

**THREE YEARS AFTER 9/11: IS VA PREPARED TO
FULFILL ITS ROLES IN HOMELAND SECURITY?**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

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AUGUST 26, 2004
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THREE YEARS AFTER 9/11: IS VA PREPARED TO FULFILL ITS ROLES IN HOMELAND SE- CURITY?

THURSDAY, AUGUST 26, 2004

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The committee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Miller, Beauprez, Evans, Snyder, Rodriguez, Michaud, and Herseth.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The committee will come to order. I wish everybody a good morning.

Today's hearing is prompted in part by the release of the final report of the 9/11 Commission chaired by my good friend and the former governor of New Jersey, Tom Kean, and Lee Hamilton, a distinguished member of the House and former chairman of the International Relations Committee, and also a good friend. This Commission undertook a very difficult and emotional task, examining a series of events that began many years ago, but ending with stunning and tragic consequences almost 3 years ago.

The report of the Commission paints both with broad strokes and very precise ones that capture excruciating and important details. Reading it arouses diverse emotions from anger at the cold-blooded assassins, regret that plans to protect our country did not envision such a murderous plan, admiration for those who struggled to save their fellow citizens who gave up their own lives in the process, and resolve that we should not be caught unaware in the future.

Notwithstanding all of these emotions given the passage of time, there is a human tendency to become complacent, to let down our guard. Many of us face multiple challenges that demand our attention, including unanticipated changes in our work, family and crises such as a relative with a serious illness or even an unexpected car repair. Although some wish it were not so, our thoughts and members of the attacks of certain are sometimes displaced by more pressing recent events. I view the 9/11 Commission report as a national alarm bell and a blueprint for action. I do not think that the Commission estimated the dangers which still confront this Nation

as we gather here today, although no one can say for certain when and where our enemies will attack next.

And although the Commission has made no specific recommendations with respect to the Nation's plan to provide needed medical response if the next attack results in mass casualties, we would be myopic in the extreme if we did not realize that this is an essential part of preparedness planning.

In October of 2001, this committee examined in some depth the plans of the United States to respond to the need for medical treatment in the event of a disaster or attack. We learned how much was anticipated by the planners, and how insistent the planners had been on the need to practice the response to disaster or attack. A sinister plan to harm American political leaders resulted in the deaths of several postal workers from exposure to poisonous anthrax. I would point out parenthetically that the letters that contained anthrax were processed in a postal facility in my hometown of Hamilton, New Jersey.

That facility was closed for more than a year and has only recently been available for reoccupation. Congress was stunned by the dangers which had literally arrived in our mailboxes particularly over on the Senate side, and massive office buildings were sealed off for weeks or months because of the danger that they posed to the men and women who worked in them.

In the midst of that second attack, we learned that no one had really anticipated an event of that nature. Public safety officials lacked essential information about how to respond to this attack, how to treat the effects of that poison or what further preventative efforts might be undertaken. And I would just again say parenthetically I sat in on many of those meetings. Many, many good people at the State level, the local level, CDC and the like, were all there trying to work that issue, but in many ways the protocols weren't there. The prescribed how to's weren't there in the event of that kind of an attack, and chaos was regrettably the order of the day.

Although the attacks we have experienced in the last 3 years can be seen perhaps as a local crisis, foresight requires that we plan our response to future attacks with the entire Nation in mind, and perhaps even simultaneous attacks. Our inability to imagine the nature of past attacks is an important lesson for those planning a medical response to future attacks. It is instructive to review one of the most important questions about security planning asked by the 9/11 Commission and its grim conclusion. They said who is in charge? Who ensures that agencies pool resources, avoid duplication, and that they plan jointly? Who oversees the massive integration and unity of effort necessary to keep America safe? Too often the answer is no one.

Although the Commission was referring to struggles to protect our Nation's security, its questions seemed equally applicable to efforts to provide medical treatment to our service members and to our citizens in the event of an attack by terrorists, especially chemical, biological or radiological. At our hearing in 2001 we probed the role of the Federal Emergency Management Agency, or FEMA, in coordinating the medical responses to disasters, both natural and man-made.

Unlike national security agencies as the NSA and FBI, FEMA must rely on other agencies, community-based organizations, and volunteers to respond to emergencies. Every year hurricanes, floods, and wildfires test FEMA's ability to coordinate federal and local forces called to respond to threats to life and to property. In many cases, the VA has played an important, and, in some cases, an essential role in that response.

According to an article written by Dr. Kristi Koenig last year, she points out, and I quote her, "The VA has been requested to assist in every disaster declared by the President, beginning with Hurricane Andrew in 1992 when the Federal Response Plan was first used."

Although property damage from natural disaster easily exceeds billions of dollars a year and lives are tragically lost in many of those disasters such as Hurricane Charley less than 2 weeks ago, the system for responding to mass casualties has fortunately not been put to the test, and we hope it never will be, but we have to be prepared for the worst. Perhaps it is better to refer to the national network of medical responders as an alliance or a cooperative instead of a system. Surely and clearly, we have no federal health system designed to meet the needs of Americans injured by terrorist attacks. In absence of such a system, that makes the VA increasingly important.

Our hearings of 2001 and 2002 also give us a baseline from which we can evaluate the planning and actions which have taken place since 9/11. Several conclusions can be made based on the earlier hearings and more recent discussions with administration officials such as from a national planning perspective, the VA is the only Federal agency capable of assembling a large number of individuals to treat mass casualties.

Although other providers may volunteer to care for the injured or wounded, they cannot be ordered to do so. Thus the VA is seen as an essential element of any planned response to an attack using weapons of mass destruction. As we all know, VA operates 158 hospitals, over 850 outpatient clinics, 133 nursing homes, 206 counseling centers, and 42 rehab residential rehabilitation treatment programs. VA employs over 15,000 physicians, 58,000 nurses and assistants, 3,600 pharmacists and more than 130,000 ancillary staff.

However, VA sees its main preparedness function in narrower terms since it has not received resources or authority to carry out any broader function. There are explanations, but perhaps not justification for this apparent contradiction. In the past 3½ years, VA Secretary Tony Principi and other top officials such as Deputy Secretary Gordon Mansfield, who will testify shortly, have had their hands full in terms of responding to the record number of veterans seeking VA health care and disability benefits.

So the tyranny of the urgent tasks may be crowding out the important ones requiring perhaps more reflection and action. Second, the Congress and the administration have consolidated many functions pertaining to homeland security and the new Department to "oversee the massive integration and unity of effort necessary to keep America safe." How effective this organization has been in improving our ability to respond to attacks is an important but still

not fully answered question. More importantly, this reorganization could also contribute to an attitude of it is up to the Department of Homeland Security to figure that out.

Even though cooperation among agencies continues, the sense of urgency perhaps might dissipate. It should also be noted that some of the most important 9/11 Commission recommendations are addressed to the Congress and the way it divides power into competing committees. Whether and how Congress will make changes in its structure and operation to improve the Nation's security is also an unanswered question. Nevertheless, this committee must ask if enough is being done to reassure Americans and the Nation that we have an effective medical response plan. Are we paying enough attention? If the resources are not flowing to ensure that VA and its employees can respond in the event of an attack, what should be done?

In that regard, I must mention my great frustration with the short-sighted efforts which have led to the denial of federal funding for four emergency medical preparedness centers which we authorized 2 years ago. Last year, the House acted overwhelmingly to make funding available only to see its voice silenced in an unamendable conference report that kept the bar in place. I personally have spoken to those opposed to funding these centers, and I was the sponsor of that bill and that amendment. Their attitude is that some agency other than the VA should undertake the mission of understanding how to treat veterans injured from chemical, biological nuclear or explosive weaponry.

This attitude defies rational explanation and is an example of the "failure of imagination," to use the memorable phrase used in the report of the 9/11 Commission. Although it appears that Iraq destroyed or transferred its stores of chemical and biological weapons prior to being invaded last year, who doubts that Iran and North Korea possess or seek to possess such weapons? Our relationships with both Pakistan and India, nations that already possess nuclear weapons, could foreseeably lead to our troops being exposed to such weapons, if peace-making efforts and diplomacy do not succeed. Although the Department of Defense has generated important scientific information concerning the health effects of these weapons, it is the VA which must be prepared to deal with the long term and as well as intermediate term effects if service members are exposed to them. The VA must be an active participant in understanding the prevention and treatment of illnesses and injuries caused by such weapons, and I call upon the members and the administration who are against it to rethink their opposition to funding these centers.

Let me conclude by calling attention to one of the more successful collaborative research efforts between the VA and the Department of Defense. As we learned at a committee hearing last month, the Federal Government is organizing an effective and compassionate response to the needs of American soldiers who have received wounds resulting in amputations during the wars in Iraq and Afghanistan. Witnesses from the Army's Walter Reed Medical Center and the Veterans Health Administration depicted a commendable spirit of cooperation and discovery guiding their efforts

to provide the best care to these severely wounded service members and veterans.

Because the mission is clear and these service members are so deserving, providers have been ignoring at times regulations and budget restraints and are cataloguing new knowledge about treatment choices that will improve the lives of all humans who suffer from limb loss.

It was both inspiring and instructive to hear what it takes to ensure that the treatment needs are being met, nothing is being left to chance. Further, service members and citizens are counting on us to learn from this successful effort. In doing so we must be mindful that the formulation of new policy and plans cannot succeed if we do not make it our highest priority. As the chairman and vice chair of the 9/11 Commission noted, and I quote them, "We are in the midst of a presidential campaign. Our two great parties will disagree, and that is right and proper. But at the same time, we must unite to make our country safer.

"Republicans and Democrats must unite in this cause. The American people must be prepared for a long and difficult struggle," they went on. "We face a determined enemy who sees this as a war of attrition, indeed, as a great struggle. We expect further attacks against such an enemy. There can be no complacency. This is the challenge of our generation. As Americans we must step forward to accept that challenge."

[The prepared statement of Chairman Smith appears on p. 79.]

The CHAIRMAN. I would like to now recognize my good friend and colleague who is here. We will be joined shortly by Lane Evans. He is on his way back, the ranking member, but he has had some plane difficulties, I understand. But Mr. Rodriguez will also give an opening statement.

OPENING STATEMENT OF CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And I want to personally thank you, first of all, for conducting this particular hearing, especially during the recess, and for bringing us back to talk about a key issue that we all recognize that is important to all of us, and to our military as well as our veterans and the Nation as a whole.

But first, I want to take the prerogative as the ranking member now to just recognize a San Antonian who is here, Dr. Jay Wise who is a CEO of Wise Knowledge Systems in San Antonio, Texas. I am going to ask him to rise. Wise Knowledge Systems has produced an important medical readiness application known as Smart Tool that is now used by the Navy and Marine Corps that addresses medical readiness of active-duty personnel.

As you well know, the VA, we have always strived to try to be able to pick up that military personnel as soon as they become a veteran, and this is a system that might be worthwhile looking at. This program has strong support at the highest level of the Navy and I believe that it may be very useful to the VA system as well. This Wise Knowledge Systems technology could help assure the optimization of scarce VA resources and provide needed strategic planning assistance in support of the VA mission. And I want to thank Dr. Wise for being here. Dr. Wise, would you please rise?

Can I ask for a show of hands for Dr. Wise. Thank you very much for being here.

Mr. Chairman, let me once again thank you, and I am pleased to be here to discuss the VA's role in the medical emergency preparedness and how important that is. Congress will soon be considering the 9/11 Commission report, which includes recommendations in preparing our Nation to prevent future terrorist attacks. However, I am concerned that the report did little to address improvements needed in the emergency response in the wake of another major terrorist event. We have all been told that it is not a matter of if, but when one will happen, and I believe, as many of my colleague on this committee do, that the VA system can play a very critical role in responding to the medical emergencies that may accompany such an attack.

And one of the missions of the VA is to do just that. And we need to do whatever we can, and I want to thank you for highlighting what the infrastructure of the VA throughout this country already has, Mr. Chairman, because with we all know that one of the few areas in this country that can respond from a medical perspective is the VA system.

So I want to personally thank you for doing that. The committee certainly thought so when we approved legislation almost 2 years ago to establish four new centers of emergency preparedness. And when we drafted that legislation, it was with the intent that we could move on that as quickly as possible so we could begin to prepare not only for the medical but be able to respond to an emergency, both man-made and natural.

Congress went on to approve the legislation, and I want to thank the chairman for his efforts in that area on a bipartisan way which was sent to the President for his signature. However, help is needed in order for these medical emergencies and medical centers to be funded. Unfortunately, we have come across numerous stumbling blocks in this process, not the least of which is a federal funding that has not occurred. Since we have enacted the authority for these centers, I have attempted to seek emergency supplemental funding for them but have lacked the crucial support of the congressional leadership despite widespread support from members on both sides of the aisle.

Chairman Smith and Ranking Member Evans, your leadership on this issue has been unwavering, and once again, I want to thank you for your efforts in those areas and the words that you have already expressed with the introductory comments. I am pleased that we have a new provision, H.R. 4768, which may help us ensure that these centers are funded in the near future. I intend to work closely with the concerns of the members to make this happen. This is an area that we can make happen, we need to move on, and I know that the committee on Homeland Security and the appropriations had some concerns about the role that the VA should play. We are the only ones that have the hospitals. We are the only ones that have the clinics, with the exception of the Department of Health but this is one of the areas where we can play a very significant role and we should be doing that. So Mr. Chairman, I want to thank you for conducting this hearing.

The CHAIRMAN. I thank very much my friend and colleague from Texas. The Chair recognizes the gentleman from Florida, Mr. Miller.

OPENING STATEMENT OF JEFF MILLER

Mr. MILLER. Thank you, Mr. Chairman. And again I appreciate your calling this hearing today. As you may well know, my good friend and colleague, Mr. Boozman, and I just returned from the Middle East just yesterday afternoon and I do want to say that Iraq and Afghanistan are not the same places that they were a year ago. I think it is important that we talk about and remember the sterling job that our armed services are doing in those areas of operation. I wanted to take a small moment to highlight the successes that they are having and have realized in their liberation and reconstruction efforts because as usual the mainstream American media continues not to focus on the positive there, but to the events at hand this morning I think that it is important that we look at the VA and the fact that they have unparalleled infrastructure available all across this Nation to deal with biomedical research and expertise and the VA is uniquely situated in helping America to respond to national medical emergencies or terrorist attacks.

I feel that VA has been underutilized as a primary response in the preparation for and response to domestic terrorism. I want to say I appreciate the panelists that are going to be here to talk to us. Many of you have spent your entire lives dealing with issues like this, but we need to remember that we need to use VA's capital assets in the most efficient way, but to be very prepared in times of national emergency and that the assets and the personnel are coordinated with local emergency response efforts.

I think we need to listen very carefully to the testimony. Some will be positive towards VA, some may not be, but I think it is important that we look at both sides of the issue and that is why we are here today. I have additional comments that I would like added to the record.

The CHAIRMAN. Without objection, those comments will be made a part of the record, and anyone's additional comments or opening statements that they would like to add will be made a part of the record.

I would like to now recognize Mr. Michaud.

OPENING STATEMENT OF MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you, Mr. Chairman. I am pleased to be here today to consider the role of the Department of Veterans' Affairs in protecting our homeland security. Our highest priority must be ensuring the safety and security of American citizens. With access points including hospitals and outpatient clinics from Maine to Guam, the VA would be a valuable resource in a time of national crisis. No other public health system has the depth and breadth of the VA medical system here in the United States.

Following 9/11, every American and every Federal agency examined what role we could play in ensuring our security. I know that VA has a plan, but today it appears that this resource is not being fully developed in a manner which could be fully important to our

national interest. VA's primary responsibility is providing timely and appropriate care to our Nation's veterans. Without additional funding and resources, VA will have difficulties in becoming a resource in a time of national crisis. So, therefore, it is extremely important that they have the funding needed.

I am concerned with a number of VA Inspector General reports which indicate deficiencies in meeting continuing operation of criteria and homeland security needs. We must move quickly and constructively to make sure that VA is fulfilling its national security mission.

I am interested in hearing from the witnesses today concerning action that this committee and Congress can take to ensure what is the best use that can be made of the VA network in an event of a disaster. So therefore, Mr. Chairman, I would like to thank you very much for having this important hearing today.

The CHAIRMAN. Thank you very much. The Chair recognizes the gentleman from Colorado, Mr. Beauprez.

OPENING STATEMENT OF HON. BOB BEAUPREZ

Mr. BEAUPREZ. Thank you, Mr. Chairman, and let me add my thanks to you for holding this hearing. I think it is critically important that we get together and work on this issue from this committee's standpoint and our purview.

In viewing the 9/11 Commission's report, much, of course, comes to our attention, but one of the most telling and maybe commanding indictments of that report as we look at the failures as they cited them was the failure of imagination. And I think that that is our challenge. Especially those of us elected Members of Congress, and certainly this morning members of the VA in front of us, the failure to imagine the hatred of our enemies, the lengths that they would go to to perpetrate terror, but then the tools that they would use to seek their end point, the means.

That is, I think, the challenge in front of us. We too often, I think, tend to try to lead by looking over our shoulder, looking backwards at the last event or the last incident. And certainly we need to learn from history. We need to learn from the terrible destruction of 9/11 and how that happened. But the bigger challenge, I think, is that key word again of "imagination." I think that is where the VA can be very helpful to us.

I think we all need to imagine, as I think it was Lee Hamilton who said once to me at least in my hearing that we need to maybe read more Tom Clancy novels and he wasn't joking. He was dead serious about it. And I think we do need to test all of our imaginations, and one of the frightening thoughts I have is that it may not, the next attack, whenever it comes—hopefully it doesn't come—may not be limited to one location. It may be broad-based. It may be throughout the country. As we think about that possibility, is there a better network relative to health care and treatment than the VA system?

So again, Mr. Chairman, I think it is critically important that we have this hearing. I think it is critically important that we don't just stop at this hearing, that we urgently and continually try to imagine how we might need to be prepared to respond to a terrorist attack, God forbid it ever comes again. I yield back.

The CHAIRMAN. Thank you very much, Mr. Beauprez. Ms. Herseth.

OPENING STATEMENT OF STEPHANIE HERSETH

Ms. HERSETH. Thank you, Mr. Chairman, and I want to echo the appreciation that all of us on the panel and those in the room today I know feel toward you for scheduling this hearing and the foresight of what is necessary by this committee in looking at the integrated health care system of the VA and the role that it plays and thank you to everyone for being here to discuss the Veteran's Administration's role in preventing and responding to national medical emergencies and terrorist attacks.

First I want to thank the VA and everyone associated with the VA for the tremendous work that you do on behalf of our Nation's veterans. We owe a tremendous debt of gratitude to the men and women who every day provide health care and benefit services to the country's veterans, including those new veterans returning from Iraq and Afghanistan and the treatment that many of them have been receiving from the VA utilizing current-year appropriations.

The terrorist attacks on 9/11 have raised new concerns about the readiness of our health care system in dealing with large-scale disasters. The tragedy of September 11 demonstrated our vulnerability to well-planned attacks by terrorists and forced the Federal Government to make unprecedented changes to strengthen our homeland security position. In preparation for another terrorist attack, which we would like to think is unthinkable but we know, based on the findings of the September 11 Commission's report, can no longer be unthinkable.

We can't take that posture. Substantial amounts of time and money have been spent on medical training programs, personnel, equipment, and research and development plans. These efforts have gone a great way to strengthen our Nation's health care capabilities. However, almost 3 years have passed since September 11, and we are still confronted with many questions and challenges. As the Nation's largest integrated health care system, the VA will undoubtedly play a major role in responding to a large-scale attack or national disaster. Therefore, it is critical we take a closer look at the VA's emergency preparedness, which we will be today, and I agree with Mr. Beauprez that it shouldn't stop at this hearing but that we continue to focus on the needs and answering these questions.

I am pleased that we have the opportunity to hear from today's panel of experts, and I am grateful to have the opportunity to hear your suggestions and answers to many of the challenges and questions facing our Nation's health care system, some of which were revealed in the September 11 commission's report. I look forward to hearing your testimonies, and again I want to thank everyone for taking part to discuss this important matter.

The CHAIRMAN. Thank you very much. The Chair recognizes Dr. Snyder.

Mr. SNYDER. I don't have an opening statement.

The CHAIRMAN. Thank you. I would now like to welcome our very distinguished panel of witnesses beginning with Deputy Secretary

of Veterans Affairs Gordon Mansfield, who serves as the chief operating officer for the Federal Government's second largest department. He is responsible for a nationwide system of health care services, benefits programs and national cemeteries for America's veterans and their dependents. Gordon previously served as VA assistant secretary for Congressional and Legislative Affairs since August of 2001. Prior to his appointment, Gordon Mansfield served as the legislative adviser to the Secretary of Veterans Affairs and was responsible for VA's congressional relations. Secretary Mansfield previously served as executive director of the Paralyzed Veterans of America, PVA, and he also served in the Department of Housing and Urban Development during the first Bush administration. A graduate of Villanova University with a law degree from the University of Miami, Gordon enlisted in the Army in 1964 where he served two tours of duty in Vietnam. While serving as company commander with the 101st airborne division during his second tour, he was wounded during the Tet Offensive in 1968, sustaining a very serious spinal cord injury. For his actions while his unit was under fire, he was decorated with the Distinguished Service Cross. He was medically retired by the U.S. Army at the grade of captain. His other combat decorations include the Bronze Star, two Purple Hearts, the Combat Infantryman's Badge and the Presidential Unit Citation. Mr. Mansfield is also the recipient of the Presidential Distinguished Service Award.

We then hear from Major General Lester Martinez-Lopez, who has been Commanding General of the U.S. Army Medical Research and Materiel Command at Fort Detrick, Maryland since March, 2002. For the 2 years prior General Martinez-Lopez was in command of the U.S. Army Center for Health Promotion and Preventive Medicine at Aberdeen Proving Ground in Maryland. General Martinez-Lopez joined the active army in 1978 at Fort Bragg, North Carolina, where he received his specialty training in family practice. Some of the general's assignments during his military career include flight surgeon and family physician at Davison U.S. Army Airfield, Fort Belvoir, Virginia; Chief, Department of Family Practice and Community Medicine, Fort Benning, Georgia; Director of Health Services/Commander, U.S. Army Medical Department Activity and Commander, Blanchfield Army Community Hospital located in Fort Campbell in Kentucky.

General Martinez-Lopez graduated from medical school in 1978 at the School of Medicine in the University of Puerto Rico and he completed his master's degree in public health at Johns Hopkins University in 1983. His military education includes attending the Army Medical Department Officers' Basic and Advances Courses, the U.S. Army Command and General Staff College and Army War College. General Martinez-Lopez has also received many awards, decorations and badges. A few them include the Legion of Merit with three oak leaf clusters, the Defense Meritorious Service Medal, and the Army Meritorious Service Medal with three oak leaf clusters.

We will then hear from the Honorable Stewart Simonson, who was sworn in as the Assistant Secretary for Public Health Emergency Preparedness at the U.S. Department of Health and Human Services on April 28 of 2004. Mr. Simonson serves as the Sec-

retary's principal adviser on matters related to bioterrorism and other public health emergencies. He also coordinates interagency activities between HHS, other federal departments, agencies, offices and State and local officials who are responsible for emergency preparedness and the protection of the civilian population from acts of bioterrorism and other public health emergencies. Most recently Secretary Simonson served as special counsel to the Secretary and acted as the Secretary's liaison to the Homeland Security Council and the Department of Homeland Security. He also supervised policy development for Project BioShield and other countermeasure research and development programs. From 2001 to 2003, he was the HHS Deputy General Counsel and provided legal advice and counsel in that regard. Prior to joining HHS, Secretary Simonson served as corporate secretary and counsel for AMTRAK. Secretary Simonson is a graduate of the University of Wisconsin where he received a Bachelor of Arts degree in 1986 and a juris doctor degree in 1994. He is member of the Bar in Wisconsin and the District of Columbia.

STATEMENTS OF HON. GORDON H. MANSFIELD, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY HON. ROBERT N. McFARLAND, ASSISTANT SECRETARY FOR INFORMATION AND TECHNOLOGY, JONATHAN B. PERLIN, MD, ACTING UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, ROBERT J. EPLEY, ASSOCIATE DEPUTY UNDER SECRETARY FOR POLICY AND PROGRAM MANAGEMENT, VETERANS BENEFITS ADMINISTRATION; MAJOR GENERAL LESTER MARTINEZ-LOPEZ, COMMANDING GENERAL, U.S. ARMY MEDICAL RESEARCH AND MATERIEL COMMAND AND FORT DETRICK DEPARTMENT OF DEFENSE; AND STEWART SIMONSON, ASSISTANT SECRETARY FOR PUBLIC HEALTH EMERGENCY PREPAREDNESS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

The CHAIRMAN. I would like to welcome Secretary Mansfield and please ask you to proceed however you would like.

STATEMENT OF HON. GORDON H. MANSFIELD

Mr. MANSFIELD. Mr. Chairman, members of the committee, I thank you for this opportunity to testify. I am accompanied this morning by Dr. Perlin, Mr. McFarland, and Mr. Epley.

Secretary Principi and I consider the VA's security and preparedness, our readiness to meet any threat, natural or man-made, accidental or deliberate, a grave responsibility. Our concern is not only for the welfare and lives of our veteran patients and our staff, but also for the communities in which we work and live. My written testimony details VA's readiness plans and programs; so I will concentrate here on the basics of our overall readiness to meet any and all contingencies.

Immediately following 9/11, a review of the Department's preparedness posture and potential vulnerabilities was completed. In answer to that, we reorganized to provide a comprehensive all-hazards approach to emergency management. We established an Office of Operations and Readiness within the Office of Assistant Secretary for Policy, Planning, and Preparedness, which has focussed

our collaboration with other Federal, State and local agencies. We have pledged significant resources to emergency preparedness training, education, and exercises, as well as the studies and evaluations.

VA's funding for initiatives relating to Homeland Security rose from \$84.5 million in fiscal year 2002 to \$271 million in fiscal year 2004, and our fiscal year 2005 budget submission includes a request for \$297 million. And we have tasked our Office of Research and Development to include projects related to terrorism and emergency management in its portfolio. While VA's primary responsibility in the event of an emergency is to ensure the safety of our patients, personnel, and assets, we have a number of national level responsibilities, including serving as the principal health care backup to the military in the event of a national emergency.

VA's Office of Operations and Readiness provides a coordinating function and comprehensive all-hazards approach to emergency management for the entire Department. We have expanded our continuity of operation sites from two locations to four and our central office readiness operation center to covering issues as needed including 24/7.

