission of the Emergency Preparedness and Response Directorate is very clear – helping people in need, be it a response to a natural disaster, terrorist event, or any other catastrophic event. DHS looks forward to a continuing strong working relationship with VA, and all of our federal agency partners.

Mr. Chairman, that concludes my prepared remarks. I will be pleased to answer any questions you may have.

TESTIMONY BY MARIA MORGAN, COL., NEW JERSEY DEPARTMENT OF MILITARY AND VETERANS AFFAIRS BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS, COMMITTEE ON VETERANS AFFAIRS

Mr. Chairman, Members of the Committee.

I am Col. Maria Morgan, Deputy Adjutant General for the New Jersey Department of Military and Veterans Affairs and the New Jersey National Guard (NJNG). I am here today to testify about the New Jersey National Guard's role in disaster preparedness and response to a Weapons of Mass Destruction (WMD) event in New Jersey. As you know the National Guard has a dual mission both State and Federal. Federally, we have always responded to Presidential call ups and rotated routinely through federal taskings such as Air Expeditionary Force (AEF) rotations, contingency operations (such as Northern Watch, Southern Watch and Allied Force) as well as NATO peacekeeping missions such as Stabilization Force (SFOR) in Bosnia and KFOR in Kosovo.

In the State, the NG has traditionally provided military support to civil authorities (MSCA) for natural disasters such as hurricanes/floods, blizzards, etc. This support is initiated when the Governor activates the NG and the process of deployment occurs through the State Office of Emergency Management operated by the New Jersey State Police. New Jersey has taken a number of dramatic steps in counterterrorism efforts and prevention through the hardening of assets/critical infrastructure by working with the public sector. This process has been managed by the NJ Domestic Security Preparedness Task Force where the NG is an active member. The role of the NG in State support changed dramatically on 9/11 and has expanded considerably. Key to managing WMD events is:

- Prevention
- Preparedness
- Response
- Mitigation

The New Jersey National Guard has a role in the following capabilities for response as identified in the State of New Jersey Emergency Operations Plan 2002:

- Communication
- Transportation
- Public Works & Engineering
- Recovery Plans
- Mass Care
- Support Services
- Health and Emergency Medical Services
- Law Enforcement (Security)
- Hazardous Materials (Decon)

Any assessment of whether New Jersey is thoroughly prepared to handle a future WMD incident would be incomplete without a discussion of the important role of WMD Civil Support Teams (CST). The Committee should be aware that like Indiana and Oregon, New Jersey failed to obtain a federally funded WMD Civil Support Team (CST)-Heavy from the Department of Defense.

A team was fielded from the traditional force (CST-Light). The mission of the WMD CST-Heavy is to be an enabling force for the incident commander providing succinct military support in response to a weapons of mass destruction emergency. The CSTs are envisioned to be employed on short notice to assist local and state governments in protecting public health and safety, restoring essential government services, and providing emergency relief to governments, businesses, and individuals affected by the consequences of terrorism.

The CST-Heavy team has capabilities in: nuclear, biological, and chemical technical expertise in the areas of early detection, sample collection, NBC reconnaissance, ***initial medical assessment***, initial assessment of security requirements and force protection, initial resource and logistics requirements and coordination of transportation or air movement.

The differences between a Light and a Heavy team are significant. For instance, the members of the CST-Light are traditional members with fulltime civilian jobs that would delay response. The light team also does not have the assets of a fully funded federally designated team including the mobile communications van and, most importantly, a ***mobile laboratory with onsite chemical and biological analysis*** (PCR-polymerase chain reaction for DNA identification) capability.

Eighteen months ago, on September 11, 2001, the NJ NG responded with direct assistance to New York City with aviation and ground assets. That mission continued over many months. The NJ Air National Guard provided combat air patrols with the F-16s at its 177th Fighter Wing refueled by the tankers of its 108th Air Refueling Wing.

The NJ Army National Guard provided security for the bridges and tunnels, the airports across NJ and at our two nuclear plants. The mission at the nuclear power plants continues today uninterrupted. Although we terminated the missions at the airports and NYC crossings late last spring, those missions were re-initiated on March 19th when the federal homeland security alert system (HSAS) raised the national alert level to orange in anticipation of the current operations in Iraq. All of our missions are continuing without incident thus far. Today we have over 1500 soldiers and airmen mobilized in either federal or state active duty status and we will be increasing that number to almost 2,000 as mobilizations continue. Our members are in NJ, five other states, and at least six countries including the CENTCOM theater of operations.