VHA's Emergency Management Strategic Health Care Group, (EMSHG), coordinates emergency medical preparation and management at the community level. Across the Nation, EMSHG is staffed by 37 area emergency managers and three district managers located at major population centers around the country. EMSHG also manages the Medical Emergency Radiological Response Team, a team of VA physicians, radiologists, and health physicists that functions as a Federal asset to FEMA. VA also maintains a partnership role in the National Disaster Medical System (NDMS) supporting NDMS at the local level through several activities including recruitment of nonfederal or civilian hospitals which dedicate available staffed beds for victims of disasters or other catastrophes. Since 9/11 the VA has responded to over 35 preparedness activities including emergency preparedness exercises, high visibility events, hurricanes and floods.

Currently, the VA is assisting in the aftermath of Hurricane Charley by providing more than 90 allied health care professionals to supplement local emergency response.

In addition to its role in the NDMS, VA is a recognized national partner in other emergency planning and preparedness activities and has taken a number of actions in this area since September 11. Actions we have taken include work in the area of smallpox vaccinations where VA developed a national preexposure plan for the vaccination of VA smallpox health care response teams and vaccination teams and the Homeland Security Advisory System where all VA facilities have adopted the Homeland Security Advisory System.

Prescriptive and specific response requirements for each of the threat levels have been developed and distributed to the field. The National Infrastructure Protection Plan where VA has provided a report to OMB highlighting VA's plan for protecting its physical infrastructure, cyber-critical infrastructure, and other key resources. In the Physical Security Assessment Methodology, the proximity of some of VA facilities to high vulnerability targets requires that

these facilities be protected. VA has developed a physical security assessment methodology which has been adopted by the Federal Emergency Management Agency and implementation of the Health Security Protective Document No. 5.

VA is participating in the development of a single integrated national plan in accordance with the Homeland Security Presidential directive. VA has adopted the incident management system to organize our emergency operations.

In the area of JCAHO standards, VA has produced the Emergency Management Program Guidebook to facilitate compliance with JCAHO standards. This is a definitive guide on emergency management and was an important research to JCAHO in developing standards to all accredited U.S. hospitals.

Most VHA facilities have been successful in meeting police staffing goals established by the VA. Of the 135 police units, only 10 have police officer staff levels below the minimum requirements at this time, and that is an ongoing operation to bring them up to the required staffing. VA is in a constant state of readiness to respond to national or local emergencies. We have participated in senior governmental exercises and training, and to date, we have held 26 continuity of operations or COOP exercises to test the validity and completeness of our plans. And I might make the point too that VA lives beyond exercises and plans.

Over the course of time since 9/11, we have been involved in 48 different exercises that include national events, but also include real-time, real-life operations in emergencies like the recent hurricanes, and I have a list here of 48 national events that include them. So it isn't just again planning our exercises. We do this as we keep this system operational across the timeline.

VA is in a constant state of readiness to respond to national or local emergencies. VA's national acquisition center manages four pharmaceutical and medical supply caches for the Department of Homeland Security and FEMA as a part of our NDMS and two additional special caches for other Federal agencies. And these stockpiles assist with medical consequences of disasters, including weapons of mass destruction.

In the wake of 9/11, the VA created 143 internal pharmaceutical caches at VA medical centers. Ninety of those are classified as large, which can supply 2,000 casualties for 2 days and 53 would supply a thousand casualties for 2 days, and those are directed at our first requirements which is to stabilize our patients, our workforce, and those that are protecting the area. Although the VAMCs are not first responders, there is a need for mass decontamination capability if the facilities are to be safe.

So accordingly, the VA has developed and is implementing training and acquisition of standardized processes and equipment for decontamination of biohazards. Also VA has increased its emergency preparedness research portfolio. This year, VA investigators at 16 facilities conducted 11 research projects focussing on contagious diseases, protective immune responses, and DNA-based vaccine development. Those 11 projects represent in excess of \$7 million.

Mr. Chairman, I have spoken primarily of the activities involving either VHA or the Department as a whole, but both the Veterans

Benefits Administration, (VBA) and the National Cemetery Administration, (NCA) play roles in ensuring departmental preparedness and continuity of operations. In VBA, the benefits payment system has two redundant systems in place at alternate locations to ensure timely payment of benefits. Backup tapes are stored at several locations to ensure that data can be transmitted to the Treasury to make the payments from alternate locations, and all VA corporate applications currently in operation in Austin, Texas can be successfully recovered in less than 12 hours and with less than 2 hours of lost data.

And for NCA in the event of a mass casualty event, NCA is prepared to advise on methods of internment for fatalities and to assist in the disposition of human remains.

To improve or enhance our emergency preparedness programs, the VA has completed or initiated evaluations and assessments including the VA medical facilities emergency preparedness capabilities; physical vulnerability; essential paper records, VA research laboratories; and our emergency planning, exercise, and evaluation program.

Mr. Chairman, the VA's goal is to continue to provide needed emergency response services on both the local and national level. Taken as a whole, the activities of the Department provide solid evidence of our willingness and ability to respond effectively and efficiently.

This completes my statement, and my colleagues and I will be happy to answer any questions you or other members of the committee may have. Thank you.

[The prepared statement of Mr. Mansfield appears on p. 94.]

The CHAIRMAN. Secretary Mansfield, thank you for your very comprehensive statement and the good work that you are doing. Your full statement does contain some additional detail, which I hope all members will take the time to read; so I do thank you for that.

I would like to invite Major General Martinez-Lopez for his testimony.

STATEMENT OF MAJOR GENERAL LESTER MARTINEZ-LOPEZ

General MARTINEZ-LOPEZ. Mr. Chairman and members of the committee, thank you for the opportunity to briefly discuss the contributions of my command toward medical preparedness in the event of a biological attack on the Homeland and cooperative efforts and research collaborations with the Department of Veterans Affairs.

As commanding general, I am responsible for delivering the best medical solutions, for today and tomorrow, to enhance, protect, and treat the warfighter on point for the Nation. This responsibility includes protection against biological and chemical attacks on the battlefield and, since 9/11, has expanded to include attacks on our homeland. My command is actively involved in many pertinent activities, some of which involve collaborations with the VA, which I will share with you today.

As the anthrax attacks demonstrated, the new bioterror respects no borders our homeland is at continual risk. After the attacks, many turned to Fort Detrick for answers because throughout our

60-year history, Fort Detrick has contributed scientific breakthroughs and medical solutions for the Armed Forces and the Nation. In fact, for over 20 years, all Centers for Disease Control and Prevention, CDC, samples came to our biodefense laboratory in the United States Army Medical Research Institute for Infectious Diseases, better known as USAMRIID, for Bacillus Anthracis testing.

Because of its history and leadership in biodefense, USAMRIID will be the cornerstone of the National Interagency Biodefense campus at Fort Detrick. Through partnerships between United States Army Medical Research and Materiel Command and agencies of the Department of Health and Human Services, the Department of Homeland Security, the Department of Agriculture, the campus will be the Nation's primary center for development of defenses against biological terrorist attacks. These agencies have complementary programs and specific expertise that, through this interagency partnership, will compress the discovery cycle.

An interagency campus master plan has been developed and construction has started. The National Institute for Allergy and Infectious Diseases at the NIH will break ground for its new facility this year. The National Biodefense Analysis and Countermeasures Center, or NBACC, of the Department of Homeland Security, will soon release an environmental impact statement for its Fort Detrick facility. The National Bioforensic Analysis Center, a component of NBACC, has renovated a laboratory inside the USAMRIID building and now conducts the forensics and confirmatory testing mission in support of the FBI and other government agencies. The Department of Agriculture already has laboratories at Fort Detrick.

Since 1992, my command has been a key trainer of first responders, military and civilian care providers, and other personnel throughout its Medical Management of Chemical and Biological casualties course. Through the on-site, on-line and satellite transmitted distance learning courses, we have trained more than 134,000 people throughout the world, including more than 58,000 military, over 75,000 civilians, and over 1,000 public health service personnel. Among the civilian trainees are many VA personnel. Just this month an off-site course was presented at the Baltimore VA which trained 40 of their personnel. We have also published textbooks, handbooks, field manuals, and multiple videos that are standard teaching aids used by the VA and other government and civilian agencies.

The United States Army Medical Research and Materiel Command is heavily involved in the national Laboratory Response Network. Established in 1999 by the CDC, the Association of Public Health Laboratories, the FBI and USAMRIID, the LRN ensures rapid recognition and reporting of laboratory results that could indicate a biological attack. USAMRIID continues to serve as a national laboratory within the LRN, and, although there are no formal agreements, under the LRN, the VA can be directly supported by USAMRIID if requested or as required.

Through our Electronic Surveillance System for the Early Notification of Community-based Epidemics program, or ESSENCE, we are collecting military patient encounter information into an analysis database, looking for geographic-based disease trends that would indicate a biological attack. The next version of ESSENCE

will track military and civilian outpatient visits, over-the-counter pharmacy sales, school absenteeism, and animal health care data. The new CDC program BioSense plans to integrate DOD and VA and other national data to provide a comprehensive national syndromic surveillance program.

Other government agencies are increasingly relying on USAMRIID products or information in response to bioterrorism. The NIAID and commercial manufacturers have sought USAMRIID's biodefense medical products for civilian applications. Collaborations between USAMRIID and NIAID have supported the development of next-generation anthrax vaccine, multivalent vaccines for botulinum neurotoxins, and research on Ricin, plague, Rift Valley Fever, Ebola virus, SARS, Severe Acute Respiratory System and orthopox viruses including the virus that causes smallpox, using technologies developed by USAMRIID. USAMRIID has also collaborated with Dr. Hostetler from the San Diego VA, whom you will hear from shortly, to develop and test an oral drug to treat smallpox infection. In addition, we have four research agreements with VA medical centers two for the study of marine and bacterial toxins, one for the study of *Francisella tularensis*, and the last for the study of Bacillus anthracis.

I am also responsible for medical research that focuses upon Gulf War Illnesses and Force Health Protection for the DOD. My command began organizing and directing this research effort in 1994. We have made enormous progress in the past decade. The best scientists in the government and renowned universities have collaborated to understand the cause and develop treatments for affected veterans.

The DOD and VA medical research programs now dovetail such that the DOD concentrates on long-term consequences of operational threats and the VA identifies exposure risks to better prepare and protect warfighters. For example, researchers of at least three different VA centers are currently collaborating with DOD investigators to interview soldiers at Fort Lewis, Washington who have just returned from Iraq. This effort is part of an ambitious study jointly funded by VA and DOD to identify the most sensitive neuropsychological tests that can be used to detect early signs of a change in neurological status of soldiers following a deployment. This was one of the important diagnostic gaps identified in our Gulf War experience. Another example is the shared funding support by DOD, the NIH, and the VA to the neurodegenerative disease imaging center at the VA Medical Center in San Francisco. This center is developing state-of-the-art methods to use objective brain measurements to explain subjective symptoms of chronic multisymptom illnesses, other DOD programs, as well as early changes that may forecast brain diseases. Other DOD programs, started in part because of issues raised in Gulf War illnesses, are identifying hazards to the brain, including the most susceptible neurons whose loss leads to illnesses such as Parkinson's Disease, Lou Gehrig's Disease, or amyotrophic lateral sclerosis, or ALS.

These studies will follow up on important Gulf War illnesses studies such as the VA, DOD study that suggests deployed Gulf War veterans may have a higher rate of ALS than nondeployed forces. This current research effort, which includes over 100 stud-

ies, is providing new insights into causes of Parkinson's Disease and related neurodegenerative diseases, earlier diagnostic methods, and preventative measures.

Successes in Gulf War illness research conducted by DOD and the VA who help our national response against weapons of mass destruction.

The Telemedicine and Advanced Technology Research Center, TATRC, is collaborating with the VA in several areas. For example, the Amputee Center and Prosthetic Device Technology enhancement project addresses shortcomings in the management of blast injury amputations; Veterans Administration staff have augmented the Walter Reed Army Medical Center staff for this project. The Hawaii Integrated Federal Health Care Partnership is a VA/DOD telehealth and telemedicine research, development, prototype evaluation and technology transfer program. There are additional VA/DOD telemedicine collaborations that will enhance the care of our beneficiaries and, in addition, may become an asset in the response to a bioterrorism attack.

Many agencies are working closely together to ensure our Nation is medically prepared to respond to attacks on the Homeland. There is much work to be done but I am confident that we are headed in the right direction.

Mr. Chairman and members of the committee, this concludes my remarks. I will be pleased to answer your questions.

[The prepared statement of General Martinez-Lopez appears on p. 111.]

The CHAIRMAN. Thank you very much, General, for your testimony and for your service to our country.

I would like to now recognize Secretary Simonson.

STATEMENT OF HON. STEWART SIMONSON

Mr. SIMONSON. Thank you Mr. Chairman and members of the committee. I appreciate the opportunity to be here to comment on the collaboration between our Department and the Department of Veterans' Affairs. As you know, several aspects of HHS's mission are closely aligned with those of the VA. There is a longstanding tradition of collaboration between the staffs of the two departments. We share a lengthy history in health-related matters including emergency preparedness activities beginning with the extensive collaborations which led up to the creation and management of the National Disaster Medical System. While NDMS is now part of the Department of Homeland Security, HHS continues to partner with DHS, the Department of Defense, and the VA with respect to deployment of specialty teams, patient movement, and definitive care.

Following the precedent established in the Federal Response Plan, the current interim National Response Plan continues to designate HHS as the lead agency for emergency support function 8 which addresses the coordination and provision of health and medical services in a public health emergency. In such an emergency, VA will provide critical assistance that includes designating and deploying available medical, surgical, mental health, and other health service support assets. Homeland Security Presidential Directive 10 designates HHS as the lead agency for mass casualty

care and directs VA as well as other federal agencies to support HHS in carrying out this mission.

Of particular concern since 9/11 is the possibility of a public health emergency occurring that would eclipse State and local capabilities, creating a phenomenon often called surge. Such an event, whether resulting from a naturally occurring or man-made disaster, might overwhelm the ability of States and local governments to respond. My office is leading an interagency working group that is conducting an end-to-end analysis of surge capacity and developing an appropriate action plan. VA, along with other Federal departments, is collaborating with HHS in this important project.

It is clear that the provision of medical care to large numbers of casualties is an enormous challenge. The availability of sufficient numbers of health care providers represents a daunting impediment to the development of an effective mass casualty care plan. HHS is currently working with Homeland Security and the interagency working group including the VA to develop options and recommendations to address the availability of health care providers to respond to a mass casualty event. Our collaborative efforts with VA extend beyond patient care.

Last year Project BioSense, a multi-agency program, was initiated to facilitate rapid near real-time electronic transmission of public health information from a variety of health data sources to permit early detection of disease outbreaks resulting from either naturally occurring or terrorist-triggered events. One of the sources of information for BioSense is the VA, which transmits data electronically from its ambulatory care treatment facilities. Specifically, the VA provides diagnoses and procedure codes on a daily basis from outpatient and emergency room patient visits. These data are received by the CDC, merged with data from other sources, and analyzed by zip code to detect signals that may indicate an unusual or unexpected pattern of disease.

Should such a signal appear in the VA provided data, CDC would work closely with the VA to provide evaluation and other information and initiate a prompt investigation. To date, BioSense has received over 30 million records from VA ambulatory care treatment facilities. The VA's national acquisition center is HHS's principal Federal logistics partner for emergency operations and the strategic national stockpile program, which was recently transferred from HHS to DHS.

In carrying out a broad range of SNS-related activities including day-to-day operations and exercises to test the capability of State and local health departments to receive and distribute contents of the national stockpile, CDC has leveraged existing VA contracts in the operation and maintenance of the SNS and in the design, execution and evaluation of deployment exercises. CDC has also collaborated with the National Center for Post Traumatic Stress Disorder at the VA. Much of this collaboration includes surveillance and needs assessment as well as some work on compliance issues. CDC is co-sponsoring an upcoming conference with the national center for PTSD that will be held in Atlanta at the end of this month. The objective of this conference is to help us identify flash points that could precipitate negative collective behavior as well as

mitigation strategies for behavioral issues that could emerge in the aftermath of a bioterrorist attack.

It is important to recognize that in the case of a biological or chemical terrorism attack or other sizable public health emergency, VA facilities and staff would undoubtedly serve an invaluable resource in the response. To underscore this point, the cooperative agreements awarded by HHS's health service resources and services administration for State and local hospital biopreparedness programs identified the VA as an institution that should be represented at the State bioterrorism preparedness advisory committee.

I am happy to report that States have taken this recommendation seriously and are collaborating with regional VA representatives in developing public health emergency readiness plans and exploring the use of VA staff and facilities to create surge capacity.

The VA is also a critical resource for the education of our Nation's health care professionals. As training sites for the majority of health professional schools, VA facilities play a prominent role in the earliest stages of medical training. The VA has tremendous potential for ensuring that our physicians, nurses, paramedics and other health providers are trained to meet the challenges of caring for casualties resulting from a chemical, biological, radiological or nuclear attack.

HHS views VA as a very important partner in our readiness planning efforts at the Federal level as well as the State and local levels. VA brings a breadth and depth of critical experience to bear on preparedness issues of concern to both Departments.

During emergencies, whenever HHS is called, VA has responded, and we appreciate that. It is a partnership between our two agencies, and it is a durable one. We are very pleased to have the VA at the table with us, and we look forward to working with them in the future as we better prepare our Nation.

I would be glad to answer any questions you might have.

[The prepared statement of Mr. Simonson appears on p. 120.]

The CHAIRMAN. Thank you very much, Mr. Secretary.

Let me thank, again, all of our witnesses and those who have come with them today, who also bring a wealth of experience to the table and very, very noble service.

I do have a few questions I would like to ask, first, to Secretary Mansfield.

As you know, the Battaglia report had some 58 separate recommendations, very, very mutually reinforcing where deficiencies were found. As a matter of fact, Mr. Battaglia wrote, "The failure to correct deficiencies is not an option," in the opening paragraphs of his report; and I found it to be a very sobering and troubling analysis of just where we were back in 2001 when that report was done.

I was wondering if you could provide us with, either now or for the record—preferably as much as you can now—feedback on several of those very specific recommendations that were made in the area, for example, of sensors or the lack of sensors at VA health care facilities; and the issue dealing with, or the belief that our resources would be overwhelmed very, very quickly if there were huge casualties.

One of the saddest aspects of 9/11 was it was so lethal, and so many of the men and women who died in the World Trade Center, many of the widows who are from my district or from environs just outside of my district, I have met with so many of those individuals over the years.

As a matter of fact, just for the record, I think all of us know there would not have been a 9/11 Commission had it not been for the survivors, the families who made Congress step up to the plate and authorize the creation of that 9/11 Commission, including Kristen Breitweiser, Mindy Kleinberg, Lori van Auken and Patty Casazza, and many others from my area who are friends. They talked to Members of Congress, both sides of the aisle, and that report was produced.

I would also point out that the report, as good as it is, missed out on the VA's role. I read that with great attention looking for the analysis of what the VA can provide, and that is very troubling.

I would just point out again, parenthetically, when anthrax hit Hamilton Township, New Jersey, and then, of course, Brentwood and the Hart Building and led to the shutdowns, and five people died. Seven people got sick in my own State, there were no deaths, thankfully, but they got sick, with two inhalation cases of anthrax, and five cases of cutaneous. With one of the things we found as the team was assembling to address that crisis, was that the VA was not counted on as a partner. And when there was a lack of Cipro to treat the postal workers, who were really brave during that whole crisis, no one knew, or seemingly knew, that the VA had a cache of Cipro that could have been immediately made available; and there was a period of time where that and doxycycline and their whereabouts were in question. And thankfully the VA did make itself available, so they would use it, and I certainly tried to help in that regard. But it amazed me the key people were unaware of that fact.

So I would ask, Mr. Secretary, a couple of questions with regards to that.

The VA seems to play more than second fiddle, third fiddle, in the planning, and it ought not to be that way. You look at the fourth mission of VA, after medical care itself, research, education, the fourth mission is emergency planning and preparedness, and when you have such an integrated network, it seems to me the U.S. Government is missing out on an enormously important resource.

Regarding some of the things that the Battaglia report recommended, the ability to prepare for casualties of chemical and biological events in 2001, lower than it was in previous years, was degraded. Hopefully, that has been built up. You mentioned some of that in your testimony, Mr. Secretary.

The training of our men and women who are the first responders, my understanding is that about half have been trained. When will the other half be trained?

The contamination issue: As people with chemical or biological or radiological contamination are coming into the emergency rooms, how do we protect those first responders so they are not then sick. And in terms of the ability to react effectively, not only do they get

sick and perhaps die, it leads to more paralysis in treating the casualties as they are coming in. So those are issues.

I don't know if we have sensors yet. I know within the postal department, there is a huge procurement under way to buy sensors that would detect anthrax and other contaminants early before they get through the system and then contaminate the public at large. What is the VA doing with regard to that?

Finally, let me just ask about those emergency preparedness centers one more time, because I know you and the Secretary has been very supportive. President Bush signed the bill. It was my bill. It was bipartisan, and Lane Evans was the principal cosponsor. It seemed to make an enormous amount of sense.

Nobody was working these issues, and to my knowledge, no one is working them the way they ought to with regards to our veterans who may be coming home. I don't think we are working on the knowledge base the way we could so it could be shared for all of those contaminants that are out there, and there are dozens of them, there are scores of them. That bar that has been put on implementing that law is extremely troubling to me and to my friends on both sides of the aisle.

Mr. Secretary.

Mr. MANSFIELD. In response to that particular question, sir, I think you know that we have had discussions down here on the Hill with other committees of this Congress, and we remain in a situation due to that.

The CHAIRMAN. Okay. But, again, it is a bill or law that President Bush has signed—does support the creation of these medical preparedness centers.

Mr. MANSFIELD. Sir, as I think we have discussed before, one of the serious concerns we have, and as you mentioned in your prepared statement—and other members did also, that we have a first responsibility to ensure that we take care of the patients we have, and that those medical care dollars be expended in that area.

We have gone through a process over the course of the last 2 years in removing a waiting list that at one time approached 300,000, down to 6,000 now, where it is a workable situation. I think we are still looking at a situation, though, that whatever has been proposed would require us to take some of those medical care dollars to match the research dollars. So I think we are still in a discussion phase.

The CHAIRMAN. Okay. On the other issues dealing with the Battaglia recommendation?

Mr. MANSFIELD. Sir, I have a copy, as of August, of the implementation status and recommendations of the Battaglia report. If I could get a clean copy from my staff behind me, we could send that to the dais. Mine is marked up a little bit. But we do have a status report on all the issues and where we are.

You did mention a couple of specific issues. In the area of sensors, I may ask the experts here to talk about it, but my understanding is, we are still in the process of those actually being developed for public access or distribution. I don't believe they are currently available.

Dr. Perlin, do you want to comment on that one?

Dr. PERLIN. Good morning, Mr. Chairman. Thank you very much for your support and the support of the committee in this particular area and your recognition of the process. The Battaglia report outlines a number of areas for preparation, and I appreciate your commenting on the progress of that.

The sensors specifically are not yet at a point of development where they could reliably be placed in a public building. Perhaps the best work in terms of early identification of threat and responses is training. In many ways we view training as the best sensor. We have shared with your staff, and would be pleased to share with you, a number of materials that have actually been used to support early identification, early treatment, decontamination, both within VA and made available as resources for hospitals and health care throughout the country.

The CHAIRMAN. I appreciate that. When we get the feedback on the recommendations, I would like to perhaps further engage you on that.

Just regarding one statement that will be made by Dr. Livingstone later on in his testimony, I think this is done in the realm of constructive criticism. Even as I mentioned earlier, the 9/11 Commission was an exemplary effort of bipartisanship with 70-odd staffers; the Committee on International Relations heard from some of the staff the other day—they worked these issues and worked them hard. But still the VA was not found anywhere within those pages, as well as in their analysis; and there were other omissions as well, and I could go into those, if you would like.

But one point that Dr. Livingstone raises, is whether the VA able to respond effectively in the event of a major biological attack? Sadly, the answer is no.

I don't think that is a dig. I think the effort is so large, and it seems to me we are in the beginning phases of getting ready to face the unthinkable, which is here and now.

How do you respond to that kind of criticism?

Mr. MANSFIELD. Well, sir, again it is one we would like to think we could take care of, whatever happens, but we recognize that we don't know what might happen, so we have to be prepared as best we can.

As my testimony and as the status report show, we made a number of improvements in areas that were identified. One example is, I believe, we have a—1,200 or 1,600 physicians or medical professionals that are registered with us that are available to move from any part of the country to a spot where we may need them to assist the VA in providing whatever we may need to do in an area.

I think we do recognize that probably no matter what might happen, no matter where it happens, the VA is either going to be there or close by, and we would expect that the VA is going to be called in. We have obligations, as indicated under FEMA. We are prepared to meet them, as I indicated, to deal with some of these issues, and have not only the training and the planning, but actually the execution behind us.

I think we have done a good job of continuity of government. I just ran an exercise with two of our under secretaries, four assistant secretaries, myself and 120 people from the VA central office at a removed site from Washington over a 2-day period in conjunc-

tion with the rest of the Federal Government. So we are doing more than we were, but I wouldn't argue with you that there is more we can do.

In the area of decontamination, for example, you mentioned as a response, we know that that is an area we are going to have to work on. As I indicated, the first concern we have is our patients and our hospitals and our medical personnel, and then the support staff in that area, and we have made arrangements to attempt to deal with that.

One thing we are finding though is, although we have minor caches in place to deal with that aspect of it, the decontamination equipment is an area where we have got orders in—we have got some places that have it on site, and we are waiting for them to build more of these units and get them delivered on site.

I do know, for example, including the hospital at Irving Street, our folks have gone out in many cases and put together their own decontamination units. They are not the professionally executed, built, prepared ones, but they have put together the materials that may be needed. We have trained across the system, so we have the folks trained to be able to deal with this, and we are moving forward with acquisition. That applies in the other areas, too.

The CHAIRMAN. Let me just say, we will be going under the 5-minute-plus rule, so if people want to exceed that, I think this is too important to limit members' questions.

One of the recommendations dealt with pharmaceuticals. Again, the finding was, and I will read it, "In the event of chemical, biological, radiation attack or exposure, the VA inventories of equipment and pharmaceuticals are not adequate or available in time to address medical needs."

One of the recommendations dealt with stockpiling 2- or 3-day supplies for immediate response to local emergencies, and the divisions each having plans to address shortages. Has that recommendation been acted upon?

Mr. MANSFIELD. Yes, it has. As I indicated in my statement, we have large caches to treat 2,000 persons for 2 days, and small caches for 1,000 persons for 1 day. In addition to that, we also work with HHS in the responsibility for the overall national caches, so we are aware of what those are and where they are.

The CHAIRMAN. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Let me thank the panel for your testimony and thank you for what you do for all of us.

Secretary Mansfield, the VA, as it prepares to reserve capacity, one of the things that has occurred—and I want you to respond to this—is, we have lost on the availability of beds. There has been a decrease since 9/11. I heard your testimony prior to that in terms of the importance of meeting the need there now.

In preparing this, it seems to be an afterthought. It seems like we have to got to—I understand we have to take care of what is there now, existing problems there; and it seems to be like an afterthought. And I know you need additional resources, because I know at the same time, the administration's budget for next year is almost level funding, which creates a problem in terms of even existing resources.

But I also want you to respond to the fact that we are decreasing the number of beds and what an impact such as that is going to have in case of an emergency.

Secondly, Mr. Simonson, in March of 1992 at an oversight subcommittee hearing on the VA Department of Defense contingency hospital system and related issues, an HHS witness, the director of the Office of Emergency Preparedness National Disaster Medical System, Dr. Thomas Rudeshan, defined the worst-case scenario for us.

I would want to ask you, what would be our worst-case scenario in today's situation. And to respond to that, I am just going to read to you what he gave us then, quote, unquote.

He said that an 8.3 earthquake somewhere in this country might instantaneously, within a matter of minutes, produce 100,000 seriously injured people that would need hospitalization.

The threat of an 8.3 earthquake is still there, and where are we in terms of hospitalization of 100,000—you know, that might be needed, when at the same time we have less beds than we had before 9/11?

Mr. MANSFIELD. Sir, in the area of the bed capability, that is a responsibility that we have normally as part of our mission to deal with DOD. In their ongoing reporting that takes place there, right now we have the capability of identifying, filing and providing 4,620 beds within 72 hours, and 6,035 within 1 week.

I might make the point also, as I testified to, that we do have an additional responsibility in these areas to work with identifying non-Federal or civilian beds that may be available in certain areas. That would be in addition to these.

Mr. RODRIGUEZ. From the perspective in terms of the worst-case scenario? I know you talked about those planning things that you are looking at, and I am glad to hear that.

Mr. SIMONSON. I am not sure I would say today an earthquake would be our only worst-case scenario. We have a few others that we think of as well, in the post-9/11 world. But we do use a 100,000-casualty event as a planning device, and we have got some way to go before we are able to say with certainty that we could respond in a seamless way to that sort of emergency.

But there are plans every day being improved upon that I believe give us a very robust capability to project field assets right into the area that is affected.

No amount of work at local hospitals, or at VA hospitals, is going to allow us to accommodate 100,000 people who have been seriously injured. It is going to require alternate care facilities, projectable assets and so forth; and that is what we are working on right now.

Indeed, I was struck by one of the questions earlier about the VA's collaboration in emergency planning. In my office, the person who runs the surge capacity and mass care program is a VA physician who, thanks to Mr. Mansfield, is detailed to the Office of the Secretary of Health and Human Services. So we have a very close collaboration on that.

Certainly an event that yields, God forbid, 100,000 casualties, would require us to leverage the VA, the military hospitals, that is to say, the existing established military hospitals, but also the

use of deployable assets from the National Disaster Medical System and from the services.

But this is a very daunting scenario, and it would be disingenuous of me to say that all of the plans have been made in order to accommodate such an event seamlessly.

Mr. RODRIGUEZ. What concerns me also, and I will say it once again—and I know the Secretary had kind of verbalized it in a different way in that we have to take care of existing problems now, and that is our first priority—mission four, in terms of preparing, seems to be kind of like an afterthought.

We have got to get it on the front burner. That also requires resources, and that also requires an obligation on our part, Mr. Secretary, and I know that there is a need for us to move in that direction, and we have not. So in order to do that, I know that 4,000 beds and identifying others outside is key in this whole process.

One of the things I would like to share, that same report that the Chairman was talking about, the Battaglia report, also talks about the post-traumatic stress disorders, the fact that we are still not prepared.

You mentioned, Mr. Simonson, the meeting you are going to be having in Atlanta. I would ask you to look at what happened in New York and at the Pentagon, to look at that, because if any of those individuals that went to New York, that experienced that, and the rest of America that experienced that, go through a process—and I know that our soldiers now are going through that process, and I know we are trying to do everything we can to pick up on those veterans, on those soldiers when they get released and become veterans—in order for us to service that. And that is an area that we also need to continue to move forward on.

I would maybe ask for comments from both of you.

Mr. MANSFIELD. Yes, sir, that is obviously an important issue and one we are aware of, and one I think we have done additional efforts since 9/11. In the efforts that took place then, we actually had VA professional people on the ground in New York and here in Washington and northern Virginia to help deal with that issue.

In recognizing that, plus also some of the issues that we are in the process of learning from Iraq and Afghanistan, we have moved forward in this area. We have some clinical practice guidelines that have been developed, we have more additional training being done, and we are doing, I believe—a better job of attempting to help identify these issues, especially with the returning troops. But also that capability will carry over in any emergency situation we find ourselves in.

Mr. SIMONSON. That is exactly our aim here, to leverage the experience, the tremendous experience the VA has with PTSD and to apply it to the bioterrorism context.

Mr. RODRIGUEZ. My last question—I know General Martinez-Lopez. Thank you for your service.

Let me ask, I know we have talked about bio and chemical warfare and the importance of vaccines. And for the last—I have been here 7 years, we have talked about some kind of world vaccine center, because we know the private sector does not want to produce some of those vaccines because of the cost and they might never

be utilized—and hopefully they never would be utilized. But we have not moved on that.

I know HHS mentioned a center to look at that. I know we have talked about it, and that hasn't occurred.

Where do we find ourselves from a medical perspective in terms of responding to a biological and chemical attack from a vaccine perspective and any other we might need to respond?

General MARTINEZ-LOPEZ. Sir, our experience has been a very good experience actually since 9/11. The interagency collaboration has been nothing but outstanding, and I will give you examples.

Many our products, the way we used to develop them, a vaccine, was within the Department of Defense. Nowadays, we have a very strong collaboration with NAIAD; and in partnership with NAIAD and other agencies of the Federal Government, we will be able to advance the discovery of these vaccines. And many of the solutions—it is not just vaccines, you are going to hear about drugs. We cannot count on just one solution. We have to put a couple of things in that, too, in making the decision, so if the vaccine fails, then you have treatment.

But the good news is, we have a system now that we integrate interagency. As you can read from my testimony, there are many products that we are advancing, not within the Department of Defense, we are advancing in partnership with the Department of Health and Human Services.

The other good news out of this story is that bioshield legislation. I am not an expert on the whole legislation, but from my vantage, I think it really kind of helps industry to come in early on, to collaborate in advancement of these products. We need to really compress the discovery cycle. From the moment we have a need to the moment we feel something, we really need to work it out, and the only way we are going to be able to do that is to approach it as a team effort. It is not an effort of the Department of Defense, or an effort of HHS, and is not an effort of the Department of Homeland Security; it is all of us. Academia, industry, all of us have to play a role; and I am optimistic we are heading in the right direction, and through many of the interventions, you have helped us out through legislation.

Mr. RODRIGUEZ. Thank you, gentlemen. Thank you.

The CHAIRMAN. Mr. Miller.

Mr. MILLER. Mr. Chairman, this question will go to both Secretary Simonson and Mr. Mansfield.

You talked about surge in your opening comments and your office was leading an interagency working group to deal with that. Can you give us an idea of the timeline as to, when did you start, when do you expect to have a product from recommendations, and then do you anticipate any action required by Congress to assist?

Mr. SIMONSON. Our timeline is very compressed. I expect—it is a continuum. I don't think we are going to end up with just one product that says, This is how you take care of 100,000 people. I think we are going to see it developed in increments.

We are, at this very moment, working on a program to purchase some pilot materials so that we can sort of understand what the footprint looks like for a Federal contingency hospital, if we had to

develop one in the place where they are outside of an existing hospital or perhaps projected even further.

So I don't know whether congressional action will be necessary beyond the work that we will have to do on our sizing of the budget for this and so forth. The President requested \$20 million in his 2005 submission, and so the program we are working on now is a way to use that \$20 million to build up a very sizable capacity to project into an affected area.

But as Dr. Claypool would tell you, my colleague working on surge, I would very much like to have a product by the end of the week, if possible, but it is not, maybe, so practical—so sooner, rather than later.

Mr. MILLER. Secretary Mansfield, if I could go back to the four National Medical Emergency Preparedness Centers that the Chairman and others have talked about—and we are all interested in finding out when, obviously—I think your response was something to the effect of, we have current needs now. I know we have authorized the centers. The funding has not been either requested or made.

My comment is, we have got a very aggressive capital improvement program ongoing right now within the VA system, a lot of new medical centers, VA clinics. In my district, a 220,000-square-foot joint use facility that will be located adjacent to Naval Hospital, Pensacola.

I am interested, and I am sure my colleagues are too, has there been any movement towards even designating areas where these facilities will be located, and if not, why can't you look at the current construction or capital improvement programs that are ongoing and follow that in so we can speed this process along?

Mr. MANSFIELD. Sir, I will make a commitment to going back and sitting down with my boss, the Secretary, and discussing this issue and getting an answer directly back to the Chairman and the committee.

Mr. MILLER. Thank you. Remember, Pensacola.

Mr. MANSFIELD. Is that in Florida, sir?

Mr. MILLER. Yes, sir, it is.

(Subsequently the Department of Veterans Affairs provided the following information:)



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 25, 2005

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

Dear Mr. Chairman:

It is my pleasure to inform you that the Department of Veterans Affairs (VA) has awarded a design/build contract for the VA/DOD (Navy) Joint Ambulatory Care Clinic (JACC), Pensacola, Florida.

This project is for replacement of the existing VA-leased outpatient clinic in Pensacola and an existing Navy clinic at Corry Station. Funding for this project was appropriated in FY 2004.

The 200,000 gross square foot, 2-story Joint Ambulatory Care Clinic (JACC) will be situated on a 25-acre site within the boundary of Corry Station. The new facility will be a state-of-the-art ambulatory care clinic providing a full range of primary care services to area veterans to include mental health services, women's clinic, audiology, optometry, dental, pain clinic, cardiology and urology. Associated ancillary services including radiology, laboratory and pharmacy services will be included in the new construction. The construction of the new clinic is expected to be completed in January 2007.

The contract was awarded to Heery/PMC, Joint Venture, of Atlanta, Georgia, in the amount of \$48,101,500.

This notification has been sent to the leadership of the House and Senate Committees on Appropriations and Veterans' Affairs and the local members of the Florida Congressional Delegation. If you have additional questions, please have a member of your staff contact Mary Kay Stack, Congressional Relations Officer, at (202) 273-5628.

Sincerely yours,

A handwritten signature in black ink, appearing to read "R. James Nicholson".

R. James Nicholson

**FY 2005 AND 2006 VHA DETAILED MAJOR CONSTRUCTION
PROJECT INFORMATION**

FY 2005 Projects

Project Location	Tampa, FL
Planned Project Name	SCI Expansion
Fiscal Year	FY 2005
BA Requested (Capital)	\$7.1M
Total Acquisition Cost (\$000)	\$7,100
Asset Type	Major Construction

Project Description

This project requires \$7.1M in FY 2005 budget authority. This project will provide for the construction of a 30-bed, approximately 17,100 Departmental Gross Square Footage (DGSF), Spinal Cord Injury Extended Care addition at the James A. Haley Veterans' Hospital. It is a CARES, VISN 8, Central Market, and Special Emphasis Program Gap Planning Initiative. As background, Major Construction Project 673-087A, "Spinal Cord Injury Addition" was originally designed as a 100-bed project. A subsequent decision, however, reduced the project scope and deleted the originally planned 30 Extended Care Beds. The remaining 70 Acute Bed Spinal Cord Injury facility was activated in 2002. This project constructs those 30 Extended Care or LTC beds. SCI Long Term Care (LTC) patients have better outcomes under VA care, rather than in contract facilities. Few facilities will accept this category of patient as required staff ratios are high, yet reimbursement rates are barely above those for more typical patients.

Project Location	Cory Naval Air Station, Pensacola, FL
Planned Project Name	Joint VA & Department of Navy Outpatient Clinic
Fiscal Year	FY 2005
BA Requested (Capital)	\$55.5M
Total Acquisition Cost (\$000)	\$55,500
Asset Type	Major Construction

Project Description

This project requires \$55.5M in FY 2005 budget authority. This submission is for the replacement of the existing leased outpatient clinics in Pensacola, Florida with a Joint/Shared VA/DoD (Navy) Outpatient Clinic. The new clinic will consist of approximately 200,000 gsf and will replace the existing VA Outpatient Clinic (Lease expiring 2006) and the Navy Corry Station Branch Clinic. CARES future workload projections for this market indicates that workload will peak in FY 2008 and will continue to remain above FY 2001 levels through FY 2022. The projected outpatient primary care gap for 2022 is 77,386, the outpatient mental health gap is 27,343, the outpatient specialty care gap is 117,498, and the outpatient ancillary/diagnostic gap is 152,941. The services to be provided in the proposed VA/DoD joint clinic include: Primary Care, Mental Health, Women's Clinic, Audiology, Optometry, Dental, Pain Clinic, Cardiology and Urology. The ancillary services including Radiology (with MRI), Laboratory and Pharmacy will be provided jointly. At this time VA has sharing agreements with DoD (Navy Hospital) for inpatient services, emergency room services, orthopedics (including joint replacements), OB and ancillary services. VA is exploring additional sharing arrangements.

The CHAIRMAN. Thank you very much. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Mr. Mansfield, you mentioned actually about the 6,000 waiting list. I don't believe that accounts for the Priority 8 veterans. My only concern is that number on the waiting list is much higher.

I have a lot of veterans in Maine who say they need not apply, because they will turn you away anyway. So I don't want to leave the American public with the thought that veterans are being totally taken care of.

My question is, I have a big concern with whether we are prepared to take care of the needs. I know in the clinics and the hospital we have extremely well-trained professionals. I know they are in Maine. They do an excellent job for the veterans who are able to get the assistance they need, and they definitely are very pleased with that.

My big concern is when you talk about if there is a disaster, what are we going to do, because we are not taking care of Priority 8 veterans currently in Maine; and I believe elsewhere in the United States there is a health care shortage.

Currently, with the new rules dealing with overtime that just went into effect, I know there is some dispute of who is affected by overtime and who is not affected by overtime. But I can tell you a lot of health care professionals in Maine are running into a lot of overtime. There is a lot of burnout that is occurring, and therefore a lot of health care professionals are dropping out because they cannot stand the stress.

Also what is occurring is you have these, in some cases, private companies forming, that nurses belong to, which are going around; and they are contracting with these companies at a much higher rate and therefore adding to the cost of health care in this country.

I guess my question is, is the VA looking at how we can help assist, working with States in higher ed facilities? Because, here again, with the unfunded mandates from Congress, whether it is No Child Left Behind, special education costs, whatever it is, the backlog in waiting list needs at the State level, at higher education, is there.

I am wondering if the VA is looking at ways they can work closely with the States to help encourage more health care professionals, and also looking at whether or not they might be willing to look at what is happening, particularly now with Iraq and Afghanistan, at the Guard, because there are Guard people going home now that no longer have a job to go to, whether or not they might be willing to help train Guardsmen and women into the health care arena to take care of the needs that are currently out there.

Mr. MANSFIELD. As I travel around the country and visit our facilities, I ask those same questions, sir. And it is a concern of mine because we have a workforce in the VA, out of the 220,000 employees, that is approaching retirement, many of them, in the next 4 to 7 years; and we have to look for replacements.

One of the things we have done, for example, in the area of nursing care, is the Secretary put together a Commission on Nursing, and that group brought in a report just recently, and they have

some interesting recommendations which the Secretary has accepted that deal with education.

One of the things I learned in talking to that group was that currently, right now, today, there are 11,000 people that would like to go to school and get certified as nurses, and there aren't slots available in the facilities to train them. Mostly that is because there are not enough educators to take care of that. So they recommended that the VA look at doing the same thing with nursing schools, the same relationship that we do with medical schools where we do such a good job; and I believe some 70 percent of the medical doctors get trained in this country, and we are looking at doing that.

We have asked for additional abilities in the physicians and nurses pay act that is up here before the Congress that will allow us to provide better working conditions. So it is a concern, and one we are working on.

Mr. MICHAUD. You mentioned during national disasters that the VA has been able to help out in those areas. In what way were they able to help out? Were they taking care of just veterans, and if not just veterans, did you get a payback or reimbursement for services provided?

My next question is—and I know a lot of focus has been dealing, and rightfully so, with natural disasters. What about an economic disaster? In Maine, we have had a certain whole section of the State of Maine that has been hit with mill after mill, paper machine after paper machine that was shut down. And last year, in some labor market areas, over 30 percent, which threw a lot of veterans that worked in the factories out in the cold with no health care benefits at all, yet they could not get any services from the VA because they were classified as Priority 8s. What do you do in an economic disaster as far as helping out veterans?

Mr. MANSFIELD. Well, to go back to the first part of the question, sir, I know for example in the situation with Hurricane Charley, I believe it is, in Florida, that we were asked to provide not only medical doctors, but radiologists and other health care professionals that would be available to help the local folks. And I would imagine, beyond that, to get to the details—I would ask Dr. Perlin to address the question specifically—I saw bits and pieces each day of what they were asking for that day. He can give you the totals and also refer to the reimbursement part, because I haven't gotten to that part yet.

Dr. PERLIN. Thank you. When a disaster is officially identified by FEMA, it allows us to participate as members of the National Disaster Medical System and allows reimbursement in that case.

Beyond that, as Secretary Mansfield testified, we are members of the community. In addition to our care for veterans, we care for the people who are members of that community, many of whom work for VA and certainly the veterans in those communities.

Florida is a great example. VA provided 120 medical personnel, health professionals, not all of whom were from Florida. People from throughout the system were able to come, at requests from our partners at Health and Human Services, to meet needs ranging from nursing homes to social work and placement of individuals who were in vulnerable situations.

So the answer is, yes, we do provide support, and there are mechanisms for reimbursement that we work with Secretary Simonson, in particular, to sort through.

Mr. MICHAUD. If I might follow up, if we do have a catastrophe, in trying to get health care professionals in to help out outside the VA system and looking at trying to help the States as far as moving forward in training health care professionals, when you are looking at that, are you looking in areas of potential high disaster areas, or are you looking at areas—as the chairman mentioned earlier, a lot of folks from the State of New Jersey and a lot of folks from the State of Maine went down to help out.

Are you looking at areas to help out that might not be high on the disaster potential list to help encourage professionals into the field?

My last couple of questions, if I might, Mr. Chairman, how does the VA ensure that the pharmaceutical caches are kept up-to-date, and what process does the VA go through, have in place, to assess the continued readiness of an internal VA cache?

Mr. MANSFIELD. Sir, I can answer the first part, and then I will turn the last part over to Dr. Perlin.

I was on site at where one of the caches is maintained the last time they were doing a turnaround on it, and that means that what they do is keep track of what the deadlines or the dates are on those. And on a periodic basis they are reviewed.

The whole cache, if it is not at this particular site, is brought in there, repackaged, and then sent back out to where it belongs. So that is done on a regular basis, we have people responsible for doing that, and we work with HHS in making sure we maintain the standards we both agree on.

Dr. PERLIN. Congressman, as to your first question regarding the ability to provide training across the country, a potential shortage of nursing professionals, of health professionals, especially in the area of nursing, is profound enough that it has to be a national effort.

We want to work not only in those environments where there are already training programs, but VA, by virtue of the provision of health care, provides a training platform. So, as Secretary Mansfield identified, the Nursing Commission's report really suggested that we be more aggressive in terms of using that clinical environment to help serve two purposes: first, the training of health professionals for the country and, for us, the ability to bring those nursing professionals to veterans as well as to our service members.

Mr. MICHAUD. Thank you.

The CHAIRMAN. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman.

Mr. Simonson, first to you, if I might. It strikes me that we are sitting here focused like a laser, the members of this Veterans Committee, rather obviously on the VA today. But it strikes me that in the event of a national emergency, one, question at least to me, arises: Who is in charge? Who calls the shots? Who integrates the various pieces to react to a national emergency that would require specifically a health care reaction?

Mr. SIMONSON. The incident manager is the Secretary of Homeland Security. There are lead agencies then designated who support the Secretary of Homeland Security in managing the incident broadly. So we are, as I indicated earlier, Emergency Support Function 8, the Department of Health and Human Services, which is the medical and public health response to an emergency.

So HHS is responsible for marshaling the Federal Government's resources to respond to a mass casualty event.

Mr. BEAUPREZ. Good, as I thought it might be.

Now, given that and given an inference that you made just a little bit ago about number of beds and so on and so forth, I recall a conversation I had with some health care professionals—not VA for the moment—back in the Denver area, which I represent, specifically the folks that created Flight for Life, which now I think is pretty well-known across the country.

But that organization was very frustrated that of all of the communication efforts, significant as they are, with our first responders, to react to emergencies in the wake of 9/11, they said we are still waiting for somebody to contact us, because they don't know exactly what their mission might be.

In this very large hospital, they had tried to coordinate some kind of plan in the event of a big emergency and they had to take on a lot of casualties, where are they going to move people around?

My question to you, sir, is if we have got kind of an inventory of beds, be they at the VA or be they wherever, have we got really a communication strategy that integrates our health care professionals that is going to be able to respond in some kind of a significant capacity to a disaster, wherever it occurs?

Can the left hand talk to the right hand?

Because I guess one word that has become part of our vocabulary as we all talk about this 9/11 Commission, is this business of silos. I am concerned in the health care industry, not unlike any other industry, because of a competitive nature, one hospital with another, or even the VA with the private sector, we don't routinely communicate with each other. But yet in the case of a natural disaster, in whoever's community it might be, we are going to want all hands on deck.

I am very nervous that we don't have that kind of integrated effort, that rather instantaneously we would know where the drugs are, where the bandages are, where the surgery room is, where the decontamination facility is, and who is going to show up where and when.

Mr. SIMONSON. Well, I think integration is there. It isn't, though, I think, a fixed point. This is a continuum and we have got to continue to improve. But we do have an operations center that seeks to involve State health officers, hospital associations like the American Hospital Association, to try and ensure that we have got an adequate picture of what the bed capacity looks like in a particular region.

Now, a lot of that is dependant upon them actually reporting information into us. We have a computer application that allows hospitals to report into us, tell us what they have and what they can make available to us.

We are also trying to do a similar thing with the supply side, the hospital suppliers and the pharmaceutical suppliers, to figure out where things are in the inventory system, are they being taken off the shelf—a reverse distribution system, as it were.

So in our operations center there is a mechanism for integrating that information, and it is getting better. But is it at a point where it is seamless? I think the answer to that is no.

But I appreciate what you are saying. The Secretary's view from the beginning is there, has to be a way to ensure that the right hand does know what the left is doing.

Mr. BEAUPREZ. Well, I would suggest to you that “seeks to” and “tries to,” with all due respect, sir, is not going to be adequate if we go through another event.

Mr. Chairman, I think this is not an issue only for the VA; this is an issue for the United States of America and for all of us. The public, frankly, is not going to tolerate a “we sought to” or “we tried to.” we must somehow get better.

Let me follow up, if I might, with a couple of other questions. Again, we are focused like a laser on the VA today, but if I understand correctly, and I am not certain that I do, but are—I believe that perhaps in the last Congress some \$40 billion, Mr. Chairman, was identified in the bioterrorism bill that came out of Energy and Commerce for just that, for bioterrorism.

But as we sit here today, looking at the VA for all kinds of answers—and I would think that it is a reasonably decent place to be looking for bioterrorism protection, response, research—I think only about \$2 million of that \$40 billion went to the VA. Is that correct, Mr. Mansfield or Mr. Perlin? Do you know?

Mr. MANSFIELD. I think you are in the right neighborhood, sir.

Mr. BEAUPREZ. So we are talking about pennies on the total dollars, relatively speaking, and yet we look to you folks.

I would simply ask a question again of Mr. Simonson. In my district, we are preparing with great jubilation to build one of the VA's new facilities at Fitzsimmons Army Base, the old Fitzsimmons Army Base, and we are rather ecstatic about that and think it is going to be a new standard in the way we deliver health care.

General Martinez-Lopez, one of the things that we are jubilant about is, it is not only going to be a VA hospital, but it maintains a partnership with the University of Colorado Health Science Center, the greatly expanded research facility that it will be, and jointly with the DOD, all of which we are very proud of.

I would hope we take full advantage of that research and treatment capability.

I see you nodding. I assume that means in agreement. I think that is a good thing.

But if indeed we are looking at the issue—I hope, forwardly—about bioterrorism, why in the world would we not be funding our VA better to accomplish that end point?

Mr. SIMONSON. Well, the funding that we have to improve hospital capacity, the funding goes through HRSA, the Health Resources and Services Administration; it goes through its States. We make grants to the States and then the States determine what the best way to use those funds are. The assumption is that they are—

being on the local level, they have the best ideas as to how to improve their hospital infrastructure.

Now, that is the way, as I understand it, the legislation, the appropriation, is set up, that gives us those funds, that it is a program for State hospital preparedness. So I am not sure we have the flexibility to enter into cooperative agreements with the VA to do that.

The CHAIRMAN. Would my friend yield, just to point out, Mr. Secretary, that the second round of awards provided \$498 million to States to improve hospitals' response to bioterror and other disasters.

Again, as I said earlier, some of our soldiers, God forbid, but some of them may come back having been now affected by these contaminants, whether it be biological, chemical or radiological. And despite our previous hearings and every bit of due diligence I and my staff and all of us have done on it a bipartisan way, we are not ready.

Why is it? You said you don't know whether or not there is a legal bar to sharing some of these dollars with VA facilities. The gentleman from Colorado was on to a very good line of questioning. Why not?

We have these VA health care facilities. Why can't some of this \$498 million have been at least earmarked for VA medical centers? Is there something in the law that precludes that? If so, we want to know, and we can take a look at lifting that.

Mr. SIMONSON. My understanding of the legislation was the funds were to go to the States. Now, the States may have flexibility to fund the VA hospitals within their jurisdiction as part of a response program.

The CHAIRMAN. Let me remind you, if the gentleman will continue to yield, when anthrax hit in my State, in my own township, the acting secretary of health for the State, who was the quarterback for all of the efforts to try to mitigate the damage of anthrax, did not even know that the VA was a partner, didn't even know that the VA had the capacity, the capability, of providing Cipro to the ill-affected people at the post office. Didn't even know it. When we told them that, it was new knowledge.