In October 2001, further complicating the events of 9/11, anthrax attacks were launched and a hub was determined to be postal locations in New Jersey. The NG assisted with gathering samples for analysis at several locations. Hundreds of residents were affected,

postal operations were compromised, and nationwide there were 23 confirmed cases of anthrax infection (11 inhalational; 12 cutaneous) resulted in 5 deaths--all inhalational. This case of bioterrorism remains unsolved today. At the time, the ability to manage the anthrax cases by the State's health system and the CDC was called into question. In addition, the NJ State Laboratory was overwhelmed with the task of sampling. An increase in the laboratory designation for the University of Medicine and Dentistry of New Jersey (UMDNJ) as a backup lab was immediately sought so that UMDNJ could begin to assist. Since then, the NJ State Health Department has formed partnerships with the private sector in order to be better able to respond to the next potential event, regardless of type. The State has continued to pursue the needed expansion of the State Lab.

There are numerous sources of subject matter experts in the field of bioterrorism: USAMRIID, Sandia Labs, CDC, Johns Hopkins Center for Civilian BioDefense. USAMRIID has the premier data on research they have conducted for over 50 years into the use and defense against a variety of agents. They produce two worthy documents: the Medical Management of Biological Casualties and the Medical Management of Chemical Casualties.

However, the distribution of material and education to the medical, nursing, and general healthcare provider communities remains one of the large gaps in the ability to prevent, prepare, and respond to another WMD event. The education of the entire healthcare provider community has been undertaken by the State Health Department with the assistance of federal grants and the Medical Society of NJ coupled with the Academy of Medicine of NJ. Consistent material and a general consensus of opinion on medical management has been identified as lacking. Certainly the results nationally on the President's smallpox program are indicative that more education of the provider community is needed.

The VA medical care system has an important role in helping to move our nation further down the path of medical preparedness to handle WMD incidents. For instance, the Veterans Health Administration (VHA) provides an enormous amount of medical training to our nation's physicians and nurses, and in fact a large percentage of all practicing doctors and nurses today received a portion of their training at a VA medical center. Therefore, it makes a lot of sense for the VA to be a key engine for disseminating standardized information on WMD treatment protocols and standards of care.

For these reasons, I believe it is important for Congress and the Administration to rapidly implement Public Law 107-287, authored by Chairman Smith and enacted by this Committee last year, which calls for the creation of at least four medical emergency preparedness centers within Department of Veterans Affairs medical centers to: (1) research and develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases, and illnesses arising from the use of chemical, biological, radiological, or incendiary or other explosive weapons or devices posing threats to the public health and safety; (2) provide education, training, and advice to health-care professionals; and (3) provide laboratory, epidemiological, medical, and other appropriate assistance to

Federal, State, and local health care agencies and personnel involved in or responding to a disaster or emergency.

An additional need for preparedness and education has been identified at the 85 licensed acute care hospitals in New Jersey. The hospitals have been working hard with the State Department of Health and the New Jersey Hospital Association to upgrade their capabilities relative to treating mass casualties from a WMD event. But they are in various, mostly beginning, stages of development regarding education of providers and staff as well as adding enhanced capability such as decontamination. And an additional issue for all hospitals nationwide is their capacity particularly with respect to the nursing shortage. It is our feeling that the more we do to augment our resources and improve our processes such as with the VA Program, positive outcomes will result. Maximizing our resources also includes obtaining a CST-Heavy.

New Jersey's alert level remains at orange and with our continuing security missions, we again requested a WMD CST to be stationed in New Jersey—prepositioned for ready response. Our rationale was based on the fact that New Jersey's current enhanced security posture is closely coordinated with and directly supports the measures implemented in New York City. The New York National Guard's WMD CST-Heavy has been forward deployed in anticipation of a WMD attack. It is our belief based on the previous anthrax scenario of 2001 that New York would not be able to support New Jersey.

The New Jersey Domestic Security Preparedness Task Force under the direction of the Governor has taken many aggressive steps to educate more hazmat teams, strengthen law enforcement, tighten identification procedures, and upgrade counterterrorism measures. At the New Jersey State Department of Health and Senior Services a 24/7 system of medical consultation in infectious diseases has been implemented with the Commissioner's Medical Emergency and Disaster Prevention and Response Expert Panel (MEDPREP).

The New Jersey National Guard has developed and opened a state of the art Homeland Security Center of Excellence with a Joint Operations Center that has satellite capability and secure/non-secure communications. The NJNG has also developed a quick response force (QRF) configured geographically north, central and south in line with the NJ State Police theater of operations. The Joint Operations Center has been 24/7 overseeing Task Force operations on the bridges, tunnels, airports and nuclear power plants since March 18th.

STATEMENT

of the

American Medical Association

to the

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
United States House of Representatives

Presented by
John C. Nelson, MD, MPH, FACOG, FACPM
Member and Secretary-Treasurer, AMA Board of Trustees

RE: PROGRESS BY THE DEPARTMENT OF VETERANS' AFFAIRS IN THE DEVELOPMENT OF A MEDICAL EDUCATION PROGRAM MANDATED BY SECTION 3 OF THE DEPARTMENT OF VETERANS' AFFAIRS EMERGENCY PREPAREDNESS ACT OF 2002 (PL 107-287).

April 10, 2003

Mr. Chairman and members of the Subcommittee, my name is John C. Nelson, MD. I am a member of the American Medical Association's (AMA) Board of Trustees and serve as its Secretary-Treasurer. I am also a practicing obstetrician-gynecologist from Salt Lake City, Utah. On behalf of the physician and medical student members of the American Medical Association (AMA), we are honored to have been invited to discuss with the Subcommittee the level of preparedness in the medical community to respond to casualties resulting from unconventional weapons or catastrophic events, and what other opportunities exist for the medical community to collaborate with the Department of Veterans' Affairs (DVA) to improve knowledge in this area.

Introduction

For the medical community – for all our communities – the world turned upside down on September 11, 2001. In the aftermath of the unprecedented September 11th attacks on America and the subsequent anthrax events, the medical community and our nation now confront a new potential type of terror on the home front – casualties resulting not only from catastrophic events but also from weapons of mass destruction. The elevation of the country's terrorism alert status to orange, the second highest level, and the current war with Iraq, have

only heightened the need to ensure that the medical community is prepared to respond to bioterrorism and other catastrophic events.

The events of late 2001 were a wake-up call to the medical community. In their immediate aftermath, there was a dramatic surge in physicians' education and training, particularly in bioterrorism. The primary challenge now is continuing to reach out to and educate physicians in order to sustain that knowledge and maintain their sense of urgency as a priority. The Fall 2001 events demonstrated the need for a sustained, comprehensive medical response to disasters, both inflicted and natural. The effort required by the medical community, just like the President's determination to bring terrorists to justice, must be multi-faceted, broad-based, and implemented with a long-term approach. The AMA is prepared to meet this challenge, but we cannot do it without the help and support of other organizations in the private sector and the federal government, such as the DVA.

AMA Policy and Activities

This country, like many other countries, had already faced events involving mass destruction prior to the September 11th attacks and the anthrax events. Whether resulting from natural disasters, such as earthquakes, hurricanes or tornadoes, unintentional events, or terrorism (Oklahoma City), medical professionals have a long history of treating mass casualties and responding to disasters.

The Fall 2001 events were a reminder that physicians are individuals who make a critical difference and have distinct, critical roles to play in the nation's response to disasters. Indeed, physicians have an ethical obligation to do so. One of the long-standing, basic principles of the AMA's Code of Ethics is the physician's responsibility to participate in activities contributing to the improvement of the community and the betterment of public health. This public health obligation has been continuously reaffirmed since the Code was first adopted, but in recent years, the relationship between medicine and public health had drifted apart. The September 11th attacks and the ensuing anthrax events suddenly reversed this trend and sharply revealed the need for interdependence.

Given the physician's obligation to the health and safety of communities and the nation, organized medicine has a duty and responsibility to ensure that every physician is equipped with the knowledge and skills to discharge his or her public health responsibilities, especially in helping our nation respond to disasters. As the leading voice for physicians, the AMA has taken this obligation to heart by establishing a new initiative, the Center for Disaster Preparedness and Emergency Response, to address what is necessary in order to have a ready and prepared physician workforce. Through this Center, the AMA is developing methods to prepare physicians to deal with terrorism or natural disasters, how to field test these procedures, and how to disseminate them to the physician community. More information on the Center is provided later in this testimony.

The AMA has a long tradition of involvement in helping to lead the response to terrorism and disaster preparedness. AMA policies relating to terrorism and disaster preparedness have been shaped by contemporary events, ranging from informing the Executive and Legislative branches of government (as well as physicians and the public) on the medical consequences of nuclear war, to condemning the use of chemical, nuclear, and biologic weapons. For instance, since the early 1980s, the AMA has maintained policies directing the organization to prepare appropriate educational materials for the physician community and the public on the medical consequences of nuclear weapons, while supporting cooperative efforts in responding to national emergencies.