So it seems to me, again, the left hand not knowing what the right is doing.

We want the VA to be seen as integrated, not apart from. Again, when you just say it is going to the States, maybe or maybe not they have the ability to do so; it gets rid of that partnership and that team spirit I think are so important.

Mr. SIMONSON. This is the reason that we specified in the grant agreement that the States have to coordinate with the Veterans Administration. The idea is to coordinate it at that level.

Now, clearly that wasn't in place when we had the anthrax attacks of 2001. But I think what we are seeing is that each of the States—I am not aware of one that has not—has included the VA in their cooperative agreement planning, in the regionalization of these assets.

Mr. BEAUPREZ. If I could reclaim my time—and I thank the chairman—if I understood you correctly, we are trying to, we are seeking to, but as of yet, almost 3 years after 9/11, we really can't

stand up straight-faced to the American public and say that we have a well-integrated, left-hand-talking-to-the-right-hand health care emergency response system in the United States of America.

Mr. SIMONSON. I think we can say we have a reasonably well-integrated health care infrastructure in the United States. I think it could be better. But I think the progress from 9/11 to where we are today is breathtaking.

I think there has been tremendous progress there. I think a lot more can be done.

Mr. BEAUPREZ. I would submit to you, when someone as obvious in my State—and perhaps you are telling me it is a State problem, I don't know; I guess I am just looking for the answers. But when somebody as obvious as the Lutheran Hospital in Wheat Ridge, Colorado, which is the largest hospital in Jefferson County, tells me we have not been contacted in our emergency room by anyone remotely connected with the first responder network, when they are the creators, the inventors, of Flight for Life, the first ones that were ever stood up in the United States of America—a couple pilots came home from Vietnam and said hey, we can do this—when they tell me that they have yet to be contacted by anyone from DHS or the State or anyone else, I asked what to me is a rather obvious question: How can we straight-face answer that question to the American public, that we have done what we should do to integrate the health care network?

I don't think we have.

Mr. SIMONSON. What we have tried to do, what we have done, I believe, is to set up an arrangement so that the local authorities, the people who know their health care system, the State health officer, the State department of health, where the grants flow through, use that knowledge and use the funding to create a regional approach.

Mr. BEAUPREZ. I don't mean to be abrupt, but I respect the fact that there is a tremendous flexibility in authority and local accountability—well, I will stop and not use the word “accountability” yet—local autonomy.

I am a big States' rights person. But if we are going to be passing out the checks from here, we ought to be able to mandate, we ought to have some accountability measures and know that the States are doing it. In my case, I don't believe that that is done yet.

Let me move on in the questioning, if I might. Another rather obvious “I can't believe this,” if I have my facts right, Mr. Chairman, is that if there is someplace to point to that understands post-traumatic stress syndrome, it is the VA. But yet, if I have my information right—and I think I do—in the Department of Homeland Security's final response plan, the VA, for some reason, is removed from being the PTSD Center of Excellence. We don't have a role.

Is that correct? Or am I wrong? I hope I am wrong.

Mr. MANSFIELD. I would just state from experience, we will go back and double-check, but from experience, we had people on site on 9/11 in northern Virginia at the Pentagon and in New York, and they were there for a considerable period afterward, and I know that that is a part of our ongoing collaboration.

Mr. BEAUPREZ. That part I don't dispute. My question is, in the final response plan, in the response plan, I don't think—just like in the 9/11 Commission report for some reason, I don't think the VA is noted. And if that is the case, if that is the case, I don't think that is a huge issue for today, but I would suggest to somebody, you ought to recognize the rather obvious, that the VA is as expert as anyplace you could go to.

Mr. SIMONSON. We do. This is the reason why we have a relationship with the National Center for PTSD. I am not aware of exactly what the text is in the plan that is at issue here, but I would be happy to go back.

(Subsequently, the Department of Health and Human Services provided the following information:)

While the Department of Veterans Affairs' (DVA) National Center for Posttraumatic Stress Disorder (NCPTSD) is not specifically named in the National Response Plan (NRP), DVA is a Support Agency under Emergency Support Function # 8 (ESF #8), Public Health and Medical Services Annex. Under ESF # 8, NCPTSD and other DVA assets are integral to the Department of Health and Human Services (DHHS) response activities.

Furthermore, DHHS has worked actively with NCPTSD on a number of initiatives to better prepare our nation for the behavioral aftermath of terrorism and other health emergencies. We fully expect this vital partnership to continue.

Mr. BEAUPREZ. I would ask that.

Lastly, if I might, Mr. Chairman, I think this is the second hearing that I have had on a committee I serve on relative to the report of the 9/11 Commission. I want to applaud that Commission. I think they did yeoman's work, legacy work. The challenge probably now falls to people like ourselves.

I think one of the great demands placed upon us will be to adopt what I think is perhaps not impossible, but maybe unique in this business of Federal Government and bureaucracy that we deal with, the Congress as well, and that is a culture of continual improvement.

I will commend you and Ranking Member Evans. I think on this committee, my short time on this committee, I think that is the kind of culture we have tried to adopt. But it is not something, frankly, that Congress nor the Federal Government does very well.

If we learned anything from 9/11, it is that we do have to—again, to use the words of the Commission, we have to be imaginative and we have to be rapid responders and we have to be adaptable to change.

I think for all of us that is going to be a very, very difficult culture to adopt, because we tend to like to maintain life pretty much the way it is and the way we understand it, rather than the way it may actually be in reality, especially tomorrow.

Mr. BEAUPREZ. So I would just submit to you, Mr. Secretary, and I, Mr. Secretary, and all of us in this room, but especially us Members of Congress, that rather than singularly focus on yesterday's events, our biggest challenge will be to make sure we are focused on tomorrow's. With that, I yield back.

The CHAIRMAN. Thank you very much, Mr. Beauprez.

Ms. Herseith.

Ms. HERSETH. Thank you, Mr. Chairman.

I want to go back to another point that Mr. Beauprez made in his opening statement, and it was an issue that the 9/11 Commission report identified as a failure of imagination within the intelligence community in particular. And while I praise as well the work of the Commission and agree with many of the recommendations in that report, there are a couple that give me some pause.

One relates to the allocation of Homeland Security funds as it relates to rural areas. Most of South Dakota is classified as a rural area, and the improvements to VA preparedness appear to focus on major metropolitan areas where there are VA medical centers. However, in a State like South Dakota and others with a large geographic area and a small population, most people do not have easy access to a medical center, but rather the CBOCs, the Community-Based Outreach Clinics. And I do not think any of us assume—and we certainly should not—that rural America is immune from a terrorist attack. If anything, if we allow our imagination to go in the direction it should for our level of preparedness that we need, we need to make some assumptions that getting at the heart of the American psyche would be to attack a rural community in a rural area and the necessary allocation of resources for rural areas to coordinate regionally through their response and communications networks.

Now, part of the Integrated Health System of the VA is these CBOCs. And so, can you tell me how you think they have been integrated, either at the level of coordination by the VISNs themselves or at least through some of the training that the individuals that work at those clinics may be utilizing so that, in the event of a catastrophe or any kind of attack in small town America, that they also have that level of preparedness and readiness to respond?

Mr. MANSFIELD. Thank you.

I would agree with you that we cannot put anything off the table, that we have to be prepared for anything to happen anywhere in the Country. I would make the point that the VA is situated, much better situated because of the fact that we have 850-some CBOCs around the Country able to deal with it.

I would make the point that, whether you are in one of our major hospitals or a CBOC, that you are, as a VA employee, included in the communications. And that meets the requirement that you be informed of what is going on and what we are planning for and what we are doing, and also you are included in the training, and that this training does extend down to that level.

I would suggest that, as in other issues where the CBOCs look to the hospitals for certain support, i.e., specialty care that they do not have on-site or maybe a radiology capability, that this, too, would be one where the capabilities of the major sites would be available to move towards the location of the problem. As I mentioned, we have these caches available in large sizes and small sizes and that we are hooked in with HHS for the major caches that would be moving. And we are aware of what they are and where they are going, because we are handling that.

So I think we are prepared to deal with issues at any location, and I believe that our training is such that, again, it recognizes that any of our people are liable to be involved and, then again, as I mentioned earlier, that we do recognize that we are a part of the

community and, as such, as community partners, have responsibilities. And those responsibilities are the same in a rural area as they are in an urban area.

Ms. HERSETH. Well, along that same line, Mr. Secretary, do you then feel that, whether it is a clinic, an outreach clinic or a medical center, that, in your opinion, there has been a more than adequate level of integration with local law enforcement as it relates to planning, either in a certain community or a certain region, throughout the Country where facilities exist in the VA?

Mr. MANSFIELD. I have had discussions with the Deputy Assistant Secretary for Security and Law Enforcement, who is here in the audience with us—and if you wish, we can bring him forward—about this whole issue, and he assures me that wherever VA is, that they are in touch with whatever Federal law enforcement agencies are sited there or are available there, as well as the local areas. And we are working, again, as community partners to ensure that we work with them and they work with us.

Ms. HERSETH. Just a couple more questions, if I might.

On page 10 of your written statement, you talk a little bit about the availability of the decontamination equipment and that 28 facilities have it on-site. You also made reference, I think in response to an earlier question, that some have orders in; some facilities have actually constructed maybe their own type of unit.

Can you just fill us in on the status of those orders? Are we contracting these, or is there just one supplier for this equipment, just so we have a sense in terms of the timetable in which the other 78 facilities would be receiving this equipment?

Mr. MANSFIELD. I will ask Dr. Perlin to answer the specifics, but again, it is one where the 118, I believe, is the number we are looking at planning for originally, and then the 28 are on-site, and we have others ordered, but I am not sure about the time of delivery. We may have a further update.

Do we?

Dr. PERLIN. Thank you. In fact, this is a comprehensive program that begins with training, and 130 sites are, to date, trained. That means four individuals at least from each and every site came for minimally 2 to 5 days of training at some of our advanced facilities. They had to get trained first. Thereafter, they could go back and assess the environment, large or small or otherwise, and the community contingencies, to understand what the best equipment to purchase was. As Secretary Mansfield indicated, 28 sites have equipment in place from this program.

Preceding this program, VISN 3, the area of New York City and the 5 major hospitals there, as well as many sites in VISN 7, the Atlanta area, as well as a number of other facilities, already had equipment. Eighty-eight more sites will take delivery of equipment through this year.

As Secretary Mansfield indicated, unfortunately, this is a very popular item. In many instances, we are in the queue.

Ms. HERSETH. One last comment, and that would be to reiterate Mr. Miller's point about evaluating the Capital Improvement Plan and at least identifying these centers, because I think it is clear that there has been, from our Chairman, from Ranking Member Evans, bipartisan support of getting the authorization for these na-

tional centers that would help in the preparedness of the VA. And I think that, as all of us go to the plate once again to get the dollars, it would help us in making the best case if we are moving forward on other fronts and that we have identified those centers, whether they are in Florida or Sioux Falls, South Dakota, or who knows where.

But to reiterate that point, and also, if we can get a copy of the status report which may be made available to us on the Battaglia report recommendations to be distributed to the committee, I would just make that request. Thank you.

The CHAIRMAN. Thank you.

Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Thank you, gentlemen, for being here. I am sorry we do not have more people here with us today to, I guess, interrogate you even further, if we had a full committee here.

Secretary Mansfield, I would like your personal opinion, please. I have read your statements and heard your comments this morning. What is not going well? In your personal opinion, what is not going well?

Mr. MANSFIELD. Well, I think, as you just heard, what is not going well is that there are a lot of people in line for a lot of things. And for example, in the area of the decontamination units, we have identified the need. We have identified what we need to solve the need. And we have gone out and gone through the process that the Government has to go through to buy something. And now we have to wait for it to be finished and then deliver it and brought on-site.

Of course, the initial training is just, you know, preacquisition. Once we get it on-site, we are going to have to go through a use training once we get it. So that is part of the question. And that also applies, in the communications area where, I think, it is single-site communications may be a need where, again, we started out, we were at 25 or 30 percent of the need, and now, we are up to 65 or 75 percent of the need. But again, it is one where we are in line to acquire the needed equipment to go forward. So that is one area.

Mr. SNYDER. The communication you are talking about, you are talking about direct contact between VA facilities and local police, fire, and local EMTS?

Mr. MANSFIELD. For the tie-in to the FEMA emergency network, yes.

Mr. SNYDER. And is that an equipment issue?

Mr. MANSFIELD. Yes. As I mentioned, we have orders to buy the equipment, and we are waiting for it to be built and delivered.

Mr. SNYDER. I know in your written statement, in terms of that, the facility for the decontamination equipment, you specifically mentioned Little Rock, which is where I am from, that they have been noted by OSHA to be one of seven facilities in the State or in the Country that are doing well, is that correct?

Mr. MANSFIELD. It is one of the ones that trained on-site.

Dr. PERLIN. Dr. Snyder, that was indeed one of the first sites to really pilot some of the material and has served as one of two national training sites because of their expertise in the area.

Mr. SNYDER. I want to ask, Mr. Secretary, what—you have talked about the priority of treating veterans and even in the kind of a mass casualty situation, but most of your facilities are in the middle of very populated areas, and I can assure you if, you know, I am just—I live within a mile of my VA hospital. And if we have a mass casualty situation, I will be loading up the neighbors in my pick-up truck, and we are going to the nearest hospital, and that is going to be you. And I am not going to let you screen a 3-year-old for whether he has veterans service or not.

Are you all prepared to be just overwhelmed? Prepared is not the right word. Have you had that discussion about what will happen if you are just overwhelmed with nonveterans showing up on the doorstep?

Mr. MANSFIELD. We have had the discussion, and we have had some attempts at planning. I agree with you. I recognize that, when it happens, where it happens, it is going to be like the battlefield. And I have been there, and I know what chaos you have and what you have to do to respond.

I would make the point though—and Mr. Beauprez, I think, brought this up—but I will give you an example. Down in Houston, I think it was hurricane Allison, the VA medical center was the only medical center that was not flooded out during that incident. And I think there are four civilian hospitals in the area, if I am not right, and a military hospital. And we wound up being the site where health care was delivered for those four civilian hospitals and the military hospital. Because, again, as I say, I recognize, and at least from my direction, we are members of the community. We are going to have to react as members of the community.

Mr. SNYDER. Does that mean, do VA hospitals then specifically have the ability to administer pediatric-dose drugs to babies under the age of a year, or is that expecting too much for this kind of a situation?

Dr. PERLIN. Sir, as a humanitarian approach, we would do what was necessary. I, personally, have delivered two babies in the VA system, not in my job description, per se. But we have, sir, developed our best attempt to consider the unimaginable. And this is our rapid contingency response, and it alludes to what resources we could make available, including crowd control, so that we could provide not only the maximal service but the maximal safety for all involved.

Mr. SNYDER. One of the times I was working overseas as a doctor, I was in the middle of a cholera outbreak, and we knew it was coming. We had heard of cases some miles away, and it was very impressive as the numbers increased. And they increased every day, and you always feel like you are on top of it, but then, at the end of about 3 weeks, it was incredibly impressive how high the numbers were that you were actually treating. And my guess is that this kind of situation would be like that. You work real hard at staying on top of things.

Mr. Secretary, the opposite of that is, have you all considered in your scenarios, your imagining what would happen if the VA hospital in an area is the targeted facility, and you have to shut it down and transfer all VA health care someplace else? Is that a scenario you all have considered?

Mr. MANSFIELD. That is part of what I think we have to do as part of our ordinary business planning to meet certain certain Commission standards. Plus, the other point I made is, we lived this in the real world.

Mr. SNYDER. Excuse me, if I can interrupt, so what you are saying is, to meet your normal hospital accreditation standards, you all have to have the ability to show a plan to evacuate quickly and get people out. And then you also have the responsibility then of providing care for veterans at some other facilities? So that is something you consider on an ongoing basis?

Mr. MANSFIELD. Yes, sir. And as I mentioned, we have done that in the last 2 years with two hurricanes where we shut down Hampton VAMC and moved the people out, and Tampa and Bay Pines. So it is something that we not only plan for, as I said, we have lived this.

Mr. SNYDER. General Martinez-Lopez, I got a little bit confused. I read your written statement, and then the written statement I got last night is the same as the one that was on the table, but it is not the same as the one you delivered this morning. We have multiple copies. You had added some material today. I am curious what happened. How is it—you just decided we needed to know more things or did someone tell you to add more things?

You specifically, I think, have a couple of pages on congressionally-directed medical research programs that was not in our first statement that was labeled last night as being final. What was your motivation for changing your statement the most recent time, if I might ask?

General MARTINEZ-LOPEZ. Sorry for the confusion, I put in a written statement, but I have to curtail the written statement, because otherwise, I would not have been able to meet the 10 minutes. So I stand by the written statement that you got last night. Today's statements are much shorter, just to save time.

Mr. SNYDER. All right. I think I understand that.

I wanted to ask, on page 3 of your statement, we all have our pet peeves in life, and one of mine is the use of the word synergy. Whenever I hear someone in Government use the word synergy, I get very apprehensive. It generally, to me, is a word that means we really do not know what is going to happen, but, somehow, all of these people are going to get together, and it is going to work out somehow.

I wanted to ask, specifically, you say the potential for operational synergy in the area of bio research and national defense for establishing collocated facilities with complementary and shared infrastructure were discussed.

Where do—I know HHS is obviously involved in this. Where does NIH and CDC fit into this synergistic model that you are advocating here?

General MARTINEZ-LOPEZ. Sir, from the beginning, NIAD, NCI, two of the institutes of NIH, the Homeland Security, the USDA and us formed a confederation. That was from the get-go.

The first thing we did was to develop a gap analysis to try to figure out, what do we do and what were the gaps, what were the technical areas that were not covered. And then, in those areas that we shared together, I mean, we kind of did the same thing,

which was the Center of Excellence, and can we do away and just give the Center of Excellence to one of the agencies? So where there was duplication, it would be conscious duplication and not an unconscious duplication.

In order to achieve that, sir, we put the top scientists of all of these agencies in an off-site near Frederick for a couple of days, and they worked this really hard. And that was the mapping that then allowed us to develop the concept of a biological defense campus.

What is even more interesting is that NCI, I mean, their thrust is to find solutions for cancer, but some of the areas of technology that the National Cancer Institute is working on are key to our discovery process. So this is kind of thinking out of the box to bring NCI, because they are working on vaccines for cancer, some of the very technical issues for adjuvants for vaccines. Well, NCI may have an approach; we may have an approach; NAID may have a different approach; and USDA have a different approach. The question is, which one is the best approach that will curtail the discovery cycle? In this kind of environment, I am optimistic that we are going to get there. But the synergy was really hard work on the details on what needed to be done to accomplish a mission.

Mr. SNYDER. One last question, if I might, Mr. Chairman.

General, if I might, it is the same question I asked Secretary Mansfield. The title of this hearing is, is the Nation medically prepared for these events we are discussing? In your personal opinion now, where are our greatest needs and greatest failings, in your personal opinion?

General MARTINEZ-LOPEZ. I think my personal opinion, sir, I mean, this is a national issue. This is not a Department of Defense issue. This is not a Department of Homeland Security issue. This is not an issue for the Department of Veterans Affairs. This is not an issue just for the Federal Government. This is not an issue just for academia. This is not an issue just for industry. And trying to muster all that into one team of teams, that really is tough. I mean, it is as tough as it comes.

Some of the things, some of the hardest challenges is, how do we lower the shield so that collaboration will happen? How do we lower the shield from the legislative standpoint so the processes can be speeded up? How can we lower the shields and put in incentives so that other industries will come on board? I think the Congress has acted out in that way, but we do not know.

This is a journey. And that is probably the toughest thing that we are going to have to do. How do we bring everybody, the best ideas, I mean even weird ideas, off-the-wall ideas, to bear so we can come up with a solution? I do not care who comes up with the idea. I do not care about that. I do not care who makes money out of the idea. I care that I get a solution in my pocket so I can treat my patients. That is what I care for.

And I think, as you go about your process and you encourage us, but not only just the Federal Government, it is us, America—I mean us, industry; us, academia; us, hospitals around the Nation—to work together toward finding solutions for this very complex issue, I think we are going to continue heading in the right direction.

Mr. SNYDER. I like the phrase team of teams, Mr. Chairman.
 Thank you, Mr. Chairman.
 The CHAIRMAN. Thank you very much.
 Mr. Evans.

OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate you holding this hearing, even though it has been hard for a lot of our colleagues to get here being on this recess. I know Members on both sides are having that problem. But we are glad, none the less, to have this opportunity.

I would also like my remarks entered into the Record.

[The prepared statement of Congressman Evans appears on p. 92.]

The CHAIRMAN. Without objection, your full remarks will be made a part of the Record.

Mr. EVANS. I do not know if this is a problem that other Members of the committee have found, but I was out at two or three Veterans' Administration hospitals visiting and I asked them if they were seriously being cut by things in the call-up—with the affiliation degrees, with doctors being at the VA for a potential emergency. Obviously, they are involved now in supporting our troops and so forth. But it seems that, to me, that—we are showing a double counting that we have—you know, on paper it looks like we have a good schedule, but if that is all that remains, you know, I think we have to look at that.

A friend of mine was called up for deployment from Bethesda to the Iraqi front, and they had a little party for him. And a few days later he was out, and it seemed like one of our friends saw him driving his car, and he thought he was going to be called up that day. But a number of people saw him drive to Bethesda, and he says, yes, they deployed me, but it was to Bethesda. Of course, that is a noble thing. But we might have too many people on paper being there. And we might have all of these plans, but if we have, suddenly, a natural disaster perhaps in the United States or we are just not over-stretching ourselves, potentially, maybe not now, but in the future. Do you see that as a problem? Because I have talked to a lot of doctors, and they indicated that they would not know exactly what to do if they were deployed beyond Bethesda and the other problems we are having with the National Guard and Reserve units.

I guess I would just like your reaction to this potential problem.

Mr. MANSFIELD. Mr. Evans, we are aware of that issue, and we have taken action to make sure we keep track of exactly what it is. Right now, I can tell you that 400 of our medical doctors are potentials for call-up and that we have 6,000 other health professionals in the individual ready Reserve, and a total of 11,000 in the individual ready Reserve and other Reserve units across the Country. At the current time, there are approximately 700 of those individuals deployed, and we are keeping track of this station by station across the Country each and every day.

So we are aware of the issue, and of course, the other side of that is, where we need to is where we have to back-fill behind them to

do what we can to do that. So it is an issue that we are aware of and dealing with.

Mr. EVANS. Okay.

Thank you, Mr. Chairman.

Thank you.

The CHAIRMAN. Let me just ask a couple of final questions unless some other Members have something else that they would like to add, which we would gladly entertain.

Let me just ask you, Secretary Simonson and General Martinez-Lopez, from your testimony, I get the sense that you agree with the consensus that the VA needs to be doing more or at least be a part of the ongoing research into the treatment of the effects of chemical, biological and radiological agents. How do we deal with those patients and the like?

I just want to, again, get back to something that I find very disturbing, and I am determined that, this year, we will correct it. I tried last year. As a matter of fact, as I think you know, Mr. Secretary, I was the prime sponsor of the Department of Veterans Affairs Emergency Preparedness Act of 2002. Mr. Evans was my principal cosponsor. The whole Committee, all of us were behind it. It passed the House, the Senate, and it was signed by the President.

And what it did, as a result of a series of hearings and our due diligence, which we thought we did so very aggressively, was to establish these Centers of Excellence, knowing that the VA does an extraordinarily good job, a great job with its Centers of Excellence, whether it be the Centers For the Study of War-Related Illnesses and Limb Loss, Prosthetic Engineering, Spinal Cord Injury, of Multiple Sclerosis. You know, Mr. Secretary, these Centers of Excellence do ground-breaking, landmark studies that then has applicability, not just to the VA patients, but to the patient base at large.

And in our bill, we made it very clear that all of the information gleaned from that research should be immediately transferred to the private and public sector in case it is needed, which we know would be done anyway; but we made sure statutorily that it would be done. Yet, there was a bar put into the appropriations bill saying none of the funds can be used to implement this section.

Now, we are talking about a \$20 million authorization per year over 5 years of \$20 million each year. But in realistic terms, the opening salvo of money, the amount of money that would be needed to get it off the ground would probably be \$5 million, \$6 million. I know, Mr. Secretary, you note in your testimony today that the amount of money for emergency preparedness has jumped from \$80 million in 2002 to \$257 million in 2004; \$281 million is requested for 2005.

So money for this kind of endeavor and initiative certainly is something that you agree with. I know Secretary Principi agreed with the legislation, testified in its favor, as did the President, certainly, when he signed it. And yet it is blocked from being implemented. And we had an amendment; I offered an amendment during the appropriations bill on July 25 of 2003, about a year ago. It passed 347 to 77 to lift the block.

In addition to that, we all know the desirability of that focus and having people whose portfolios are not so chocked full of missions,

that they get diverted. We know that there is an interim person, Dr. Mather, who is running the forth mission, the Emergency Management Strategic Health Care Group, yet we established, with your full concurrence, an Assistant Secretary who would be the Emergency Preparedness Assistant Secretary for the VA. That, too, was blocked by an appropriations bar which would have been lifted by the amendment that I offered that was then dropped in conference.

It seems to me that the time has come to fish or cut bait. This is an Assistant Secretary, growing from six to seven. The number that are within the VA is vitally necessary, I think, so that the VA can do its great work that it has done in so many other areas to be part of this team. I am baffled as to why it was blocked, and I have asked all of the key players, although I have yet to get an answer that makes any sense in any realistic terms. Perhaps you can respond to that. An Assistant Secretary, don't you think it is needed?

And Mr. Secretary, you might want to respond to it as well.

Mr. MANSFIELD. Well, Mr. Chairman, you have done an excellent job of laying out the history of this legislation and this law, and I would agree with you. As the then Assistant Secretary for Congressional Affairs, I helped the Secretary prepare for that testimony where he supported the issue, and we did support you, and we do support you.

And as you know, we also attempted to try and comply with what other committees do here, and as I suggested earlier, I have committed to personally going back and talking facetoface to the Secretary and making sure he understands, again, as I know he does, your concern about this issue and see if there is something that we can do to assist you at this point in time.

The CHAIRMAN. I appreciate that.

Just again, to reiterate, not to read the whole bill, because that would take forever. But when we talked about the mission—this is just one part of the mission, and it would be done in collaboration with medical schools. The RFPs, I know, were ready to go out. The VA had a very good set of recommendations, and the RFP was all set to go out until this legal bar was imposed upon you.