Other AMA policies also discuss weapons of mass destruction and define the importance of the Department of Defense (DOD) and the DVA in our national response. Historically, the AMA has supported collaboration with the DOD to explore ways in which we could cooperate to assure the nation's medical preparedness in the event of a national emergency. The AMA also supported implementation of the current National Disaster Medical System. As the nation's attention shifted from nuclear to chemical and biological scenarios, the AMA's attention also was directed to these potential weapons.

Over the last several years – even prior to the September 11th attacks – the AMA was at the forefront in addressing the public health implications and the level of this country's readiness to respond to bioterrorism and other means of mass destruction. For example, the editorially-independent *Journal of the American Medical Association* (*JAMA*) devoted a series of articles to bioterrorism, and more specifically, to the diagnosis and treatment of a variety of biological agents. The AMA's Council on Scientific Affairs (CSA) devoted at least five of its reports and many of its activities to ways in which organized medicine can become more closely involved in disaster preparedness for bioterrorism and other weapons of mass destruction. Under the auspices of the CSA, the AMA held a series of successful town meetings in conjunction with a conference on bioterrorism sponsored by DOD in 2000. A broad cross-section of specialty, state, and county medical society representatives, community responders, as well as members of the military, who are engaged in disaster response planning and deployment for such events, attended the meetings. The focus was on how organized medicine and community-based physicians can become better prepared (through education and development of core competencies) and more active in local disaster response planning. Specific elements related to treatment (drugs, vaccines, liability issues) and local response (national stockpile preparation and local delivery) also were discussed.

AMA Activities Post- September 11th

Building on its response to the events of 2001, the AMA is uniquely positioned to play a continued leadership role through the Federation of state, county, and specialty medical societies represented in the AMA's House of Delegates, which is comprised of over 150 separate groups that work together to advance the agenda of physicians and their patients. Working in collaboration with the Federation, the AMA can act as both a facilitator and convener, with the ability to disseminate information rapidly to thousands of physicians and bring together interested parties, in both the private and public sectors, to develop and implement educational programs and disaster response initiatives.

Our AMA activities have included the development of a comprehensive Web presence for clinicians and the public; outreach to and involvement of the AMA Federation; collaboration

with both federal and private sector agencies; communications through press releases; and personal representation by AMA officers. Many of these activities are ongoing and include the following:

- Contact with HHS/CDC began very quickly to determine the level of response that might be needed in communicating more widely to the Federation, AMA members, and physicians at large. Similarly, contact with the Medical Society of the State of New York was established very soon after the attacks. The AMA has maintained ongoing contact with the appropriate sections of the CDC, HHS, DOD, the Office of Emergency Preparedness (OEP), the Federal Emergency Management Agency (FEMA), and the Department of Homeland Security.
- The AMA cosponsored with the Centers for Disease Control and Prevention weekly video telecasts on bioterrorism. These telecasts were designed to educate physicians on a whole host of issues about bioterrorism and preparedness, including one on diagnosing and treating anthrax, and another more recently on smallpox. The AMA continues to work with CDC in notifying the physician community about satellite broadcasts, web casts, bulletins and other resources, as appropriate, and continues an ongoing dialogue with the Administration to identify creative ways to educate physicians and the public about bioterrorism and preparedness.
- The AMA created a mechanism for gathering names of physician volunteers to assist in the immediate response to disasters, if needed. This has provided a way to augment regional response planning. More than 3,000 physicians responded, and a list of volunteers was sent to HHS. We also sent sample information from our Physician Profiles database, as an example of information that could be provided upon request and should be available to DVA and DOD facilities as part of any National Medical Response System. The physicians who answered the AMA's call to action were personally contacted and sent a follow-up letter that urged their involvement in local and state disaster efforts. The AMA continues to work with the Administration to identify additional volunteer physicians as part of our effort to respond to the President's call for the development of local volunteer networks.
- AMA elected leadership and staff have answered hundreds of calls from the media,

physicians and the public regarding the medical implications of various types of terrorism. These activities are ongoing. In addition, there have been numerous articles in AMA publications, such as *AMNews*.