But the mission, the first part of it was to carry out research on and to develop methods of detection, diagnosis, prevention, and treatment of injuries, diseases and illnesses arising from the use of chemical, biological, radiological, incendiary or other explosive weapons or devices posing threats to the public health and safety. We know now from Desert Storm that, thank God, the kevlar is saving so many of our men and women in uniform, but there are also blast problems, not only loss of life and loss of limbs, but there are blast problems relating to the incendiary devices. These centers could be studying them right now, and that has been unfortunately put on the back-burner because of this block.

But Mr. Secretary and General, if you could respond as well.

Mr. SIMONSON. Yes, it makes perfect sense to me, and I would support a specific position at the VA to do just emergency planning and response. I think, though, in the absence of that position, they have made adjustments so that they perform the mission.

But the VA in many ways dwarfs every other agency of the Government when it comes to emergency response, with the largest medical system in the world. So, yes, it makes perfect sense to me that you would create such a position.

The CHAIRMAN. Thank you, General.

General MARTINEZ-LOPEZ. Mr. Chairman, I am not prepared to talk for the Department of Defense, but I will tell you that we will seek the collaboration like we have done in the past for the best scientific ideas. Just like Dr. Hostetler is going to highlight funding a project that was funded particularly by us, we are going to continue. Because we value the collaboration; the scientific endeavors of the VA is first class. And we are going to seek them.

The CHAIRMAN. Let me just ask one final question to you, Secretary McFarland.

One of the Battaglia Commission's findings was that there was an inability within the VA to maintain a high degree of mission readiness during emergencies that they suggested was seriously compromised by the absence of an effective, reliable, and centralized communication system. The Secretary made some reference to it. The information that you have sent up seems to say that you have made some strides in that regard, but if you could elaborate on that, I would appreciate it.

Mr. MCFARLAND. Yes, sir. We have made some significant strides. We have the Telecommunications Modernization Program that is ongoing right now, and we are going to roll out a very strong network that will allow us to be backed up all over the VA, all over the Nation, and we anticipate to have that complete project finished and the whole network operational by August of 2005. It has been one of the things I have been very happy about in the 6 months I have been here, is the progress and the design of that network. It is first class, and I really think we are going to be in good shape when it is finished.

The CHAIRMAN. Thank you, Mr. Secretary.

I know Mr. Beauprez has some follow-up, and then, I will go to Mr. Michaud.

Mr. BEAUPREZ. Thank you, Mr. Chairman.

Very quickly, I need to correct the Record. My mind was thinking one thing, and my mouth said another a moment ago. The appropriate credit for Flight For Life is with St. Anthony's Hospital in the Denver area. The Lutheran hospital that I referred to needs to be given credit for having established a decontamination facility. That is why I was thinking of that hospital. It is pretty notable. They did it under their own initiative, got most of the equipment kind of on the cheap. Went to Home Depot, picked up a few pipes and a few sprinklers and a little plastic drape, and they can handle hundreds of people very quickly. And I commend them for it.

But I wanted to make sure that the Record stood as it should be, with St. Anthony's being the real innovator of Flight For Life.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Mr. Chairman, I wonder if it is possible to find out where the funds have been expended for this whole effort. I agree with Mr. Beauprez. Having served 22 years in the Maine legislature, I believe in States' rights, but I also believe in accountability. So I would like to have a list of what projects there are, because

I do know a lot of States are going through shortfalls. And I want to make sure the money is spent appropriately.

The other thing that was brought up during questioning is, when we talk about the VA working closely with local municipal or police as well as hospitals, I am just concerned about how closely are they working. And I will check when I get back to the State of Maine.

As you know, Maine is a real rural State. In Rumford, we have the Rumford Hospital, right just down over the hill, is a VA clinic. And I know Rumford is struggling with trying to find funds for their emergency room rebuild to help save and also to bring it up to standards. I am just wondering, it sounds to me like some of this funding that might be available could be utilized in helping to bring the emergency room up to snuff. But I do not know whether or not the VA clinic has actually even talked to the hospital about this sort of funding initiative. So I would like to have a copy, if we could, for the committee of where the funding has gone.

The CHAIRMAN. We will seek to get that and get it to you and make it a part of the Record.

(Subsequently, the Department of Veterans Affairs provided the following information:)

VA 5-Year Capital Plan *FY 2005 – 2010*
4. Veterans Health Administration

This program received \$182 million in FY 2005 from VA's appropriation to enhance the quality of care provided to veterans. In addition to the appropriation, approximately \$75 million is available from projects that slipped from FY 2004 due to the late release of funds. These funds will be used to continue the conversion of inpatient wards to private or semi-private rooms; adding private examination rooms and bathrooms; correcting fire and safety deficiencies including seismic-related issues; and providing sufficient heat, air conditioning, and ventilation systems.

VHA will also continue to fund minor construction projects that efficiently shift the treatment of patients from hospital-based care settings to outpatient care; realign critical services; improve management of space, both vacant and underutilized; correct dysfunctional clinical adjacencies; and accommodate modern medical equipment based on the CARES National Plan. These improvements provide a maximum return on investment for the taxpayer and continue to provide high quality service to the Nation's veterans by improving access, establishing performance measures tied to clinical program priorities, and ensuring a satisfying and rewarding work environment for VA employees.

All FY 2005 minor construction projects listed below were reviewed, evaluated, scored and ranked by a Department-wide, multi-disciplinary group using the CARES decision criteria as required by Congressional language. They fully support the implementation of CARES recommendations, which is critical to demonstrate accountability to our stakeholders and Congress.

FY 2005 VHA PRIORITIZED MINOR CONSTRUCTION PROJECTS

Table 4-3 VHA FY 2005 Prioritized Minor Projects

VISN	Location		Project Title – Brief Description	Rank	Total Est. Cost (\$000)	FY 2005 Obligations (\$000)
7	Atlanta	GA	508-331 Renovate Mental Health Inp Ward	1	3,600	200
8	Tampa	FL	673-308 TPA Mental Health Code Compliance	2	6,798	585
7	Augusta	GA	509-320 Add Inpatient Beds SCIU	3	5,200	433
21	Mather	CA	612-463 Consolidate Outpatient Mental Health	4	4,722	430
20	White City	OR	692-330 Replace Dom Bldgs 215 & 216	5	4,970	4,573
20	Anchorage	AK	463-115 Dom Seismic Upgrade	6	4,644	4,248
22	Los Angeles	CA	691-334 Bldg 212 & 117 Seismic Retrofit	7	4,230	3,907
22	Long Beach	CA	600-307 Seismic Upgrade of Bldg 126OP	8	3,954	3,903
21	Martinez	CA	612-521 Seismic Corrections Core Lab, Bldg 5	9	897	833
21	Menlo Park	CA	640-355 Seismic Corrections, Bldg 329	10	6,369	6,281
20	Seattle	WA	663-340 D&T Seismic Upgrade, B100	11	3,832	3,504
1	Providence	RI	650-305 Research Facility	12	5,984	601

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VISN	Location	Project Title – Brief Description	Rank	Total Est. Cost (\$000)	FY 2005 Obligations (\$000)
1	West Haven CT	689-374 Research Renovation, Ph 2	13	4,906	421
18	Tucson AZ	678-314 Renovate Ward 3 East	14	2,961	290
21	San Francisco CA	662-315 Animal Research, Bldg 19	15	5,520	459
10	Cleveland -WP OH	541-311 Relocate Lab Services at WP to New 3rd Floor on Amb Care Addition	16	3,893	3,574
23	Des Moines IA	636-305 Consolidation of Acute Bed Services	17	2,001	1,829
1	Boston MA	523-345 Medical Surgical Unit, B1-2N	18	3,306	2,680
16	Muskogee OK	623-301 Renovate 5-East for Bldg 53, Inpt Psy	19	1,975	1,849
12	Hines IL	578-344 Renovate Acute Care – Hema/Onc	21	5,305	4,950
4	Clarksburg WV	540-304 Outpt Support - Spec Care Services	22	3,629	3,320
1	West Roxbury MA	523-353 Support Services Modification, Ph 2	23	1,500	1,350
17	Temple TX	674-262 Expand Amb Care	24	3,061	2,760
7	Birmingham AL	521-325 Specialty Care Expansion	25	3,723	3,457
5	Baltimore - LR MD	512-514 Expand Outpatient Clinic	26	6,075	5,449
12	Chicago IL	537-313 Modernize Lab Areas 4th Fl Bldg 1	27	4,157	3,782
5	Baltimore MD	512-515 Fort Meade CBOC	28	3,614	380
6	Hampton VA	590-224 Construct Intensive Care Unit	29	2,937	2,655
20	Seattle WA	663-333 Amb Care Expansion, B100, D&T	30	3,987	3,512
18	El Paso TX	756-001 Outpatient Ambulatory Care Space	31	4,140	3,795
5	Martinsburg WV	613-102 Fort Detrick CBOC	32	5,017	528
4	Philadelphia PA	642-316 Renovate 7th Floor	33	4,050	3,630
22	San Diego CA	664-324 Parking Garage	34	6,835	6,475
4	Erie PA	562-305 Outpt Support - Anc/Diag/Spec Care	35	3,427	3,151
6	Asheville NC	637-310 Renovate Surg Intensive Care Unit	36	2,726	2,485
19	Salt Lake City UT	660-228 Surgery Renovation	37	2,620	220
12	Chicago - WS IL	537-314 Research Laboratory	38	2,931	2,717
7	Columbia SC	544-313 Comm Stand Upgd Inpt Med Beds	39	3,678	3,355
1	Boston MA	523-332 Dental Clinic Consolidation	40	1,563	1,441
8	Tampa FL	673-313 Upgrade & Expand Main Lab, Ph I	41	3,000	2,731
8	Tampa FL	673-314 Upgrade Main Lab, Ph II	42	3,173	2,726
21	Sacramento CA	612-461 Specialty Care Clinic Bldg	43	4,160	3,807
16	Biloxi MS	520-316 New CBOC at Eglin AFB Florida	44	4,310	350
8	Miami FL	546-105 Renovate 11CD (CARES PI)	45	1,387	1,272
16	Biloxi MS	520-306 Expand ER/Outpatient Pharmacy	46	4,080	3,740
8	Bay Pines FL	516-320 Emerg Dept Exp with Obsv Unit	47	2,900	2,594
17	Temple TX	674-263 Clin Spec Emph & Rehab Integration	48	1,644	1,513
8	W Palm Beach FL	548-117 Renovate 9th Floor for Outpt Clinic	49	4,306	4,081
8	Bay Pines FL	516-321 Renovate Surg, Med and Card ICUs	50	3,031	3,031
8	Tampa FL	673-318 Emerg Rm, Ph I	51	4,128	3,783
21	Fresno CA	570-205 Remodel 4th Floor for Spec Clinics	52	3,900	3,575
20	Portland OR	648-316 Renov Bldg 100 for Spec Care	54	5,140	4,730
6	Salisbury NC	659-309 Renovate Surgical Suite	55	2,220	2,035

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VISN	Location	Project Title – Brief Description	Rank	Total Est. Cost (\$000)	FY 2005 Obligations (\$000)
7	Tuscaloosa AL	679-307 New Dietetic Facility	56	3,999	3,659
7	Columbia SC	544-317 Renovate NHCU, Building 103, Ph 1	57	3,769	3,368
18	Prescott AZ	649-404 Expand Med Spec Care Clinic Space	58	4,200	3,850
6	Asheville NC	637-311 Renovate Medical Intensive Care Unit	59	2,765	296
3	Northport NY	632-319 Expand Outpatient Space	60	5,300	4,950
6	Durham NC	558-311 Renovate Patient Wards	61	3,840	3,465
4	Lebanon PA	595-455 Consolidate ICU and Urgent Care	62	3,494	3,247
21	Palo Alto CA	640-362 Research Renov B4 and B6	63	3,600	3,300
19	Ft. Harrison MT	436-107 Expand Specialty Care	64	4,092	3,751
23	Omaha NE	636-327 ICU to 2nd Floor Outpatient Clinic	65	6,459	6,063
21	Honolulu HI	459-301 VA/DoD JT. Hosp Guam & VA CBOC	66	3,920	400
22	Los Angeles CA	691-330 Renovate CCU	67	3,565	3,270
22	Los Angeles CA	691-331 Renovate HICU/SICU	68	3,140	2,864
17	Dallas TX	549-316 Patient Priv/UFAS Deficiencies, Ph 8	69	2,200	2,100
15	Kansas City MO	589-360 Interventional Cardiology	70	2,585	2,365
8	W Palm Beach FL	548-118 ER Expansion	71	2,028	200
1	West Haven CT	689-358 Dialysis Relocation	72	3,928	3,627
8	W Palm Beach FL	548-119 Renovate 8th Floor for Specialty Care	73	2,605	225
21	Reno NV	654-307 Expand/Reloc ER and Est Observ	74	3,217	2,879
8	Lake City FL	573-312 Renov Wards for Med/Surg Pat Priv	75	3,055	2,817
1	West Haven CT	689-354 Cardiac Catheterization	76	1,200	1,082
19	Cheyenne WY	442-208 Clinic Expansion	77	1,800	1,651
17	San Antonio TX	671-226 Research Addition, Ph II	78	3,648	3,278
11	Indianapolis IN	583-321 Expand Spec/Primary Care Clinics	79	5,725	5,262
16	Houston TX	580-308 Renovate NU 4H for Oncology/GI	80	2,073	1,853
15	Wichita KS	589-336 Cardiac Cath Laboratory, B2, 2nd Floor	81	1,382	1,354
8	Tampa FL	673-102 Renovate OR Ph I	82	2,995	2,726
22	Loma Linda CA	605-314 Remodel Outpatient Services	83	2,394	2,203
15	Marion IL	657-312 Interventional Cardiology	84	1,665	1,482
16	Little Rock AR	598-361 CVICU/Heart Program	85	2,079	1,675
20	Seattle WA	663-330 Cath Lab/Endoscopy Suite, B100	86	2,614	1,925
9	Louisville KY	603-315 Remodel Endo and Hemodialysis	87	3,634	3,318
17	Dallas TX	549-408 Relocate Geropsychiatry	88	3,900	3,550
9	Nashville TN	626-304 Lab Function & Infrastructure Improve	89	4,020	3,623
3	E Orange NY	561-308 Consolidate MICU & SICU Units	90	4,005	3,655
16	Alexandria LA	502-302 Construct Addition to B-45	91	3,740	3,471
10	Cincinnati OH	539-314 Outpatient Specialty Care Clinics	92	4,223	3,823
2	Syracuse NY	528-707 Construct Addition for Cath Lab/CT	93	2,647	2,474
21	San Francisco CA	662-324 Provide a Second Cardiac Cath Lab	94	2,627	2,389
9	Mtn Home TN	621-306 Consol Kitchen	95	4,339	4,139

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VISN	Location		Project Title – Brief Description	Rank	Total Est. Cost (\$000)	FY 2005 Obligations (\$000)
15	St. Louis - JC	MO	657-308 EUL Raised Parking Decks	96	2,000	2,000
16	Fayetteville	AR	564-224 Addition for MRI	97	2,665	2,402
15	St. Louis	MO	657-318 Relocate Animal Research Facility	98	1,479	1,286
4	Aspinwall	PA	646-363 V4 and VAPHS Data Center Consolidation	99	3,840	3,520
15	Kansas City	MO	589-361 Acquisition of Kaiser Bldg	100	3,000	3,000
20	Seattle	WA	663-329 Research Addition Bldg 34/ARF, Ph II	101	4,160	450
20	Portland	OR	648-318 Renovate Bldg 103 Research	102	1,695	1,587
1	West Haven	CT	689-350 SCI Rehabilitation R&D Facilities	103	3,491	3,148
6	Durham	NC	558-312 New Research Building	104	4,150	3,769
23	Iowa City	IA	636-441 Construct Research Building	105	4,167	3,882
11	Ann Arbor	MI	506-342 Install Secondary Electrical Feed	106	2,340	2,216
Total					\$367,573	\$278,862

In addition to the previously listed projects, VA will complete the projects below that are funded pursuant to Public Law 108-324, the Military Construction Appropriations and Emergency Hurricane Supplemental Appropriations Act of 2005.

FY 2005 HURRICANE SUPPLEMENTAL MINOR PROJECTS

Table 4-4 VHA FY 2005 Supplemental Minor Projects

VISN	Location		Project Title – Brief Description	Rank	Total Est. Cost (\$000)	FY 2005 Obligations (\$000)
8	W Palm Beach	FL	548-122 Full Emergency Power	N/A	6,909	6,909
8	W Palm Beach	FL	548-123 Hurricane Preparedness Improvements	N/A	6,413	6,413
8	San Juan	PR	672-754 Emergency Water Supply	N/A	2,500	2,500
Total					\$15,822	\$15,822

The FY 2006 Minor projects listed below will be ranked and provided to Congress by June 2005.

FY 2006 VHA MINOR CONSTRUCTION PROJECTS

Table 4-5 VHA FY 2006 Minor Projects

VISN	Location	Project Title – Brief Description	Total Est. Cost (\$000)
1	Togus ME	402-303 Construct Specialty Care Clinic	1,786
1	Manchester NH	608-312 Specialty Care Addition	4,652
1	Providence RI	650-301 Psychiatry Ward Renovation	3,955
1	Providence RI	650-305 Research Facility	5,984
1	West Haven CT	689-374 Research Renovation, Ph 2	4,906
2	Buffalo NY	528-362 Renovate Operating Rooms	2,749
2	Buffalo NY	528-366 Ward 5C Privacy Renovation	1,240
2	Buffalo NY	528-367 Expand PT for Cardiac Care	1,720
2	Albany NY	528-801 Consolidate Inpatient & Outpt Pharmacies	3,490
3	Bronx NY	526-321 Renovate Extended Care, Bldg 106	5,080
3	Brooklyn NY	630-406 SPD/Central Sterile Supply Upgrade	3,650
3	Brooklyn NY	630-407 OR Renovation	6,000
4	Coatesville PA	542-307 Renovate NHCU Ward (59-A)	3,763
4	Lebanon PA	595-501 Renovate 17-5 for Primary Care	1,812
4	Philadelphia PA	642-317 Renovate 2nd Floor Research	3,550
4	Pittsburgh PA	646-364 Ambulatory Surgery	5,789
5	Baltimore MD	512-515 Fort Meade CBOC	3,459
5	Martinsburg WV	613-102 Fort Detrick CBOC	4,802
5	Washington DC	688-323 Research Building Expansion	6,653
5	Washington DC	688-324 Nursing Home New Addition and Ren	5,210
6	Durham NC	558-312 New Research Building	3,900
6	Durham NC	558-313 Eye Clinic Addition	4,620
6	Durham NC	558-315 Research Expansion	6,893
6	Hampton VA	590-601 Renovate Inpatient Psychiatry	5,218
6	Asheville NC	637-312 Renovate Ward 5W	2,500
6	Richmond VA	652-304 Expand Specialty Clinics	6,005
6	Salisbury NC	659-310 Tower for Spec/Anc/Diag Care, Ph 1	4,290
7	Atlanta GA	508-331 Ren Mental Health Inpatient Ward	3,525
7	Atlanta GA	508-332 Research Consolidation	6,500
7	Augusta GA	509-320 Add Inpatient Beds SCIU	4,984
7	Birmingham AL	521-326 Increase Medicine Beds	5,082
7	Charleston SC	534-315 Inpatient Privacy 4BN	2,986
7	Charleston SC	534-316 CBOC Nav Weap Stat. Goose Creek	4,903
7	Charleston SC	534-317 Expand Surgical Suite into 2C	4,898
8	W Palm Beach FL	548-118 Expand ER	2,000
8	W Palm Beach FL	548-119 Renovate 8th Floor for Specialty Care	2,500
8	Gainesville FL	573-309 Correct Inpatient Psychiatry Def	2,999
8	San Juan PR	672-302 Surgical Retrofit	4,977
8	San Juan PR	672-751 Electrical Distribution Upgrade	6,985
8	Tampa FL	673-308 TPA Mental Health Code Compliance	6,499
8	Tampa FL	673-319 Renovate OR, Ph 2	4,562
9	Memphis TN	614-309 Inpatient Mental Health Renovation	5,606
9	Memphis TN	614-312 VMU & Research Lab Upgrade	5,327

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VISN	Location		Project Title – Brief Description		Total Est. Cost (\$000)
9	Nashville	TN	626-305	Pharmacy Consolidation & OP Expan	6,617
10	Cincinnati	OH	539-316	Animal Research Facility	4,852
10	Cleveland-WP	OH	541-315	Renovate Research, Ph 1	3,806
10	Cleveland-WP	OH	541-317	Renovate Radiology, Ph 1	6,248
10	Dayton	OH	552-310	A/C B410	2,650
10	Dayton	OH	552-311	ER Expansion	2,650
11	Danville	IL	550-306	Replace Boilers (3) & Controls	5,255
11	Saginaw	MI	655-303	Correct Electrical Deficiencies	4,457
11	Detroit	MI	553-301	Expand Primary Care	5,370
11	Ann Arbor	MI	506-352	Secondary Electrical Feed	2,650
12	Chicago	IL	537-312	Modernize Radiology Department	4,992
12	Hines	IL	578-345	Ambulatory Sub-specialty Clinics	4,834
12	Hines	IL	578-356	Standby Electrical Power for ARF	3,322
12	Hines	IL	578-357	Relocate Surgical Suites, Bldg 200	6,406
12	Iron Mountain	MI	585-332	Renovate/Relocate NHCU	5,789
12	Madison	WI	607-387	Renovate Research 4C & Bldg 12	2,880
12	Tomah	WI	676-312	Renovate 3rd Floor, Bldg 408	4,970
12	Milwaukee	WI	695-300	Install HVAC Bldg 70 Research	6,639
15	Columbia	MO	589-320	Imaging Center Site Prep	3,884
15	Topeka	KS	589-325	Exp Prim Care/Consolidate Pharmacy	2,336
15	Leavenworth	KS	589-376	ICU Renovation	2,657
15	Topeka	MO	589-378	HRC - Renovation of Side C, Bldg 9	4,815
15	St. Louis	MO	657-319	Rem Space for Research, Bldg 1, JC	2,616
15	St. Louis	MO	657-320	Remodel Space for Clinics, Bldg 1, JC	1,706
16	Alexandria	LA	502-301	Renovate Bldg 6 for Primary Care	4,675
16	Biloxi	MS	520-316	New CBOC at Eglin	4,310
16	Fayetteville	AR	564-332	Exp Prim Care Clinic Bldg for Specialty	1,750
16	Jackson	MS	586-393	3 rd Fl Bldg 7 for Med/Surg & NHCU Beds	6,900
16	Little Rock	AR	598-370	Relocate PC to NLR-Expand Specialty	2,800
16	New Orleans	LA	629-321	Add Elevators	6,180
16	Oklahoma City	OK	635-312	Renovate A Mod	1,750
17	Dallas	TX	549-501	Transitional Care Unit	3,300
17	Dallas	TX	549-507	Mental Health Patient Privacy, Ph 2	3,475
17	Dallas	TX	549-509	Ambulatory Care Renovation, Ph 2	4,662
17	Dallas	TX	549-516	Patient Privacy/UFAS Def, Ph 9	4,509
17	San Antonio	TX	671-227	Accommodate Specialty Clinics, Ph 1	3,300
17	San Antonio	TX	671-228	Expand Specialty Clinics, Ph 2	6,960
17	Temple	TX	674-266	Cardiovascular Research, Ph 2	1,658
18	Albuquerque	NM	501-315	Medical Subspecialty Behavioral Health	2,100
18	Prescott	AZ	649-403	Renovate for Medical Specialty Clinics	2,704
18	Tucson	AZ	678-313	Research Wet Labs	3,332
18	Tucson	AZ	678-314	Renovate Ward 3 East	2,900
18	Tucson	AZ	678-315	Renovate for SDU	2,003
19	Cheyenne	WY	442-209	Expand Ancillary Care	6,547
19	Salt Lake City	UT	660-228	Surgery Renovation	2,620
19	Salt Lake City	UT	660-304	Research Relocation	3,626

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VISN	Location		Project Title – Brief Description		Total Est. Cost (\$000)
20	Boise	ID	531-308	Construction of Specialty Care Tower	4,550
20	Portland	OR	648-317	Replace Exterior Skin B100 & B101	5,663
20	Portland	OR	648-320	Bldg T51 Seismic Upgrade	2,153
20	Vancouver	WA	648-321	Seismic Mitigation	4,367
20	Vancouver	WA	648-323	Expand Outpatient Care	3,830
20	Vancouver	WA	648-327	Seismic Upgrade NSCU	3,000
20	Vancouver	WA	648-328	Seismic Upgrade D-7	4,000
20	Vancouver	WA	648-329	Seismic Upgrade Boiler Plant & Ancillary	1,800
20	American Lake	WA	663-327	Correct Seismic Defs, B18	2,950
20	Seattle	WA	663-329	Research Addition B34/ARF, Ph 2	4,160
20	American Lake	WA	663-341	Primary/Radiology Clinic Expansion	2,815
20	White City	OR	692-332	Renovate Dom Bldg 217	4,953
20	White City	OR	692-335	Footprint Reduction	1,551
21	Honolulu	HI	459-301	Guam CBOC	3,920
21	Martinez	CA	612-423	Stroke Rehab	3,886
21	Sacramento	CA	612-463	Consolidate Mental Health	4,723
21	Palo Alto	CA	640-356	ER/OBS Unit Expansion	3,800
21	Palo Alto	CA	640-363	Expand Specialty Care	4,400
21	Menlo Park	CA	640-364	Seismic B-205 & B-114	6,832
21	Palo Alto	CA	640-365	B-4 Wet Labs	6,625
21	Reno	NV	654-309	Expand Primary Care	1,961
21	San Francisco	CA	662-315	Animal Research Facility	5,300
21	San Francisco	CA	662-323	Bldg 200 ER Expansion	3,765
21	San Francisco	CA	662-331	Clinical Spt Annex B-200	4,900
22	Long Beach	CA	600-308	Seismic Upgrade Bldg 138	3,005
22	Long Beach	CA	600-309	Demo Bldgs 3, 5(P), 13, 47, T162(P)	4,372
22	Loma Linda	CA	605-316	Remodel 4SW Patient Privacy	3,662
22	Loma Linda	CA	605-318	Modernize Veterinary Med Unit	3,391
22	Loma Linda	CA	605-320	Parking Garage	6,416
22	San Diego	CA	664-313	Expand Specialty Clinics	5,182
22	San Diego	CA	664-322	Expand Research Labs	5,605
22	W Los Angeles	CA	691-332	B209 Research Renovation	6,269
22	Sepulveda	CA	691-333	Building 2 Demolition	3,681
22	W Los Angeles	CA	691-335	B256 Seismic Retrofit Project	3,533
22	W Los Angeles	CA	691-336	Demo Various Bldgs	859
22	W Los Angeles	CA	691-337	Outpatient Mental Health	5,973
22	W Los Angeles	CA	691-338	B500 Clinical Lab Renovation	5,894
23	Fargo	SD	437-306	Audiology/Eye/Ophthalmology	2,594
23	Des Moines	IA	636-303	Outpatient Services Consolidation	6,927
23	Des Moines	IA	636-307	Remodel Dietetics	998
23	Omaha	NE	636-326	Research Building - 4th Floor	3,010
23	Omaha	NE	636-338	Animal Research Addition	2,360
23	Iowa City	IA	636-441	Construct Research Facility	3,996
23	Iowa City	IA	636-535	Renovate 3rd Floor Research	2,178
23	Iowa City	IA	636-540	Upgrade Animal Research Facility	1,995
			Total		550,274

Mr. MICHAUD. Thank you.

The CHAIRMAN. If there are no further comments by my colleagues, I want to thank our very distinguished panel and thank you for your answers and look forward to some of the ones that you will provide for the Record, and thank you for doing it as quickly as you can.

Mr. Secretary, thank you for your leadership.

If you have no final comment, then I would like to invite our second panel then to the witness table.

Dr. Neil Livingstone is CEO of GlogalOptions, an international risk management and business solutions company headquartered in Washington, DC. He has spent more than two decades advising clients regarding a wide array of difficult and complex problems ranging from the prevention of industrial espionage to conducting special investigations, suppressing of the theft of intellectual property, advising corporations on political and economic risks, protecting corporate leaders and celebrities and recovering kidnap victims. He has advised top Government officials and testified previously before the Congress.

Dr. Livingstone is a familiar face on the Nation's newscasts as a commentator on terrorism, intelligence and other national security issues. He has authored nine books on terrorism, security and foreign policy. Some of these books include, Inside the PLO, The Cult of Counterterrorism, The War Against Terrorism, Winning a War Against Terrorism, and America The Vulnerable: The Threat of Chemical/Biological Warfare.

An honors graduate of the College of William and Mary, he also has his MA from the University of Montana and a Ph.D. From Fletcher School of Law and Diplomacy.

Dr. Jerry L. Mothershead is the former Senior Medical Consultant, Navy Medicine Office of Homeland Security. He is currently the Physician Adviser for the Medical Readiness and Response Group at Battelle Memorial Institute.

Dr. Mothershead is an emergency medicine physician and recognized national planner, author, educator, and lecturer in emergency medical services, emergency management, and health care operations for casualties of terrorism, disasters and chemical, biological, radiological, nuclear and explosive events.

During his military career, he has held a number of significant operational, clinical and administrative positions. He led the first medical team to respond to Operation Desert Shield where he provided humanitarian assistance to initial Kuwaiti refugees. During Operation Desert Storm, he deployed in support of Special Operations Forces inside enemy lines and led medical operations in support of those forces, downed coalition aircrew and Iraqi enemy prisoners of war.

In addition to his military duties, during his final assignment, he served as an adviser to a number of Federal agency committees, including the VA Emergency Management Strategic Health Care Group, the Technical Advisory Committee, and the Federal Inter-agency Committee on Emergency Medical Services.

Dr. Karl Y. Hostetler has had a very distinguished career in the medical field. He is currently an associate member, Rebecca and John Moores Cancer Center, University of California, San Diego.

He is also the professor of medicine in residence, School of Medicine at the UCSD, as well as staff physician for the San Diego VA Medical Center. He has also been a director of the Endocrine Clinic since 2000. He was previously the director of the Metabolism Clinic at the VA Medical Center from 1973 to 1983.

Dr. Hostetler is the holder of numerous patents and also has received many awards. He has been published in numerous medical journals and is a member of the International Society for Antiviral Research, American Society of Microbiology, American Society For Bone and Mineral Research, and the American Society of Biochemistry and Molecular Biology.

Dr. Hostetler received his B.A. in chemistry cum laude from DePauw University and his M.D. from the School of Medicine, Western Reserve University.

STATEMENTS OF NEIL C. LIVINGSTONE, Ph.D., CHIEF EXECUTIVE OFFICER, GLOBAL OPTIONS, INC.; JERRY L. MOTHERSHEAD, MD, FORMER SENIOR MEDICAL CONSULTANT, NAVY MEDICINE OFFICE OF HOMELAND SECURITY, AND PHYSICIAN ADVISOR, MEDICAL READINESS AND RESPONSE GROUP, BATTELLE MEMORIAL INSTITUTE; AND KARL Y. HOSTETLER, MD, VA SAN DIEGO HEALTHCARE SYSTEM

The CHAIRMAN. So thank you, Dr. Livingstone. If you could begin your testimony, please.

STATEMENT OF NEIL C. LIVINGSTONE, Ph.D.

Mr. LIVINGSTONE. Thank you, Mr. Chairman and Members. It is a pleasure to be with you today.

Let me apologize in advance. The hearing has run longer than I anticipated. I have a flight to catch and will have to leave at approximately 1:20 at the latest.

When I first published my book more than 20 years ago, *America the Vulnerable: The Threat of Chemical and Biological Warfare*, some people saw it as a warning, but others saw it as science fiction. Even some in the defense community said it was not a problem that we were ever going to have to face. And we have been woefully ill-prepared and inadequate in our response until 9/11, and now we are playing catch-up.

I cite just one example of the type of threat that we face in my statement which I have submitted for the record. There are a lot of serious challenges ahead. I have been providing training for over 20 years to firefighters, law enforcement, first responders and States and localities when no one else was doing it regarding the threat of chemical and biological warfare.

One of the things that we looked at in some of the gaming that has been done are the kinds of problems that we are going to encounter if we suffer a major attack here in the United States. As the gentleman from Little Rock said: we are going to have people storming hospitals all across the Country. In every exercise I have been involved in, they go to the nearest hospital. They do not go to the hospital of choice or the hospital with which they have a relationship; they go to the nearest hospital. If that is a VA facility,

the VA is potentially going to be overwhelmed in terms of various attack scenarios that we can postulate right now.

Because it is the largest provider of health care in the United States, it is woeful and it is shameful that the VA is not more intimately involved in the weapons of mass destruction response especially the bioresponse, in the United States, because whether you want to be or not, you are going to be on the front lines. People are going to pound down your doors, and this is going to raise a whole series of other contingencies that the VA is going to have to deal with.

I was the head of the security committee in the design of the emergency room of the future which was initiated about 4 or 5 years ago with Federal money and focused on the Washington Hospital Center. We looked at mass casualty attacks and how they would affect the hospital of the future and our medical delivery systems. We found all sorts of difficulties. We know that we are not prepared to deal with a biological attack in the United States. There is no hospital in the United States that is fully prepared to deal with a biological attack, much less certain types of chemical and radiological emergencies.

We looked at the necessity of having to triage mass casualties in parking lots and in inclement weather, because you cannot bring them into the hospital without impacting the other patients in the hospital. You have a primary responsibility to veterans, yet you are going to expose them to whatever the agent or the pathogen is that the public has been infected with. Most hospital rooms do not even have double-pane windows to prevent the escape of an infectious agent, as we found in the research that we did at the time.

Most hospitals lack water purification systems. Currently most hospitals bring up a water truck if the water system goes down. Hospitals do not have the type of air filtration systems that are going to be needed to contain an infectious agent. We are doing pretty well regarding detection of Biochem agents in this Country, but we are not doing as well in the various response areas.

There was a piece in *The New York Times* just a day or so ago that said that New York City is not prepared for the Republican Convention if there is a biological attack. They do not have the protective gear that is needed. They do not have the respirators. They lack the various protective systems that are going to be needed and should be in place today to deal with even a relatively minor biological attack, and I commend the article to the members of this committee.

Quarantine questions have not been resolved. If we to quarantine whole cities, in the event of a major disaster, are we ready to shoot people if they try to leave the city or if they try to get into the city to aid relatives? What about the fact that, in every scenario that we have run, there are hospitals in the plume of a chemical attack. Hospitals may even be the target, as one of the Members of the committee suggested, the actual target of a biological attack. It is conceivable.

Crowd control is another issue that is often overlooked. The Secretary touched on it briefly, but you are going to have people walking into hospitals with guns demanding treatment for their children. How are you going to deal with thousands of people con-

verging on hospitals in the event of a mass casualty emergency? This was one of the problems we saw on 9/11, with people converging on hospitals, looking for relatives, trying to get some type of information about missing people.

As the gentleman from Little Rock said, people are going to jump into a pick-up truck and drive to the nearest facility. There are literally dozens of things that we have looked at that are not being addressed today in any systematic way by any hospital in the United States, much less the VA system. The VA will be the shock troops of a major disaster in the United States. You need more funding. You need a bigger role, because when attack which we all dread occurs, the afflicted are going to converge on the VA health care system. They will look to you for answers and treatment, and you will still have responsibilities to the other who are already in the system who will have to be protected as well as your own personnel.

I think we also have to be aware of the issue of emerging viruses coming to the United States, given modern jet travel and the interdependency of our world today. It may not be a hostile attack; it may just come out of the rain forest from some distant part of the world, brought by traveler to the United States, infecting everyone who comes into contact with the vector. We are looking at some very alarming scenarios today. More planning needs to be done. The Veterans' Administration is a national treasure and needs to be a major part of the solution to the catastrophies that we can anticipate in the future.

So with those opening remarks, I will leave my statement for the record and I would be happy to answer any questions you have.

[The prepared statement of Mr. Livingstone appears on p. 127.]

The CHAIRMAN. Thank you so much for your testimony, and your full statement will be made a part of the record.

Dr. Mothershead.

STATEMENT OF JERRY L. MOTHERSHEAD, MD

Dr. MOTHERSHEAD. Mr. Chairman, Members of the committee, distinguished guests, thank you very much for the introductory bio. I did not know that you had that complete a one on me, because I abbreviated.

Before I talk about any observations or thoughts I have specifically on the VA, I would like to make four general observations concerning health care in the United States and disasters and preparedness as it relates to health care in the United States.

The first point I would like to make is that our health care experience in large disasters in this Country is essentially nonexistent. Disasters in America, certainly in the last 50 years or so, have been typically nonprogressive, defined scenes, sudden impact disasters: hurricanes, building fires, wild land fires, things like that, in which the economic and structural damages are way out of proportion, thank goodness, to the number of casualties and deaths that occur from that. There is only a handful of events that occur annually that result in total casualty counts in excess of 50, and almost all of those are transportation-related accidents. With notable exceptions, resources in most U.S. health care facilities have not been exceeded, few suffered staff shortages, but even fewer still suffered

supply shortages in traditional disasters in this Country. Most facilities are able to return to normal or near normal operation within 48 hours of the event. That is our experience.

Now, the disasters we are talking about today, we are talking orders of magnitude, greater than anything this Country has witnessed in over 100 years. Even smaller-scale events using the variety of weapons of mass destruction could produce thousands of deaths, thousands of casualties and both requiring acute care and chronic, long-term care. There would be unfathomable numbers of psychological casualties and potential for displaced populations and loss of health care facilities and their staff.

Two quick examples: If you take the data from the Spanish flu epidemic of 1918 and translate to today's time, you are talking about, in 4 months, killing the State of Nevada. That is a number you can understand. In Canada, in 1979, there was a train accident that resulted in a big chemical spill, and in 48 hours, they had to evacuate a quarter of a million people. And they had to find places for those people, including seven nursing homes and two hospitals. That is a number I think we can understand. So that is my first point.

My second point is that the health care system in the United States is already in crisis, and I am not saying anything that has not been said probably to this committee, other committees, the full House and the full Senate numerous times, because I have seen it on the Internet on some of the postings. With the burgeoning health care costs, reduced reimbursements and our increasing uninsured population, all the fat has been cut out of the civilian health care system. There is none. I mean, doctors are not getting rich. Hospitals are not getting rich. Stockholders are not getting rich.

In the last 10 years, over 500 hospitals—and that is about 10 percent of the total hospitals in this Country and 25 percent of the emergency departments—have closed. But the demand has not gone down. In fact, the latest data from the American Hospital Association says, in those same 10 years, the number of visits nationwide to emergency departments has gone up by 20 percent, and I think you can easily do the math and see the number. Your supply is going down by 25 percent, and your demand is going up by 20 percent. You potentially have a problem here.

The market forces have also affected the Federal institutions as well with closure of military facilities in excess of those linked to the BRAC base closures. The VA Cares program, which one of you mentioned, I do not think by name, may result in similar effects within the VA system as well, with the transference of a lot of that care into this already burdened civilian sector. And the net result is that we have almost no true sustainable national surge capacity.

Hospitals additionally have very few surplus funds to invest in disaster preparedness, and without any kind of significant change, this is only going to get worse over the next 10 to 15 years when people like me, the baby boomers of America, start demanding more health care.

The third point I would like to make is that the failure to recognize the health sector preparedness as a public safety function has hampered readiness initiatives. It is my contention that medical

disaster preparedness has to be recognized as a public safety function and, as such, is a governmental responsibility which must be appropriately subsidized. If public policy does not change to address this, we are probably never going to be adequately prepared, and I am going to couch that adequately prepared with my fourth point.

The big issue is that disaster preparedness is an insurance policy. You hope you never need to use it. But there is always a cost involved. And with all of the other competing priorities that are going on in the health care system—and I mentioned just a couple of them—which Peter do you rob to pay Paul? And I would take that to the VA system as well as any civilian system. If there are going to be additional mandates for change, I think they have to be accompanied by appropriate capitation. If they are not, then somebody is going to lose out. And in the case of the VA, it is going to be our vets, and I do not want to see that happen.

My fourth point and final point before I talk about the VA specifically is that I think that the efforts to improve bioterrorism and disaster response in the medical sector have accelerated and have improved, but much remains to be done. Now, yesterday, when I was driving up here from where I live, I had the radio on. And Secretary Ridge made a statement to the people of New York about the readiness for the Republican National Convention, and he said, “We are ready.” the same article that was already referred to, I actually would like to submit for the record.

(See article follows:)

New York Hospitals See Lack of Preparedness for Disaster

By MARC SANTORA

Published: August 24, 2004

Nearly three years after Sept. 11, and with New York bracing for the Republican National Convention, hospital officials across the city say they still lack much of the important protective clothing, decontamination facilities and essential drug supplies that could be needed to respond to a biological, chemical or nuclear strike.

Shortly after the 9/11 attacks, the federal government said it was essential that the nation's hospitals improve their ability to handle complex, catastrophic disasters, and it warned the hospitals that they might have to wage that response without outside aid from the government or military for as long as 48 to 72 hours after any terrorist attack. But hospital officials in the city say Washington has failed to provide adequate direction on how to run such extraordinary responses, and have not come anywhere close to providing the kind of money they say they need.

Those officials say the recent preparations for the challenge of the convention - they describe them as serious and ambitious - still underscore how much remains to be done.

"What the convention does is create a singular moment in time when all the planning and all the resources have to be at an optimal level," said Kenneth E. Raske, president of the Greater New York Hospital Association, which oversees 250 hospitals and other medical facilities in the region, including roughly 70 in New York City. "The problem is that the federal government has not provided the resources or done their fair share of what they needed to do."

In the aftermath of Sept. 11, the federal Department of Health and Human Services, which was given the responsibility for overseeing the planned improvements in preparedness among hospitals, said it would issue guidelines for what needed to be done and provide the expert advice. It also pledged to provide some of the money to do it. But what guidance the agency has offered has often been confused, public health experts say, and the money provided has been a fraction of what the hospitals need.

In New York City, a number of hospitals have spent about \$5 million apiece since 9/11 to install decontamination showers, buy protective equipment and train staff members.

For this effort, they have each been reimbursed roughly \$75,000 from Washington, according to Mr. Raske's association.

The hospitals, which are facing many other financial pressures, say they would have to spend hundreds of millions of dollars more to make more meaningful progress toward readiness.

Given the unpredictable nature of the terrorist threat, preparing for every situation may be impossible. But public health experts - who note that even the matter of who would be responsible for providing security at a hospital handling contaminated patients has not been clearly communicated - say there are four key areas where more progress needs to be made.

One is what is known as surge capacity: a hospital's ability to deal with a sudden influx of patients. The federal health agency has made hundreds of millions of dollars in grants to hospitals throughout the country to help them prepare, but the 2005 federal budget actually calls for a reduction in those grants.

A second concern, officials say, involves decontamination facilities, a potentially vital aspect of any response to a biological or chemical attack.

While individual hospitals, like St. Vincent's Manhattan Hospital, have taken steps to add showers and train staff members, there remains little federal information on a question as basic as how many patients a city with New York's population should seek to be able to handle per hour.

The third chief worry involves burn beds. These special beds would be needed in the event of nuclear attack, and currently the city only has a handful.

The final area of vulnerability deals with what are called isolation facilities. In the event of a smallpox attack, for instance, the ability to quarantine people in a hospital would be essential and is currently lacking.

Dr. Irwin Redliner, director of the National Center for Disaster Preparedness at the Mailman School of Public Health at Columbia University, said the lack of preparedness was inexcusable. "The fundamental fact is that this country is not ready to handle a significant terrorist event," Dr. Redliner said, referring to the hospital systems.

Officials with Health and Human Services, despite repeated requests for interviews, did not offer a response to the complaints of public health experts. But Tommy G. Thompson, the director of the federal agency, has previously defended efforts and spending.

Dr. Redliner's skepticism, though, is shared by the public. A poll conducted by Marist College for Columbia, to be released this week, found that nationwide the public is losing faith in the health care system to deal with a biological or chemical attack. Only 39 percent of those asked said they had confidence in the system, down from 53 percent two years ago. The poll, which surveyed 1,234 adults in July, had a margin of error of 3 percentage points.

Perhaps even more striking, 78 percent of those surveyed said they were not familiar with any disaster response plan in the event of a terrorist attack.

Dr. Redliner said the poll results highlighted the second half of the problem with the federal government's homeland security planning: inadequate communication and education. "It is as if we are fighting a war on the battlefield without a central command and we had platoons operating ad hoc without a sense of the goals," Dr. Redliner said.

Many of these concerns are not new, particularly when it concerns bioterrorism.

Last year, the federal government conducted its largest counterterrorism exercise since 9/11, called Topoff 2. It was planned to test the ability of Chicago area hospitals to deal with simultaneous attacks featuring both biological agents and a crude radiological device, or a dirty bomb, the test raised serious concerns. There were problems in communication, the ability to deal with the surge of patients and shortages of medical supplies. Although the drill was conducted in May 2003, one year later, Senator Joseph I. Lieberman, a Democrat from Connecticut, said little had been done to correct the problems.

In a letter that he addressed to Mr. Thompson at Health and Human Services, Mr. Lieberman wrote, "Last year's Topoff 2 exercise also showed that there continues to be confusion about roles and responsibilities of government agencies in responding to a bioterror attack, even during a carefully designed and scripted one."

Mr. Thompson, in a letter responding to the criticism, said Mr. Lieberman was "just plain wrong." While not addressing the details of the Topoff 2 drill, Mr. Thompson said the Bush administration had increased

its spending on bioterrorism preparedness annually since 2001 and would be spending \$4.1 billion on bioterror and public health preparedness in 2005.

Hospital officials in the city were careful to note that much has been done to prepare for a serious nonconventional attack, work that even predated the 9/11 attack. Ever since a sarin gas attack in the Tokyo subway in 1995, for instance, city agencies have been staging drills for a similar event in New York.

But the health care system is still not where many believe it could or should be, some politicians and public health experts insist.

"There is not a serious effort to assess what is needed in our hospital and health program," said Senator Hillary Rodham Clinton, a Democrat from New York. "It is shocking to me how poorly prepared we are."

Mrs. Clinton pointed to the response to the smallpox threat as evidence of Washington's confusion. In January 2003, President Bush talked about the threat of smallpox in his State of the Union address, and a program was started to vaccinate about 500,000 first responders from the virus. However, the vaccination program faded away and, in the end, only about 37,000 were vaccinated.

Steven Kuhr, who worked as the deputy commissioner for New York City's Office of Emergency Management from 1996 to 2000 and is now the chief operating officer for Criterion Strategies, a counterterrorism training and consulting company, said hospitals have been taken for granted by everyone.

"Hospitals and the public health care systems have largely been left to scrape up the crumbs after the more visible agencies or those with better lobbying have gotten their share," he said.

But again, he took pains to credit what had been done on the initiative of individual hospitals.

For instance, St. Vincent's will soon complete a new \$20 million trauma center at its downtown facility, built largely with private funds. It will have decontamination facilities that can treat 200 patients per hour. Currently, St. Vincent's has the decontamination showers in an ambulance bay and can treat 90 to 120 people an hour, depending on the agent used in the attack.

"We are at a high level of preparedness," said Mark Ackermann, the senior vice president at St. Vincent's.

On 9/11, St. Vincent's was the closest trauma center to the World Trade Center. Mr. Ackermann said his hospital was taking steps to be prepared regardless of the federal help that is received.

But, he said, "It is very fair to say that federal agencies have not worked well with hospitals over the past three years."

He noted that on 9/11 roughly 25,000 people surrounded St. Vincent's, many looking for information. While that may be a natural reaction, Mr. Ackermann said, "If it was chemical or biological attack, the worst place to be is near a hospital."

It is basic information like this that public health experts say should have been communicated long ago.

"What we have are basically random thoughts on one of the most critical questions of our time," Dr. Redliner said. "This should be part of national strategy."

Dr. MOTHERSHEAD. I sent it up electronically from *The New York Times*, and in that article, Dr. Irwin Redliner, who is the director for the National Center For Disaster Preparedness at the Mailman School of Health at Columbia University, said, "The fundamental fact is that this Country is not ready to handle a significant terrorist event."

Now, the only way I can reconcile these what I consider incongruous statements is to know that we still do not have in this Country any clearly-defined, functional standards by which to measure readiness. If you are going to say someone is not ready to do something, you have to define that. You have to define that by the tasks, the conditions and the standards. You have to say, not only do you have to be able to decontaminate at the hospital like the Joint Commission says, but you have to be able to do it for 50 people, 100 people, 1,000 people in 1 minute, 10 minutes, 3 hours, sustainable for 1 day, 2 days, 5 days, whatever the standards are that are set. And then you can say you are either ready by that criteria or you are not. If you do not set those, then I cannot say we are ready, but I also cannot say we are not ready, because I do not have a benchmark to compare it to.

In the past 3 years, we have seen a burgeoning of programs, bolstering existing programs, adding new programs, and basically virtually every professional organization and every governmental agency, both Federal and State, have established an Office of Homeland Security and suboffices underneath that. There has been a large amount of money, comparatively speaking, that has been earmarked for biodefense research, technological development, disaster preparedness, et cetera.

So I would say there is no doubt in my mind that, as a Nation, we have definitely increased our efforts to be prepared, but without those standards, I cannot say exactly that we have met it. On the other hand, we still have a lot of challenges. A lot of our programs have not reached maturity yet. We have yet to fully implement the surveillance systems with the sufficient sensitivity and specificity for the earliest possible detection of an attack. A lot of research still needs to be done in pharmaceuticals.

You have already heard it a couple of times, and I will say it again, we have no reserve capacity to speak of for both acute and long-term health care of mental health services that would be needed for the number of casualties that we are talking about. Our education and training in disaster medicine and the clinical aspects of bioterrorism and other weapons of mass destruction have not been universally institutionalized. We have yet to solve the post-attack environmental surety problem.

You talk about the Hart Office Building and how long it was closed down. Imagine two-thirds of New York City, both business district and people's homes. What are you going to do with those people until you can tell them it is safe to go back?

And the list goes on. The funding for health in the medical sector has improved. I will say that. But it has by no means solved the fiscal dilemmas involved.

So turning to the question concerning the VA's role, I would note that, between the VA, DOD, and the Department of Health and Human Services, they all represent a national asset in the global

war on terrorism and response in the medical arena for any disaster we might have. As you have heard, the VA operates the largest integrated health care system in the United States. We have VA facilities in every State in the union and every territory. If you combine DOD facilities and DHS facilities and some of the DHS facilities, there is probably no community that is as far removed from the fingerprint of a Federal health system.

So with that being said, all disasters are first and foremost local, and even large disasters are collections of localities. Faced with a disaster, emergency responders and emergency managers have to use every tool in their tool kit. Many VA facilities have already collaborated to some degree with their local health care systems, but I would maintain that Federal facilities—and you will note I say Federal, because I do not exclude the DOD from this—I think Federal facilities must be allowed to be more fully integrated into the entire health care system during disasters, and that means they have to work at that integration before the disaster occurs.

Today, most Federal facilities do not even participate in their local trauma systems. I will note that, in San Antonio, Texas, due to a cooperative trauma agreement between the City of San Antonio and the two military hospitals down there, they have formed a model for civilian-military collaboration that maybe should be studied, because it forms a basis that could be used for disasters.

My second point: The National Disaster Medical System which combines the Federal and non-Federal medical resources into a unified response has an important VA role. The VA and DOD's primary role is in the management of what they call Federal Coordinating Centers or FCCs. However, I would note that less than 10 percent of the geography of the United States and only about 30 percent of the hospitals in the United States are included in this system. So I would respectfully suggest that this system should be looked at from the point of expanding the roles of the FCCs as regional coordinators to potentially expand the geographic area to cover more and to do more to bring in more hospitals.

The third point, and this is a big one of mine, has to do with education training. It is now 3 years after 9/11, and we still do not have a competency-based, tiered, national standard curriculum for education for the clinical and operational medical management of victims of terrorism and disasters and weapons of mass destruction, nor do we have an organized national education program. Our Centers of Excellence, the colleges out there, it is like every day you turn on a website, and there is a new Center of Excellence. I am not exactly sure how they earn those titles, but it is like a popcorn popper out there, institutions creating education programs.

And I do not have a problem with that, but they are not all singing from the same sheet of music. I think it is time we developed such a national standard curriculum and a national education program, and I think that all of the Federal health sector partners should be the leadership backbone of that program.

The next one I already mentioned briefly, which was standards. I believe it is the responsibility of the leadership of the Government to institute standards of performance and measures of effectiveness for programs that they would oversee, and although I believe there are many stakeholders, including people like the Amer-

ican Hospital Association, the American Medical Association and all of those other associations, certainly the Federal health sector should be involved with leading that process.

I would further offer that, if the health care industry is expected to meet those standards, it is incumbent on the Federal health partners to collectively set and then meet those standards themselves.