- A web presence on terrorism/disaster response was designed in the immediate aftermath of September 11th to provide resource materials for physicians and the public. In fact, the AMA's website on this issue quickly became, and continues to be, a national and international resource, with the most up-to-date and reliable information for the physician and public on bioterrorism and disaster preparedness. The site includes recent articles from *JAMA*, along with a series of AMA Council on Scientific Affairs Reports, and links to the CDC and other government agencies. The website is in the process of being strengthened and enhanced, and made more user-friendly.
- The AMA's advocacy team has an ongoing exchange of information with the Executive and Legislative branches of the federal government regarding the clinical and public health implications of terrorist attacks. Activities have also included advocacy for adequate staffing and funding for the new Department of Homeland Security so that it can coordinate the needs of medical disaster response; increased funding for HHS agencies, state and local health departments, hospital emergency response systems and municipal/regional response systems, so that the public health infrastructure can be improved; and increased funding for research, development and production of new antiviral and antibiotic treatments and increased stockpiles of vaccines and antibiotics.
- In addition to the activities mentioned above, the AMA's educational efforts have included special sessions on bioterrorism and disaster preparedness at its regularly scheduled meetings; distribution to physicians of pocket reference guides on the diagnosis of illnesses resulting from biological weapons; distribution of an HHS Smallpox Vaccination Reference Guide; and the creation and distribution of CD-ROMs containing state-of-the-art medical and clinical information on bioterrorism awareness and preparedness, which were mailed to all physician members of the AMA. The AMA also has collaborated with the CDC to distribute the CDC's Health Alerts to physicians across the country.

Recent AMA Initiatives

Post-September 11th, it has become obvious that the challenge is to "fill in the blanks" for practicing physicians to ensure that they have the requisite skills and training to respond to disasters. The AMA's most recent initiative to respond to this need was the creation of a new Center for Disaster Preparedness and Emergency Response. Dr. James J. James, MD, DrPH, MHA, joined the AMA in December 2002 as the first director of the Center. Dr. James served 26 years with the U.S. Army Medical Corps, from which he retired as a Brigadier General. Serving as director of Florida's Miami-Dade County Health Department from 2000 through 2002, Dr. James was intimately involved in dealing with the anthrax-related incidents that occurred in the fall of 2001, and in the subsequent development of the smallpox response plan for South Florida.

As director of the AMA Center, Dr. James is responsible for managing and developing a comprehensive medical and public health program for the AMA to respond to terrorism and other disasters. Planned initiatives of the Center include the following:

1) development of an evidence-based educational/training model that will identify specific needs for physicians and other licensed health care providers, the responder community and the public at large, and ensure competency of physicians in disaster response;
2) development of a dynamic surge model that will help communities assess their ability to respond to a given event by type and magnitude, and take into account in real-time the current status of a community in terms of the factors impacting it;
3) development of a community mental health model that will target both increasing community resiliency pre-event and the ability to better mitigate post-event psycho-social morbidity;
4) development of an updated website that will provide for accurate and timely communication of information pertaining to intended and unintended catastrophic events;
5) further definition of the bioethical basis of physician responsibilities to respond to catastrophic events and, also, to recognize their role in ensuring the use of biotechnology

for the betterment of man; and

6) creation of a public private entity that the AMA has previously recommended, within the context of a medicine-public health initiative (discussed below).

With regard to the educational/training model noted above, the AMA, in partnership with others, is developing two sets of courses targeted to licensed health professionals. These courses, Basic Disaster Life Support (BDLS) and Advanced Disaster Life Support (ADLS), are patterned after two sets of courses that are widely recognized and accepted by the health care community, Basic and Advanced Trauma and Cardiac Life Support. These new courses (BDLS and ADLS) will set a standard for providing valid, standardized, certifiable content to all physicians and other health care practitioners. The committee appointed by the AMA to oversee this educational activity will also address the whole continuum of medical education and how we ensure our physicians and other practitioners are trained in and updated on this critical content.

The BDLS course, developed in partnership with the Medical College of Georgia, the University of Georgia, Southwestern Medical School (Dallas), and the University of Texas School of Public Health, is intended to provide physicians and other health care professionals with the basic knowledge and skills needed to enable them to contribute to the health and safety of their communities, especially in the aftermath of a natural or intended catastrophic event. This course is both intensive and comprehensive, using an "all-hazards" approach as opposed to looking at anthrax or a chemical attack or some other specific scenario. In its present configuration it is presented in a didactic format over a two-day period. A distance-learning capability will also be fielded. The course content is broken down into 13 modules and covers such areas as federal and state roles, Incident-Command, community mental health, disadvantaged/at risk populations, and the public health system.

The most important aspect of BDLS is that it addresses all of those areas that are critical to physicians being able to effectively respond to disasters, but that are not otherwise covered in more general medical education curricula. For example, the role of incident command

systems has been clearly established in disaster response. The physician needs to understand his or her role to maximize effectiveness. Other areas in the curriculum provide the physician with understanding vertical/horizontal communication, use of media tools, local, state and federal roles in disaster response and mitigation, and licensure and liability issues.