Two more quick points: One has to do with emergency response teams. There is a veritable alphabet soup of emergency response teams out there. The Department of Health and Human Services has DMATs and DMORTs and DVETs. And the Army has SMART teams, and the Navy has SPRINT teams. And the Air Force has BATS, and the VA has MERTs and EMRT's. And keeping them all straight just alphabetically is difficult. But, again, they do not all sing off the same sheet of music.

Each agency—and within the military, it is each service—has its own conceptual idea of how these response teams should be used, what play books they should be using, what equipment packages they should take with them. And there has never been a really serious, national, integrated look at all of these response teams to say, what do we need to take to the scene? How soon does it have to get there? And what does it have to have with it? I would respectfully submit that the VA should have a role in that, and I would think that they should also consider expanding the number of response teams they have as part of the collective force, so to speak.

My final point is that I think that the VA has done a great job. In fact, the VA has done a lot of good stuff, and so if I am saying anything negative, I want to couch it with the fact that I know they have done a lot of good things in this area. But I think they could do more, again, collaborating with their other Federal partners in developing job aids and tool kits, so to speak, for the front-line operational facilities, meaning the hospitals and clinics out there, to do their job better. One example would be in development of a comprehensive Public Health and Emergency Exercise Program for a health care system, because, in general, the health system, even today, is not as integrated into the overall exercise programs in communities as they could be.

These are but some of the areas in which the VA could progress towards enhancing its capabilities. I would finally say that, further, more intimate collaboration with the other Federal health sector partners at all levels and on all common issues could facilitate a more cohesive, integrated strategy which would only help strengthen our defense postures. Thank you very much.

[The prepared statement of Dr. Mothershead appears on p. 134.]
The CHAIRMAN. Dr. Hostetler.

STATEMENT OF KARL Y. HOSTETLER, MD

Dr. HOSTETLER. Mr. Chairman, Members of the committee, thank you for inviting me to report to you on VA research and to brief you on some new developments that have come out of the work of USAMRID, NIAID, and VA in our laboratory regarding smallpox.

Dr. HOSTETLER. As you know, smallpox is classified as a category A pathogen. It was eliminated by vaccination in the 1970's, but there is still concern that there might be stocks in the hands of unfriendly people. Although we have adequate vaccine for the country, there still are large numbers of people who can't be safely vaccinated because of immune deficiencies, cancer chemotherapy, pregnancy, skin diseases. For this reason, it would be useful to have a second line of defense, in this case an antiviral drug, which can treat or even prevent the development of smallpox in exposed persons. John Huggins from the USAMRIID screened known antiviral drugs in the 1990's and discovered that there was a drug called cidofovir that was active against smallpox, but it was an intravenous drug with side effects.

In 1999 my group was asked by the NIAID and USAMRIID to make alterations to this drug to make it orally bioavailable. The reason we were asked is because the NIAID and USAMRIID were aware of our 15 years of research in the VA on improving the performance of pharmaceuticals, especially antiviral drugs. We were able to synthesize a number of compounds which were tested against smallpox at the CDC in Atlanta by Dr. Huggins. This was referred to by General Martinez earlier.

Some of our new compounds were highly active, and I can report to you that they have high degree of activity in lethal animal models of pox virus disease and are moving toward phase one clinical trials. So we are cooperating in Mr. Snyder's words, I believe this does represent a true synergy between three arms of the government. The phase III equivalent trials will have to be done by USAMRIID investigators in primates infected with monkeypox and smallpox.

I think that is all I wanted to say. I will keep my statement very short and be available to take your questions. Thank you very much.

The CHAIRMAN. Dr. Hostetler, thank you very much for your testimony and for your leadership.

Dr. Livingstone you have made some very strong and, I think, profound statements. You have pointed out that the inevitability of a chemical, biological, or radiological attack. You say time is running out. It will happen. And you point out that we are not prepared within the VA to handle this. You did point out and I am very appreciative of that that the very modest but I think not insignificant effort that we have made on trying to authorize these centers of excellence which would again not just become another group that is looking at something, hopefully it would do some very profound research, and there would be moneys coming in not from just from the VA, but from other sources as well to make that happen.

Maybe you want to expand upon it because I think we have lost some crucial time. We have another appropriations bill coming up very shortly. The bar is in there again. I am going to seek to try to knock it out because it seems to me that these centers need to get up and running sooner rather than later. And the Assistant Secretary—again, we have a very good, competent person, Dr. Mothershead, who is, among so many other things, handling this issue. Why not have an Assistant Secretary which we have author-

ized by law but not funded or allowed to go forward through the appropriations process? You might want to touch on those.

And one other point that you made, if I could. You made a number of very good points but I will just leave it at that. And then I will go to Dr. Hostetler if you could explain—

Mr. SNYDER. Would you yield a moment?

The CHAIRMAN. Sure.

Mr. SNYDER. I am wondering, since you are always so gracious with the time, Dr. Livingstone said he has got a plane to catch, and I am wondering if we could do a quick round of just questions to Dr. Livingstone.

The CHAIRMAN. Would that be all right with our other witnesses because Dr. Livingstone has a plane to catch. That is a great idea. If we could keep it focused on you, Doctor, and then go to everybody.

Mr. LIVINGSTONE. Great. Let me just suggest that, as I pointed out in my statement, the VA is the largest trainer of medical personnel in the United States. Biochem response training has got to be part of the VA's curriculum. Moreover, over half the medical personnel in the United States have never been a participant in an exercise dealing with a chemical, biological, or radiological attack.

The VA, because of its special status and many locations often in urban areas, is better situated to respond to a major emergency than military medical facilities. There are, moreover, many fewer military facilities in the country. They are often in restricted areas. They are often not in major metropolitan centers. The VA, whether our national planners like it or not, will be on the front lines and when something happens people are going to be knocking at your door for help. If your facilities have not been updated to deal with the threat of Biowar mass casualty attacks, outfitted with the kind of overpressure systems needed to prevent the flow of infectious agents throughout an entire complex and ready to address crowd control and triaging issues. Then what starts as a disaster could become a catastrophe. I would be happy to provide additional detail to the committee if desired, but all these design features are going to have to be built into VA hospitals, whether it is part of the national response program or not.

Otherwise, when that disaster happens, you are not going to be prepared and are going to put the veterans you serve at risk within VA hospitals. I don't believe the planners who devised the national response system have really thought through all the issues. They have mandated a piecemeal response system that far from seamless. The reality is the VA is going to be a big part of the medical response and needs more funds to do it.

You need in short, to be a bigger part and more significant part of the team. This involves the retrofitting of old hospitals, the design of new hospitals with special features in them, more training and exercising. The administration is going to spend over \$500 billion in fiscal year 2005 on biowarfare defense. I don't know where the money is going and it is hard to see tangible results except in areas like detection and awareness; but we have got a long way to go, and I hope that the Veterans' Administration can be recognized today as a lead player in this response.

The CHAIRMAN. If you could on that, would the Assistant Secretary advance that effort?

Mr. LIVINGSTONE. Sure. Because right now there is not a structure within the Veterans' Administration to really focus on the response to a WMD incident. The VA doesn't have the appropriations and the structure, in terms of leadership and manpower, to address these issues. This needs to become a primary responsibility of the VA even though it is not veterans related, simply because the VA is America's largest medical delivery system.

The CHAIRMAN. Mr. Evans.

Mr. EVANS. I think that we have to be really careful again by saying we could make things safe. We can't make them safe; we can make them safer. But, actually, looking at all the different programs that you have put forth in your testimony, I think it has become evident that, for example, the Marine Corps has those ten buildings on South Capitol Street. If I am correct, those are for decon—we walk past these places every day we walk on Capitol Hill. And back on September 11, we got out of the offices as soon as we could. I guess what I am driving at is the threat of a nuclear bomb, or a biological weapon, some people said it could be like 5 to 6 million Americans. If that happens, you will have panic throughout the entire United States.

I don't know how we can do anything much more than try to make things safe, but I just want to make it clear to my colleagues when you talk about this kind of multiple threat, there is no way that you can deal with it, in honesty, to the old ways of doing things. It is going to be a shock to our system. And we are going to try to do the right things here, but their weapons are becoming cheaper and cheaper and they have an unlimited supply of them.

So I know people are working very hard, but I just don't see how this—when you triage the patients that you are talking about, you are just getting to a handful when you are dealing with decontamination. Somebody said you do like 12 examinations or treatments in a day, and I don't know if this is all what the Pentagon has said, but it is a very awesome question. We never knew, most of us in Congress, for that matter, that Greenbrier was going to serve as a backup facility for the Congress. And it kind of astonished me because we are years past that time at this point, and we have got to do something about obviously all these issues. We don't want to just sit back, but I don't exactly know what to suggest here. Could you elaborate on what we can do in a meaningful way as opposed to just reacting?

The other possibility could be that they do a nuclear bomb at a time of a natural disaster like a hurricane.

So I don't want to be the bearer of bad advice, but have you got anything to say in that regard?

Mr. LIVINGSTONE. We are sitting at ground zero right now. My office is two blocks from the White House, and I live in the District of Columbia. The fact is that we have to look now at how we are going to deal with any of these contingencies. A chemical incident is going to be containable. Chemical agents generally dissipate very fairly quickly. Most of the chemical agents break down in sunlight and certain weather conditions. It most likely will be a one-time one incident, even if there are multiple attacks. It may be multiple

attacks. And the same is likely true of a radiological, dirty bomb, incident. I was part of a U.S. team that went to Europe last year to meet with our allies regarding radiological incidents involving RDDs, or, radiological dispersion devices. Even a small RDD will be an incredible terror weapon. A small device that kills or injures only a handful of victims will have the same psychological impact on the society as a device that inflicts a large number of casualties and leaves a major part of one of our metropolitan areas as a no-go zone.

It is really the infectious agents that concern us from a medical point of view because they can spread across the United States and the problem will not be contained in Washington or New York or at one ground zero. As my colleague pointed out, we could lose perhaps tens of thousands, or even hundreds of thousands of people, if we are not prepared to deal with a mass casualty attack of national proportions. And it will not be one VA facility that impacted but it could be every VA facility in the United States. Just recall the recent SARS epidemic, which was quickly contained, but could have spread very quickly around the world. We have to have a national response to these kinds of threats.

The CHAIRMAN. Mr. Beauprez.

Mr. BEAUPREZ. Thank you, Mr. Chairman. I am not sure if I have got a question, but I have certainly got an observation. I think Dr. Livingstone, Dr. Mothershead, Dr. Hostetler, and certainly our previous panel have highlighted it. The words I wrote down just a moment ago, and I think they were yours, Dr. Livingstone, is primary responsibility.

I really don't believe, Mr. Chairman, and this is not directed at you because I think you did actually try to make this a primary responsibility of the VA, to be prepared, to be the central part of our national health care system, whatever that means, but we are not there yet. And I think that is the startling fact that is coming home today. I referred earlier to the need for a cultural change, and I think that is very much what is lacking, and I am not sure it is fair. I want to make sure the record is clear here. I am not pointing the finger at the VA. I think we have burdened the VA with numerous responsibilities and we do more every single day.

Certainly when we had open enrollment and Congress didn't step immediately up to the plate and take care of the resources to take care of the open enrollment, whether on purpose or by default, we established a whole set of priorities for the VA whether they liked it or not. And then 9/11 happened, and somehow by inference, I guess we are going supposed to have a new primary responsibility without our giving them the resources to deal with it. I think many of the serious questions, Mr. Chairman, lie to some degree with this committee but to a larger degree with the rest of Congress to step up to the plate and accept responsibility for the challenge at hand.

Dr. Livingstone, I think—well, all three of you gentlemen, but since we are dealing with you at the moment given your time constraints, I would applaud you for being one of the few, frankly, that I have had the pleasure of listening to who does seem to have the capacity for imagination. As frightening as it is, I think we do have

to be forward looking in this day that we live in and we need to hear more from people just like yourself.

A question: Given the culture as it exists, both within Congress and within the current bureaucracy at the VA, do we have the ability to change as quickly as need be?

Mr. LIVINGSTONE. I appreciate the Congressman from Colorado's comments. We are a reactive country. 9/11 demonstrated that. There were many of us who were concerned about this issue for decades before 9/11 occurred, and I disagreed very strongly with National Security Advisor Rice that this was an unimaginable thing. We had already done scenarios regarding attacks on the World Trade Center Towers. So the fact remains that we need to set our sights on the unthinkable and be prepared for it.

I am afraid it may take another serious threat or attack before the country is mobilized to react. I travel all over this country and only in Washington and New York are people are very sensitive to this issue. If you travel out to my part of the country, in the Rocky Mountains, people think the war against terrorism is over. They are focused on Iraq if they are focused on anything today, and I think the government has failed to communicate many of the real threats to the public that we are going to have to face in the future.

I hope that Congress will address this problem and get out in front of it instead of simply being reactive. Years ago I worked in both the Senate and the House as a staff member. It is very hard to move these bodies, as you know. But I think with the leadership of the members of this committee and others you can force these bodies to focus on some of these issues we discussed today.

Mr. BEAUPREZ. I appreciate both your observations and your candor. Thank you.

The CHAIRMAN. Thank you, Mr. Beauprez. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman. I would like to thank Dr. Livingstone also for his remarks as well as the other two panelists. It has been very insightful, and I have agreed with what you all have said here today. I think the Members of Congress and the public do have to think outside the box to try to find the solution, and I also agree with the comments made earlier, we are in a health care crisis here in this country, and when you look at what is happening particularly in a lot of the rural areas and what is happening with the closing of emergency rooms and what is happening—I think we have to address that and I think the VA definitely has to be the lead agency to look at taking on this responsibility with adequate funding, of course. I have no questions, Mr. Chairman. I just want to thank the panelists for their insightfulness here this afternoon.

Mr. LIVINGSTONE. Thank you, sir.

The CHAIRMAN. Dr. Snyder.

Mr. SNYDER. Yes, Mr. Chairman. Just a quick question. You outlined some different things that could happen as hospitals get flooded with people. In order for the system to work, though, not only would they get flooded with people but depending on what is going on, the agent or the attack, systematically going from house to house looking for people. I mean, if it is an infectious disease—I will use this as an example. I mentioned the cholera thing earlier. I worked overseas. We would have patients show up there on don-

key in our little hospital because we sent people out twice a day to look at every tent of this refugee camp, and there were a hundred thousand people there.

Twice a day we had a circuit. We would look at every tent to be sure there was not somebody who was just pooping their life away there and no one knew they were there. So the hospitals are going to be overwhelmed but the system is going to have to say this is probably not all the patients. We have got to go find them. Whose responsibility will that be, do you think, in your studies?

Mr. LIVINGSTONE. The government is sponsoring a number of data collection systems right now to try to better correlate the kinds of information that the CDC has traditionally collected. But a lot of that, as you know, is voluntary. A physician calls in for example, and reports that he has an unusual case. That becomes the canary in the coal mine in many respects. Now we are trying to do this more systematically, using Federal money. I think the District, if I am not mistaken, was the first funded project in the United States. I am speaking just off the top of my head, but I think George Washington University is very much involved in this process. I don't think that there is a follow-on program in place at this point, other than trying to monitor casual incidents, and maybe my colleagues can better address that.

But I will say you are absolutely right. As long as there is one host to one vector that is still out there that we don't find, the disease can continue to spread. So we need a follow-on program that is an outreach effort of hospitals. People that are, frankly, just too sick to get to medical facilities and people who expire in their apartments without family and friends should be the focus of this effort. There are all sorts of contingencies we have to look at right now.

Mr. SNYDER. In that scenario, my guess is if you had a situation where people are going out and looking for some kind of—have an infectious agent or something that they will find people that they are not going to say all right, we have just picked up 25 people on the street, now let us all see your insurance cards so we can see which hospital to take you to. They are going to take them to the nearest hospital. If it is the VA, then it is the VA.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

I know, Dr. Livingstone, you do have to leave. We thank you.

Mr. LIVINGSTONE. Thank you very much, sir.

The CHAIRMAN. Just some additional questions to our other two distinguished witnesses.

Dr. Hostetler, obviously you talked very much in depth about the smallpox issue, and it is my understanding that about 1,500—maybe the number is larger now—VA employees have been vaccinated with the smallpox vaccine, and they are part of the VA vaccination and health care response team. My understanding is that given an emergency, they could be deployed to vaccinate others, but would they also be treating those who have been made sick, and how does that work? I know that there are liaisons with States. It seems to me that if we have a massive outbreak, the VA will truly be counted on to have those folks acting in very pivotal positions.

Dr. HOSTETLER. I only know what is going on at the San Diego VA Medical Center; so I can't really offer a global answer to that.

The CHAIRMAN. Could you offer it with regards to your own? I mean would they also be in the treatment area? Would other doctors then be taken out of the equation, doctors who have been vaccinated brought in to treat those who may have been infected by smallpox?

Dr. HOSTETLER. I know that a core of first responders have been vaccinated in San Diego, and I presume that there must be also a group who could perform vaccinations should it become necessary. But beyond that, I don't know because I am here to report on my research, an oral drug for smallpox.

The CHAIRMAN. Just again, in your opinion, what would it take to stimulate additional research along the lines of your research to address other likely agents which terrorists might use in the future? And Dr. Mothershead, you might want to touch on this as well, because it seems to me I remember I looked at a list as we were preparing for our hearings several years ago of potential contaminants, biological agents and chemical, and the biological—there were many. It wasn't just smallpox. There were large numbers, botulism included—there were just large numbers of potentials out there, and it seems to me that we may get five right, leave out the sixth, and that is the one they use. Are we doing enough along those lines and what should we be doing?

Dr. HOSTETLER. If I could start, I think that important steps have been taken in the sense that the pharmaceutical industry has been reluctant to jump in and help out here because, frankly, I think they are skeptical because they don't see a reliable market for a product that would go into a repository.

I think, however, that the NIAID has come forward with a number of requests for proposals, for which I have myself applied, to develop drugs for possible use in BioShield. With the knowledge that there is a fund available that Congress has passed and President Bush has signed, namely the BioShield bill, this should provide adequate incentive for development of new products.

Dr. MOTHERSHEAD. What I would say to that particular piece is I think that in the short term we need to get vaccines out there, and I think there is going to have to be issues of accelerated approval through FDA, et cetera. Just to let you know, the whole issue of vaccinations and people against them goes all the way back to William Jenner's time. Within 2 years of the time the smallpox vaccine was out there, there were already groups, whether they were religious or for whatever reason, that were rebelling against it. We had it in this country, even as late as the 1950's, against the smallpox vaccine, and we have it today against things like DPT and stuff like that.

The vaccine is not the panacea solution, though. I will give you one example of a research project that really didn't get much attention on the front pages, but, I mean, it certainly lit my eyes up. In Australia about a year ago, a researcher named Jackson—they were using a cousin of smallpox, mousepox, to manipulate because that particular virus is easy to work with for researchers, to try to produce a birth control vaccine, and they were obviously experimental on mice with this particular virus.

And the mice that they were using are naturally genetically resistant, not immune but resistant, to mousepox. As one of those laws of inadvertent consequences, during the process, some of the confirmational changes that happened as a result of that not only created a super mousepox that killed these naturally resistant mice, but the vaccine did not protect them either. And that experiment has been repeated since then. And if you translate that to smallpox, if we were to have a—if someone can do that with that, they can do a smallpox, and all the vaccine that currently works against smallpox might not work.

We also synthesized polio in the lab. Those are the things that scare me. So we have to look at more cellular-level solutions of common pathways, which is something Dartmouth is actually funding and it is 10 to 15 years down the pike.

Dr. HOSTETLER. Could I just respond to that, sir? Regarding the genetically altered ectromelia, I want to report to you that the drug that we discovered is fully active against the altered mousepox and could provide some protection in that event.

The CHAIRMAN. Mr. Evans.

Ms. Herseith.

Ms. HERSETH. I do have a question, and it may have been asked and answered already, and it deals with emergency room preparedness. And so this is for you, and you may have addressed it in your testimony. I apologize for not being here.

The health care industry in the United States faces a lot of challenges separate from some of the issues we have been addressing today in the VA, but especially in regard to emergency departments. And are you at all concerned that the VA's efforts to bolster its disaster preparedness may accelerate the decline of emergency preparedness at private hospitals?

Dr. MOTHERSHEAD. I am not concerned that—again, I have to take a holistic approach. Certainly one of the problems with exercises a lot of times is they stop at the emergency department. You see very few community exercises that go up and use the operating rooms or evacuate whole wings of wards. Hey, we have patients there; we can't mess with them. And usually in the exercises, we do them early in the morning because by 10 o'clock the ERs are inundated and they say we can't play because we have got real casualties here.

I don't think that preparedness per se is—I don't think working in that area works against any other system provided that it is funded correctly and it has worked a holistic system. I mean a lot of ER docs—I am not supposed to use that term—emergency medical physicians have been arguing in front of Congress, in front of their State legislatures, in front of their localities about that for a long time, but it goes back to the issue that I stated about recognizing that this is a public safety function.

Face it. You have an AMBER alert in a community; a police officer gets a new cop car. You have a school or a nursing home that catches fire, and the fire chief gets a new fire truck or four new fire chiefs. Who subsidizes the hospital system? Nobody other than the people paying for insurance and paying for their health care. There is no segmented—all the way—from local all the way up to Federal—separate funding stream for medical preparedness. It is

our duty. It is just like the church's duty to take care of people that have emotional distress. It is the hospital's duty to take care of the medical problems of the community, and until we do that and say there is a public safety piece they have to reach this bar but we will help them from the local all the way to the federal, we are never going to get there.

Ms. HERSETH. Just so I am clear on your response there, let us just take an example, and I don't think this would happen in the particular community that I am going to refer to in South Dakota, but I am going to use it because it is our largest metropolitan area. So in Sioux Falls, South Dakota, we have two health systems and two community hospitals and we have a VA medical center. So I just want to be sure, in addition to the problems that our community hospitals face with regard to resources and where they are getting their resources, that as we seek to ensure a level of preparedness at, say, the VA medical center, as an emergency department to treat casualties in the event of a terrorist attack, that we are not sending a signal to any other health care providers that, oh, that is the safety net over there at the VA and that gives some sort of other justification or reason to divert resources away from their emergency departments.

But I think what you are saying, it has got to be sort of up and down as a public safety function, not that it is sort of situated in any one facility or any part of one of the teams within the teams that was discussed in earlier testimony, thinks of itself as the only team that provides that type of care in the medical preparedness.

Dr. MOTHERSHEAD. I think that goes to the standards issue that I addressed which I don't think you were here at the time. If we set a bar, set a standard, and say, okay, we expect a jurisdiction to meet these standards and then we will provide additional assistance on top of it through the State and federal level and to local coffers, those—and, of course, the localities are going to say they don't have any money, the States say they don't have any money, the Federal Government—nobody has got any money. But if we don't set the standards, then how do you define whether somebody is prepared and whether they have done their fair share in it?

The CHAIRMAN. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Dr. Mothershead, I remember years ago before I ever got interested in medicine, I was an orderly. That is how I got my start in medicine, at a very busy hospital. And I worked the 11 to 7 shift, and we had one of these exercises simulating a plane crash or something, and my job was to stand out in the street and not let any cars through except ambulances who were also in this test. I interpreted that to mean the hospital administrator, who was coming to work at 7 o'clock that morning.

So for about 24 hours I had my little moment of fame in the hospital that I was the guy that did not let the hospital administrator park where he normally did.

I appreciated your discussion here today and your statement, your talking about the health care system that is under stress, and you specifically mentioned, as one of the problems, the problems of the growing number of uninsured. I have been trying to come up with a list as time has gone by about hooks from the national secu-

rity perspective, and the reason for that is food stamps came about in our commodity programs because we were drafting so many young men that were coming in for their physicals and they were undernourished and underweight and it became clearly not only a public health problem but a national security problem.

Well, it seems to me you have made another argument about that today, that our problem of the uninsured is also creating problems with our national security. You probably are aware too that we have discovered in the last couple of years, as we have activated more and more of our Guard and Reserve Forces, that we have had a fairly significant problem with people not being medically ready, and it is a pretty good correlation with those who are not medically ready and not able to go overseas, not having health insurance.

Well, in your discussion today you talked about hospitals are so close to the bone because of reimbursements and the problems they are having, that where is their motivation going to be for investing in a disaster preparedness on an event that, as was pointed out, I think, by Dr. Livingstone, most people think is not going to happen to them in their town. And yet unless, we figure out a way to subsidize those activities or, on the other hand, to deal with the problem of the uninsured, it is going to be difficult to see the incentives there. So I appreciate your making that discussion.

The one question I want to ask was—and you can comment on that if you like, but my question is about this issue of standards. I think I need you to run through about six or eight examples, just tick them off, of what you mean by “standards.” you mentioned hospitals, that perhaps the reason Secretary Ridge—I am going to extrapolate from what you said. Secretary Ridge might have seen a self-assessment that hospitals have turned in, saying, yes, we are ready, and yet someone with a more objective standard—since we all like to think that we are looking better than we are, a more objective standard might say, no, you are not ready. But would you just run through a list of six or eight things that you think ought to be measured and standards that ought to be set so that we could have a more coordinated way of comparing?

Dr. MOTHERSHEAD. Well, I can do that. What I would say is, again, I am not the only person that has opinions on this; so I think I probably would want to draw about 15 or 20 people elsewhere to kind of refine or restate this. But, for example, one standard would be the ability of a community to prophylax, with antibiotics or vaccine, 95 percent of its population at risk within 72 hours of the awareness that that prophylaxis was needed.

Now, that might be too high a bar, but at least it is a standard to start with. Another would be the ability to decontaminate 50 patients per hour for 8 hours without outside assistance at any time of day, 24/7. Another standard might be the ability of the hospital system to create an internal surge capacity to early discharges, cancellation of elective procedures or whatever, of 20 percent within 2 hours of notification of the need.

Another standard might be to do external surge capacity within a community by bringing in either the Volunteer Medical Reserve Corps or whatever to expand the total number of capable beds within that community by 10 percent within 24 hours.

So those types of standards are the type I am referring to. JCHO, Joint Commission, does have standards, but they are qualitative. They have to have the ability to decontaminate. But what is that, one tent, one person, one hose, or is that eight people, an organized, double trained line, that you can separate the sexes, et cetera? I mean it a good starting point. To say that they need to have the ability to decontaminate is a good starting point, but it is nothing you can sink your teeth into. It is nothing you can sink your teeth into it and set a bar.

Mr. SNYDER. That is helpful. Thank you for being here. Thank you, doctor.

Mr. EVANS. Any questions?