Another ongoing effort with which the AMA has been intimately involved is the CDC's Smallpox Vaccination Program. The AMA worked closely in developing and implementing the recommendations of the Advisory Committee on Immunization Practices, and continues to work with the CDC and HHS in monitoring the smallpox vaccination program and in educational outreach to physicians and the public regarding not only smallpox itself, but the status of the vaccine and the risks and benefits of the vaccination.

Educating Physicians: Where are the Gaps and What Role Can the DVA Play?

Much has been accomplished since the events of the fall of 2001 in educating and training our physicians. We know that our physician population is much better informed about and more aware of the risks of an intended or unintended catastrophic event, as well as where to go to get the most up-to-date information. We know this because of the large amount of material that the AMA and other medical specialty societies, government agencies, and health organizations have developed and distributed via multiple outlets. We know physicians have accessed this information from the number of website contacts reported and also the number of CME certificates issued relating to disaster response content. The websites, whether AMA or CDC, for example, have dramatically improved and are much more clinician-friendly.

Yet, while we indeed have made good progress, much remains to be done, especially in shoring up the public health infrastructure. While physicians are better educated and prepared, much more needs to be done to bridge the gap between the practicing physician and the public health networks. Clinical communication, as noted above, has dramatically improved, but information on how to get physicians plugged into their own local or regional public health networks is still poor, and public health infrastructure is still weak. The next step is to prepare a physician workforce that is not simply informed, but that also has the practical skills to respond competently to disasters.

Disaster response teams have been in place for many decades. Now, it is vital that these systems be upgraded to include potential intentional disasters, and that surge capacity be increased by linking up with local, trained physicians. For example, it is not clear in most parts of the country how interested physicians could participate in their local regional disaster response teams. This deficiency could prove to be extremely critical, particularly during the time between when an event occurs and the state and federal response teams arrive at the scene.

Multiple exercises that have looked at disaster response in individual communities have clearly demonstrated that the most significant weakness is "command and control" and effective communication. The response to the anthrax event in South Florida was a good example of the benefits to be derived from active coordination and interaction between the medical community and the public health system at the community level. As a result of expeditious and open communication between the health care provider community and public health community, a clinically suspicious case was quickly identified and diagnosed, and appropriate epidemiological and health care activities were undertaken. The media were quickly involved, and a consistent message was provided and delivered in a timely manner. As a result, public fears were kept at a manageable level. Much of this resulted from the pre-event coordination and interaction that existed between the local health department, the local medical society and other elements of the public health network.

The AMA believes that it can and should play a critical role in bridging the gap between medicine and public health not only through its current mission of physician education and training, but also through its ability to convene and bring to the table the appropriate partners from the private and public sectors to develop and activate a system to link local physicians with the public health system seamlessly. One of the ways in which this can be done, we believe, is through the creation of a public-private entity (including federal, military, and public health content experts) that, collaborating with medical educators and medical specialty societies, would (1) develop evidence-based medical education curricula on disaster medicine and the medical response to terrorism; (2) develop informational resources for

civilian physicians and other health care workers on disaster medicine and the medical response to terrorism; (3) develop model plans for community medical response to disasters, including terrorism, with a mechanism for testing and evaluation of such plans and an assessment of their impact; and (4) address community physician reporting of dangerous diseases to public health authorities.

The public-private entity, as envisioned by the AMA, would be comprised of key participants, including DVA and DOD. This core group would identify specific tasks designed to enhance local preparedness and response, including educational components, and then would engage the necessary additional participants in order to accomplish relevant goals. Activities would focus on bridging the gap between the local incident and mobilization of federal resources. Creation of the Department of Homeland Security to coordinate all federal response agencies does not lessen the potential value of this concept, which ultimately would serve to integrate more efficiently local responses with existing federal components. The AMA previously raised this concept the last time we testified before this Subcommittee in November 2001; unfortunately, the proposed entity remains only a concept due to the lack of resources.

We believe that the DVA and DOD could play a critical role in making the private-public entity a reality, through their financial resources and staff expertise, and we would welcome their participation in this venture. The DVA, through its extensive network of medical facilities and affiliations with residency training programs, would be a natural partner with the AMA to help prepare the medical community for responding to disasters, whether intentional or natural. While the details of this partnership obviously would need to be worked out, the AMA envisions creating a committee, under the leadership of the AMA and the DVA, that would bring together other interested parties to develop and field education curricula for undergraduate, graduate and continuing medical education programs.

Many practicing physicians are part of the national defense medical system through hospital affiliation that has, as the organizing entity in their region, a DVA or DOD medical facility. These are natural alliances for collective education. These facilities could also play a critical

role in providing surge capacity when disasters occur. The DVA could play an instrumental role in linking education and training programs into the regional response preparation of the National Disaster Medical System. Additionally, there could be greater coordination between regional and local education and training programs, which could be incorporated into hospital disaster exercises which are a mandatory standard for hospital accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

Another area where we believe a gap exists is the lack of federal legislation providing limited immunity for medical liability claims for care provided during an emergency. Also, expedient recognition of medical licenses from other jurisdictions is needed. While many states have enacted "Good Samaritan" laws that provide immunity to physicians who provide volunteer care to others, there is no comparable federal law granting immunity across state lines. In the 107th Congress, legislation was introduced (H.R. 4634) to address this problem in the National Capital Area (the bill was later amended to be applicable across the country). This legislation would allow physicians to provide services to victims of emergencies regardless of the jurisdiction of their licensure in the event of a declared public health emergency. The bill would protect physicians from liability for all but willful, criminal, or reckless misconduct, gross negligence or a conscious, flagrant indifference to the rights or safety of others while performing such volunteer emergency service. No action was taken on this legislation in the 107th Congress, and no similar legislation has been introduced to date in the 108th Congress. AMA believes that the protection provided by such legislation would help to promote greater physician volunteerism without fear of being sued or fined.

Conclusion

The AMA stands ready, able and willing to work with the federal and state governments to assist in educating medical students, physicians and other health care professionals and preparing them for any mass catastrophe. We would be greatly honored to help in any way possible.

Thank you once again for inviting us today.

STATEMENT

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On the

Development of Medical Education Programs to Respond to Biological, Chemical and Radiological Threats

Presented by

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President
Association of American Medical Colleges

Before the

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
United States House of Representatives

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Thank you for inviting me to testify before the Subcommittee this morning. I am Dr. Jordan Cohen, President of the Association of American Medical Colleges. The AAMC represents the nation's 126 medical schools, some 400 major teaching hospitals and health systems – including over 70 VA medical centers –, 92 academic and scientific societies representing nearly 100,000 faculty, and the nation's medical students and residents. When I came before the Subcommittee in November 2001, I testified primarily about plans for the Association's First Contact, First Response initiative. I would like to take the opportunity today to update the Subcommittee on that initiative and on the great strides the medical education community has made over the past 18 months in improving the level of training and knowledge of medical students, resident and physicians to prepare them for possible biological, chemical and radiological threats.

Shortly after I testified before the subcommittee in November 2001, the AAMC convened a meeting of representatives of medical specialty, medical education, nursing, public health, and scientific organizations, including the VA, to help us identify and develop educational and informational resources to aid physicians and residents who are likely to be the first to encounter victims of chemical, biological and radiological attacks. Designated the First Contact, First Response Initiative, the meeting provided an opportunity to discuss the development of educational resources to assure that residents and practicing physicians learn the essentials of the medical conditions that may be caused by terrorist activities. At the meeting, the specialty societies and organizations affirmed their commitment to developing and maintaining ways to distribute, especially via the Web, educational material for use by all interested parties. The Centers for Disease Control and Prevention also agreed to assist by providing the educational materials they were developing. Since that initial meeting, the AAMC has monitored the development of new resources and provided this information to our constituents as appropriate.

In my November 2001 statement, I also mentioned our plan to convene a panel of experts to provide guidance to medical schools on the relevant content that should be included in the medical school curriculum. This is an education model the Association has used with great success in the past on issues such as population health and medical informatics. The group we convened included experts in medical education as well as in preparedness for weapons of mass destruction (WMD). We had representatives from schools of medicine, nursing and public health, the CDC, and the Uniformed Services University of Health Sciences (USUHS). The group was asked to respond to two questions: What should medical students learn about bioterrorism (i.e., what are the appropriate learning objectives)? and what kind of educational experiences would allow students to achieve those learning objectives?

The panel reached general consensus that responses to bioterrorism events should be considered in the context of any threat – biological, chemical, physical or radiological – that may result in mass casualties. The experts agreed that it would not be productive to have medical students memorize the characteristics of all potential agents, but rather that education should focus on general concepts such as classes of agents and the various mechanisms of injury. Importantly, the panel noted that future physicians should understand the appropriate roles and responsibilities they will play during a WMD event, and how to coordinate with the public health system. The group identifies approximately 30 discrete learning objectives in which medical students should be able to demonstrate knowledge and skills; the objectives were divided into five broad categories:

- Basic Sciences;
- Clinical Sciences;
- Public Health System Interventions;
- Public Health Roles and Responsibilities; and
- Professional Ethics.

The panelists agreed that these objectives should be integrated across all four years of medical school through a combination of didactic and experiential learning exercises; several strategies were outlined to achieve these objectives, including the use of standardized patients, disaster drills, online study modules, and additional elective opportunities. The panelists felt that most medical students could achieve the appropriate competencies, given that the relevant issues were being incorporated into existing curricular offerings. Alternatively, schools with special interests or obligations, such as USUHS, could establish the objectives as required components of discrete, separately identified segments of the curriculum. The panelists also noted that many curricular resources will be required to implement the strategies, first and foremost being the education of medical school faculty. The final report will include examples of individual institutions that have developed unique educational opportunities that go beyond isolated lectures and may serve as models for other institutions.

I am pleased to report that the group has completed its efforts and a final report is due out next month.

In my previous testimony, I reported a search of the AAMC's Curriculum Management and Information Tool (CurrMIT©) found that 10 medical schools had identifiable courses or sessions directly related to the potential effects of biological, chemical or radiological attacks. A recent comparable study showed that that number has increased to 23 medical schools. Please note that this represents the tip of what is certainly a rapidly growing iceberg. The CurrMIT tool is not designed to register the countless instances where potential terrorist agents are seamlessly incorporated into general courses such as microbiology, pharmacology, immunology or pathology. Essentially, the data show only show that identifiable classes or sessions dealing explicitly with these threats have more than doubled over the last 18 months.

What I have talked about so far is limited to the undergraduate medical curriculum. Graduate medical education, that is the education of medical residents, is also essential. It is in this phase of medical education that we can best prepare individuals who are most likely to encounter potential victims initially. A quick, informal poll of residency program directors elicited several responses describing how residency training programs have evolved to incorporate elements of biological, chemical and radiological concerns into the resident's learning experiences. Nearly all responding program directors noted the inclusion of speakers on relevant topics such as smallpox during grand rounds. Given the structure of graduate medical education, most of the residency learning experiences are experiential rather than didactic. Numerous institutions noted special seminars for housestaff, including the involvement of residents in disaster and HAZMAT drills. Several residency training programs have implemented unique training experiences such as the following:

- The University of Rochester School of Medicine is using of a high-fidelity simulator in its training;

- The University of Colorado Health Sciences Center requires preventive medicine residents to take a two-month rotation at state or local health department where they participate in the development of plans to deal with biological, chemical, and radiological threats; and
- The Geisinger Health System in Pennsylvania Requiring requires each of its resident to participate in a hospital/regional mass casualty drill and bringing in local energy plant officials to cover radiation emergency training.

The AAMC has also taken a leadership role in the collection and dissemination of information to medical schools and teaching hospitals. Our Office of Communications has established and maintains a Web site at <http://www.aamc.org/newsroom/bioterrorism/> that provides up-to-date information on initiatives at our member institutions. Divided regionally and by state, the Web site provides specific information about what schools are doing in this area. Examples include Marshall School of Medicine where students can attain a certificate in bioterrorism studies as part of a course in medical microbiology; the University of North Carolina – Chapel Hill School of Medicine, which has a course in disaster management for emergency medical residents and faculty; and the Medical College of Ohio which has a course in basic anti-terrorism emergency lifesaving skills.

Finally, I'd like to mention the Association's collaboration with the Centers for Disease Control and Prevention. Through this mechanism, the AAMC has been assisting with clinical education sessions on anthrax and smallpox identification and treatment, using a series of listserv email messages, Web broadcasts, as well as written materials. Additionally, the Association is working collaboratively with the CDC to develop educational materials dealing with smallpox immunization, which we are currently working to disseminate to all medical students. The AAMC also is helping the CDC establish collaborative relationships with other specialty societies and organizations in an effort to disseminate constituent specific information on bioterrorism and other threats.

In conclusion, I believe the nation's medical schools and teaching hospitals are doing an increasingly comprehensive job educating our nation's future health care workforce to identify and treat the effects of biological, chemical and radiological events. These experiences are being incorporated into all aspects of the medical school curriculum, as well as the residency training programs through a combination of didactic and experiential learning. Given that the majority of medical students and residents receive a portion of their training at a VA facility, these experiences are also of potential benefit to our nation's veterans. Through the formal affiliation agreements that 107 medical schools maintain with VA medical centers, the education and training of medical students and residents in these settings flows easily between the VA hospital and the university hospital.

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