Thank you for coming. I want to thank Chris and the staff on this side. I am not taking over, at least not right now.

Thank you all and I thank the witnesses that have come forward. We appreciate your work, and I think you have helped expand our consciousness about some of the implications of 9/11 and in the future in our war against terrorism. So it is very important for us to get some work done here. And this is an important part of it. So thank you, including my staff on the work that they have done.

[Whereupon, at 1:38 p.m., the committee was adjourned.]

A P P E N D I X

Statement of Chairman Chris Smith

Full Committee Hearing
August 26, 2004

Good Morning. The Committee will be in order.

Today's hearing is prompted in part by the release of the final report of the 9/11 Commission, chaired by Tom Kean, the former governor of my home state of New Jersey, and Lee Hamilton, a distinguished former Member of the House and a colleague and friend. This Commission undertook a very difficult and emotional task, examining a series of events that began many years ago that ended with stunning and tragic consequences almost three years ago. The report of the Commission paints both with broad strokes and very precise ones that capture excruciating and important details. Reading it arouses diverse emotions, from anger at the cold-blooded assassins, regret that plans to protect our country did not envision such a murderous plan, admiration for those who struggled to save their fellow citizens and who gave up their own

lives in the process, and resolve that we should not be caught unaware in the future.

Notwithstanding all of these emotions, given the passage of time, there is a human tendency to become complacent, to let down our guard. Many of us face multiple challenges that demand our attention, including unanticipated changes in our work, family crises such as a relative with a serious illness, or even an unexpected car repair bill; although some wish it were not so, our thoughts and memories of the attacks of September 11, 2001 are displaced by more pressing recent events.

I view the 9/11 Commission Report as a national alarm bell and a blueprint for action. I do not think that the Commission overestimated the dangers which still confront this Nation as we gather here today, although no one can say for certain when and where our enemies will attack next. And although the Commission made no specific recommendations with respect to the Nation's

plan to provide needed medical response if the next attack results in mass casualties, we would be myopic if we did not realize that this is an essential part of preparedness planning.

In October of 2001, this Committee examined in some depth the plans of the United States to respond to the need for medical treatment in the event of disaster or attack. We learned how much was anticipated by the planners, and how insistent the planners had been on the need to practice the response to disaster or attack. However, within days of that hearing, a sinister plan to harm American political leaders resulted in the deaths of several postal workers from exposure to poisonous anthrax. The letter containing anthrax was processed in a postal facility in my hometown of Hamilton, New Jersey. That facility was closed for more than a year and has only recently reopened. Congress was stunned by the dangers which had literally arrived in our mail boxes, and massive office buildings were sealed off for weeks or months because of the danger they posed to the men and women who worked in them.

In the midst of that second attack, we learned that no one had really anticipated an event of this nature; public safety officials lacked essential information about how to respond to this attack, how to treat the effects of that poison, or what further preventative efforts might be undertaken.

Although the attacks we have experienced in the last three years can be seen as local crises, foresight requires that we plan our response to future attacks with the entire Nation in mind. Our inability to imagine the nature of past attacks is an important lesson for those planning a medical response to future attacks. It is instructive to review one of the most important questions about security planning asked by the 9/11 Commission and its grim conclusion:

Who is in charge? Who ensures that agencies pool resources, avoid duplication, and plan jointly? Who oversees the

massive integration and unity of effort necessary to keep America safe? Too often the answer is: “no one.”

Although the Commission was referring to struggles to protect our Nation’s security, its questions seem equally applicable to efforts to provide medical treatment to our servicemembers and our citizens in the event of an attack by terrorists.

At our hearing in 2001, we probed the role of the Federal Emergency Management Agency (FEMA) in coordinating the medical response to disasters, both natural and man-made. Unlike national security agencies such as the NSA and FBI, FEMA must rely on other agencies, community-based organizations and volunteers to respond to emergencies. Every year, hurricanes, floods, and wild fires test FEMA’s ability to coordinate Federal and local forces called to respond to threats to life and property. In many cases, the VA has played an important, and in some cases, essential role in that response. According to an article written by

Dr. Kristi Koenig last year “the VA has been requested to assist in every disaster declared by the president, beginning with Hurricane Andrew in 1992 when the Federal Response Plan was first used.”

Although property damage from natural disasters easily exceeds billions of dollars a year, and lives are tragically lost in many of these disasters, such as Hurricane Charley less than two weeks ago, the system for responding to mass casualties has fortunately not been put to the test.

Perhaps it’s better to refer to the national network of medical responders as an alliance or a cooperative instead of a system. Truly, we have no Federal health system designed to meet the needs of Americans injured by terrorists acts. It is the absence of such a system that makes the VA increasingly important.

Our hearings in 2001 and 2002 also give us a baseline from which we can evaluate the planning and actions which have taken place since 9/11. Several conclusions can be made based on the earlier hearings and more recent discussions with Administration officials:

- From a national planning perspective, the VA is the only Federal agency capable of assembling a large number of individuals to treat mass casualties. Although other providers may volunteer to care for the injured or wounded, they cannot be ordered to do so.
- Thus, VA is seen as an essential element of any planned response to an attack using weapons of mass destruction. VA operates 158 hospitals, over 850 outpatient clinics, 133 nursing homes, 206 counseling centers, and 42 residential rehabilitation treatment programs. VA employs over 15,000 physicians, 58,000 nurses and assistants, 3,600 pharmacists and more than 130,000 ancillary staff.

- However, VA sees its main preparedness function in narrower terms, since it has not received resources or authority to carry out any broader function.

There are explanations, but perhaps not justification, for this apparent contradiction. In the past three and a half years, VA Secretary Anthony Principi and other top officials such as Deputy Secretary Gordon Mansfield, who will testify shortly, have had their hands full in terms of responding to the record number of veterans seeking VA health care and disability benefits. So, the tyranny of urgent tasks may be crowding out the important ones requiring reflection and action. Second, the Congress and the Administration have consolidated many functions pertaining to homeland security in a new Department to “oversee the massive integration and unity of effort necessary to keep America safe”. How effective this reorganization has been in improving our ability to respond to attacks is an important but unanswered question. More importantly, this reorganization could also contribute to an

attitude that “it’s up to the Department of Homeland Security to figure that out.” Even though cooperation among agencies continues, the sense of urgency dissipates.

It should also be noted that some of the most important 9/11 Commission recommendations are addressed to the Congress and the way it divides power into competing committees. Whether and how Congress will make changes in its structure and operation to improve the Nation’s security is also an unanswered question.

Nevertheless, this Committee must ask if enough is being done to reassure Americans that the Nation has an effective medical response plan. Are we paying enough attention? If the resources are not flowing to ensure that VA and its employees can respond in the event of an attack, what should be done?

In that regard, I must mention my great frustration with the short-sighted efforts which have led to the denial of Federal funding for four emergency medical preparedness centers which Congress authorized two years ago. Last year the House acted overwhelmingly to make funding available, only to see its voice silenced in an unamendable conference report that kept the bar in place. I have personally spoken with those opposed to funding these centers. Their attitude is that some agency other than VA should undertake the mission of understanding how to treat veterans injured from chemical, biological, nuclear, or explosive weaponry. This attitude defies rational explanation and is an example of the “failure of imagination,” to use the memorable phrase used in the Report of the 9/11 Commission.

Although it appears that Iraq destroyed or transferred its stores of chemical and biological weapons prior to being invaded last year, who doubts that Iran and North Korea possess or seek to possess such weapons? Our alliances with both Pakistan and

India, nations that already possess nuclear weapons, could foreseeably lead to our troops being exposed to such weapons if peacemaking efforts do not succeed. Although the Department of Defense has generated important scientific information concerning the health effects of these weapons, it is the VA which must be prepared to deal with the long-term health effects if servicemembers are exposed to them. The VA must be an active participant in understanding the prevention and treatment of illnesses and injuries caused by such weapons, and I call upon all Members and the Administration to rethink their opposition to funding these centers.

Let me conclude by calling attention to one of the more successful collaborative research efforts between VA and DOD. As we learned at a Committee hearing last month, the Federal government is organizing an effective and compassionate response to the needs of American soldiers who have received wounds resulting in amputations during the wars in Iraq and Afghanistan.

Witnesses from the Army's Walter Reed Medical Center and the Veterans Health Administration depicted a commendable spirit of cooperation and discovery guiding their efforts to provide the best care to these severely wounded servicemembers and veterans. Because the mission is clear and these servicemembers are so deserving, providers have been ignoring regulations and budget restraints, and are cataloging new knowledge about treatment choices that will improve the lives of all humans who suffer from limb loss.

It was both inspiring and instructive to hear what it takes to ensure that the treatment needs are being met. Future servicemembers and citizens are counting on us to learn from this successful effort. In doing so, we must be mindful that the formulation of new policy and plans cannot succeed if we do not make it our highest priority. As the Chairman and Vice Chair of the 9/11 Commission noted:

We are in the midst of a presidential campaign. Our two great parties will disagree, and that is right and proper. But at the same time we must unite to make our country safer. Republicans and Democrats must unite in this cause. The American people must be prepared for a long and difficult struggle. We face a determined enemy who sees this as a war of attrition – indeed, as an epochal struggle. We expect further attacks. Against such an enemy, there can be no complacency. This is the challenge of our generation. As Americans we must step forward to accept that challenge.

I now recognize Mr. Evans.

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS

AUGUST 26, 2004

THREE YEARS AFTER 9/11: IS THE NATION MEDICALLY PREPARED?
WHAT SHOULD VA'S ROLE BE IN PREVENTING AND RESPONDING TO
NATIONAL MEDICAL EMERGENCIES AND TERRORIST ATTACKS?

Good morning, Mr. Chairman. Thank you for calling for this important hearing today. Homeland Security is clearly one of the biggest priorities for this Congress and the federal government as we have struggled to find answers and responses to unknown threats and assailants in the days and months since 9/11.

As policy makers sought to restore our confidence by taking steps to secure our borders and protect us from foreign assailants, the Department of Veterans Affairs continued to pursue its missions to provide health care to veterans, investigate clinically relevant research, teach the nation's health care providers and provide care as a backup to the Department of Defense in times of national emergency and disaster. It is evident that VA medical centers have played significant roles in assisting with the aftermath of the terrorist attacks at the World Trade Center, where VA offered supportive services and mental health care to emergency workers and volunteers. Medical centers have also aided their local communities during times of natural disaster—hurricanes and floods, for example. But should VA be doing more?

Congress's response to this has, unfortunately, been unclear. In November 2002, the Congress authorized 4 centers of medical emergency preparedness to assist in leading the federal government's efforts in researching and developing protocols to detect, diagnose, prevent and treat conditions associated with the use of chemical, biological, radiological, incendiary or explosive weapons; to provide education, training and advice to health providers, and to provide laboratory, epidemiological or medical care support of agencies involved in responding to disaster or emergency. Congress voted overwhelmingly to support these centers, but funding restrictions have hampered any effort to make them operational.

In my view, as the Nation's largest health care provider, VA must have a significant role in coordinating a global strategy for disaster preparedness and relief. But is it adequately prepared and funded to offer leadership in these roles?

VA includes some of its beds among those available as part of the National Medical Disaster System (now under the purview of the Department of Homeland Security), but it is widely acknowledged that beds are a poor measure of capacity in wide-scale emergencies. Most of the injuries normally experienced in disasters are addressed on an ambulatory basis and VA currently lacks adequate trauma centers and decontamination equipment to play a large role in this arena. I believe that VA's current capacity to deal with the "surge" following a major public health event to which Sec. Simonson's statement refers is minimal. Unfortunately, we will also hear that capacity, even for meeting current urgent care demand in many areas of the country, is also limited for other health care providers.

It certainly may have a large role to play in developing an educational curriculum for front-line providers and a research agenda that could correspond well with many of VA's ongoing activities in its environmental hazards centers, its centers on war-related illnesses, and its National Center on Post-Traumatic Stress Disorder, for example.

I also believe VA has done a fine job managing pharmaceutical stockpiles on behalf of the federal government and others. This will be a major contribution to the ability to respond to national attacks.

Some among us believe that more terrorist events are inevitable and imminent. While we must pray that this is not the case, we must be prepared for this eventuality and VA must play an important role.

**Statement of
The Honorable Gordon H. Mansfield
Deputy Secretary of Veterans Affairs
Department of Veterans Affairs
Before the
House of Representatives
Committee on Veterans' Affairs**

August 26, 2004

Mr. Chairman and members of the Committee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) actions taken since September 11, 2001, to improve its security and emergency preparedness, and its ability to respond to bio-terrorism attacks and other emergency situations. VA regards security and preparedness as important for our veteran patients and the Nation.

Since September 11, 2001, VA has improved its preparedness posture through a reorganization designed to provide a comprehensive, "all-hazards" approach to emergency management for the entire Department. We have established an Office of Operations and Readiness within the Office of the Assistant Secretary for Policy, Planning, and Preparedness, which has resulted in improving our cooperation with other Federal, state, and local agencies. VA has also pledged significant resources to emergency preparedness training, education, and exercises, as well as to studies and evaluations, and we have asked our Office of Research and Development to include projects related to terrorism and emergency management in its research portfolio.

VA's funding for initiatives related to homeland security has risen from \$84.5 million in FY 2002 to \$271.3 million appropriated for FY 2004. The President's FY 2005 Budget Submission includes a request for \$297 million. The largest portion of that funding is in medical emergency preparedness, funding for which rose from \$80.3 million in FY 2002 to \$257.3 million for FY 2004, with \$281 million requested for FY 2005.

While VA's primary responsibility in the event of an emergency is to ensure the safety of its patients, clients, personnel, and assets, we have a number of additional responsibilities on the national level.

Under the VA/DOD Contingency Hospital System Plan, VA serves as the principal health care backup to the military health care system in the event of war or national emergency that involves the use of Armed Forces in armed conflict. Under this plan, VA may give a higher priority to furnishing care and service for members of the Armed Forces than for any other group, except veterans with service-connected disabilities.

The "Robert T. Stafford Disaster Relief and Emergency Assistance Act," Public Law 93-288, as amended, was enacted to support State and local governments when the President has declared a disaster. The Stafford Act establishes a process for requesting and obtaining a Presidential disaster declaration, defines the type and scope of assistance available, and sets the conditions for obtaining that assistance. The Federal Emergency Management Agency (FEMA), which is now part of DHS, is responsible for the coordination of Federal emergency response activities in support of State and local governments. VA is one of the support agencies that, at the request of FEMA, provide assistance to support these activities.

VA has also been an active participant in developing the Interim National Response Plan (NRP). Currently, VA is a support agency for the Catastrophic Incident Response Annex and seven of the fifteen Emergency Support Function Annexes, including Public Works and Engineering, Emergency Management, Mass Care, Resource Support, Public Health & Medicine, Public Safety and Security, and Public Information and Communications.

At this time, Mr. Chairman, I would like to highlight some of the Department's specific actions and accomplishments in the areas of VA's emergency management structure; emergency preparedness planning; protection of VHA facilities; tests, training, and exercises; pharmaceutical caches; decontamination capability; guidance, education, and training; and research.

VA Emergency Management Structure

Following September 11, 2001, the Secretary of Veterans Affairs appointed a group to look at ways in which VA could improve its emergency preparedness and response operations. This group recommended a Department-level organization to integrate all preparedness. In response, VA established an Office of Operations and Readiness within the Office of Policy, Planning, and Preparedness (OPP&P) and transferred the Office of Security and Law Enforcement to OPP&P. This reorganization has provided a comprehensive, "all-hazards" approach to emergency management for the entire Department and allowed VA to better position itself to function effectively in a post-September 11 environment.

VA's Continuity of Operations (COOP) sites were expanded from two locations to four. A complete COOP "mirror site" has also been established in the event the primary sites cannot continue to operate. The VA Central Office Readiness Operation Center (ROC) is now operating 24 hours per day, 7 days per week. It is the primary internal and external contact point for all crisis management for VA. Requests for VA resource support are coordinated with VHA, VBA, and NCA through the ROC.

VHA's Emergency Management Strategic Health Care Group (EMSHG) continues to contribute at the community level across the Nation, with 37 Area Emergency Managers (AEM) and three District Managers located at all major population centers around the country. EMSHG manages the Disaster Emergency Management Personnel System, a database that currently contains information on over 1,200 VA medical centers (VAMC) personnel who have volunteered to deploy to disasters and emergencies, at the approval of their Directors.

EMSHG also manages the Medical Emergency Radiological Response Team, a team of VA physicians, radiologists, and health physicists that functions as a Federal asset to FEMA. This team can be deployed to a radiological disaster within 24 hours to assist hospitals with professional consultation, treatment, and monitoring of patients with radiological injuries, as required.

Since all disasters are local events, strong local programs are essential. EMSHG works closely with VA facilities, VISNs, and local emergency management organizations in building and sustaining comprehensive emergency management programs. Recognizing the value of VA's participation in integrated community emergency planning and the mutual benefits to be derived from that participation, EMSHG conducts hazards-vulnerability assessments, plans development, and program implementation.

VA is proud of its partnership role in the National Disaster Medical System (NDMS). Managed by FEMA, the NDMS has responsibility for managing and coordinating the Federal medical response to major emergencies and federally declared disasters. Through its nationwide network of AEMs, VHA supports the NDMS at the local level through several activities, including recruitment of non-Federal (civilian) hospitals, which dedicate available staffed beds for victims of disasters or other catastrophes. VHA assists with the development of patient reception plans, and coordination of training and exercises with local response authorities. EMSHG staff members deploy to disasters and high-threat events when called upon.

An outstanding example of how VA can fulfill its NDMS responsibilities in a natural disaster is the Houston VAMC's role in responding to the flooding caused by tropical storm Allison in June 2001. While the five area hospitals were submerged in water, Houston VAMC provided staging areas for the Disaster Medical Assistance Teams in its education building and provided patient beds, meals, laundry, and storage areas (including freezers) to other hospitals affected by the flood. Houston VAMC became the focal point for a unified command post for medical coordination and opened a 17-bed emergency room staffed by VA and other area hospitals.

Emergency Planning and Readiness

In addition to its role in the NDMS, VA is a recognized national partner in other emergency planning and preparedness activities and has taken a number of actions in this area since September 11. The VA Office of Operations and

Readiness, created after September 11, established for the first time a dedicated Departmental Emergency Planning and Readiness section.

Smallpox Vaccinations. VA developed a National Pre-Exposure Plan for the vaccination of VA Smallpox Health Care Response Teams and Vaccination Teams. Over 1,460 employees were vaccinated. Planning for the program began in the summer of 2002 and was completed in June 2003, when VA received 9,000 doses of vaccine to stockpile if it became necessary to implement a post-exposure vaccination campaign.

Homeland Security Advisory System. All VA facilities have adopted the Homeland Security Advisory System. Prescriptive and specific response requirements for each of the threat levels have been developed at the Department level and distributed to the field. Field facilities have implemented these requirements through the development of local procedures. Facility plans include specific actions that key executives, managers, and employees need to take at VA facilities for each level of the Homeland Security Advisory System. Among the specific actions to be taken are increased awareness by employees, increased patrols by VA police at VA facilities, and activation of the facilities' emergency operation centers.

National Infrastructure Protection Plan (NIPP). VA has provided a report to OMB in accordance with requirements of paragraph 34 of HSPD-7 ("Critical Infrastructure Identification, Prioritization, and Protection", dated December 2003). This report highlights VA's plan for protecting its physical infrastructure, cyber-critical infrastructure, and other key resources the Department owns or operates. This submission is being coordinated with the Government Facilities Sector-Specific Plan, part of the overall National Infrastructure Protection Plan that is being developed by DHS.

Physical Security Assessment Methodology. VA developed a Physical Security Assessment Methodology, which has been adopted by the Federal Emergency Management Agency (FEMA). Although current assessments show that the primary physical threats faced by VA are routine criminal activity and violence in the workplace, the proximity of some VA facilities to high vulnerability targets requires that these facilities be protected. In June 2003, VA contracted with the National Institute of Building Sciences (NIBS) to manage the assessment of the physical security of 116 of the most critical VA facilities and develop mitigation strategies for the reduction of their vulnerabilities. The project team of engineering and security experts developed a methodology and database for systematically assessing, recording, and analyzing VA facilities. FEMA uses this methodology for the evaluation of Federal and private sector facilities to identify vulnerabilities and make recommendations for mitigation strategies.

Implementation of HSPD-5. VA is participating in the development of a single, integrated national plan in accordance with Homeland Security Presidential Directive/HSPD-5 ("Management of Domestic Incidents"). VA has adopted the incident management system to organize emergency operations. HSPD-5 is intended to enhance the ability of the United States to manage domestic incidents by establishing a single, comprehensive national incident management system under the leadership of the Secretary of Homeland Security.

JCAHO Standards. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has established rigorous and comprehensive standards for an all-hazards approach to emergency management. All VA medical facilities are required to comply with these standards. The most important tool VA has produced to facilitate compliance with JCAHO standards is the "Emergency Management Program Guidebook." This is the definitive guide on emergency management and was an important resource to JCAHO in developing standards for all accredited U.S. Hospitals. This Guidebook was originally published in March 2002 and distributed to all VAMCs. By request, about 1,000 copies of this

Guidebook have been provided to private hospitals to assist them in meeting the JCAHO Emergency Management standards. A review of JCAHO surveys indicates a very high level of compliance at VA facilities with these standards.

Protection of VHA Facilities

Most VHA facilities are protected by VA police officers and have been generally successful in meeting police staffing goals established by VA. Of the 135 VA police units, only 10 have police officer staff levels below the minimum requirements. VA continues to promote the use of existing special salary rate authority to address local recruiting issues. In addition, VA has worked with the Office of Personnel Management in developing government-wide solutions to police officer compensation and recruitment issues.

VA's Program to Arm VA Police, initiated as a pilot program in 1996, is nearing completion. The program is designed to screen, train, and arm officers who previously carried only batons and chemical irritant projectors. Only one facility has not been able to implement the firearm program due to staffing and police supervision issues that we anticipate resolving within the first quarter of FY 2005.

Tests, Training, and Exercises

While participating in emergency planning has been critical to ensuring that VA is in a constant state of readiness to respond to national or local emergencies, VA has also participated in various exercises and training to test the validity and completeness of its plans. To this end, VA has held 26 Continuity of Operations (COOP) exercises. In addition, all VAMCs participate in two emergency exercises each year. These exercises are required by JCAHO, and at least one of them has to be a part of local community exercises. They ensure that all VAMCs have detailed all-hazard emergency operations plans and provide an opportunity to test those plans so that the VAMCs are better prepared should a real natural or terrorist-caused disaster occur. These exercises are

carefully planned and conducted, and a written critique is subsequently shared with all appropriate staff.

VA has also been a participant in six senior level multi-agency exercises and training, as described below.

Olympic Games - February 2002. In preparation for the Olympic Games, VA initiated a decontamination and pharmaceutical cache exercise. This was a multi-agency effort.

TOPOFF 2 Large Scale Game (T2 LSG) – December 2002. The T2 LSG was a national 'senior government officials' exercise event related to preparing for the full-scale exercise. This was a four-day exercise that brought together Federal, State, and international leaders in an interactive gaming simulation. Two VA senior executives represented VA in the exercise, providing valuable insight concerning VA's emergency response capabilities.

Ultimate Caduceus (UC) 03 (DOD lead) – March 2003. UC 03 was an annual DOD multi-echelon deployment and contingency support exercise that took place March 17-25, 2003. The primary purpose of the exercise was to test tasks associated with global patient movement and evacuation and coordination of patient evacuation from a theater of war. VA initiated airport patient reception activities, bed reporting, and patient distribution as a full participant in the exercise.

TOPOFF 2 (T2) – May 2003. T2 was a congressionally mandated national weapons of mass destruction exercise designed to provide training for Federal, state and local top officials and first responders. VA was a full participant in the exercise at both the national and local level. VAMCs in the Seattle and Chicago area participated in local community response activities that included receipt of patients, activation of hospital caches and decontamination drills. The VA Medical Radiological Response Team also deployed to Seattle as part of this

exercise. At the national level, VA provided liaisons to DHS, attended senior level management briefings, and activated its Crisis Response Team (CRT). VA is currently participating in planning efforts for TOPOFF 3.

Forward Challenge 2004 (FC 04) – May 2004. FC 04 was a full-scale, scenario-based, interagency COOP exercise. Exercise play was conducted at two levels, the interagency level and the individual agency level. The exercise was the first interagency COOP exercise conducted for the Executive Branch and was conducted as a no-fault exercise. The interagency exercise provided a framework for each department or agency to conduct its own internal COOP exercise focused on specific objectives.

VA participated in FC 04 throughout the length of the exercise. It provided VA an opportunity to deploy its full COOP team, with top managers participating and deploying with their COOP staff to the designated COOP locations. VA's Deputy Secretary led two of the three Under Secretaries and four of the seven Assistant Secretaries in this two-day exercise. Approximately 120 VA staff participated in the exercise.

Determined Promise 04 (DP 04) - August 2004. DP 04 was an exercise designed to test DOD's ability to assist civil and Federal authorities in a coordinated response to simulated chemical, radiological, and explosive hazards. The Department of Homeland Security was responsible for the Federal incident management role. Interagency involvement in the consequence management aspects of the exercise involved support related to activation of the NRP and the National Disaster Medical System in the Virginia area. During this exercise, the VA ROC participated in an insightful tabletop drill, and the Richmond VAMC had an opportunity to test its emergency room and decontamination activities.

Pharmaceutical Caches

VA's National Acquisition Center (NAC) continues to manage four pharmaceutical and medical supply caches for DHS/FEMA at VAMCs as a part

of the NDMS and two additional special caches for other Federal agencies. FEMA routinely activates and moves one or more of the NDMS caches in support of special events. The NAC also provides contracting support for the Centers for Disease Control and Prevention's (CDC) Strategic National Stockpile and the Vendor Managed Inventory. These stockpiles are designed to assist with the medical consequences of disasters, including weapons of mass destruction.

Following September 11, VA recognized that modern supply methods might interfere with adequate supplies in the immediate aftermath of an emergency. Accordingly, VA created 143 internal pharmaceutical caches at VAMCs: 90 large caches, which can supply 2,000 casualties for two days; and 53 small caches, supplying 1,000 casualties for two days.

Decontamination Capability

VA has recognized that, even though VAMCs are not "first responders," there is a need for mass decontamination capability if the facilities are going to be safe. This is particularly true in the event that chemical weapons are used or when industrial accidents occur that result in exposure to toxic substances. Accordingly, VA implemented a program integrating local planning with the community, standardization of equipment (portable decontamination shelters and level C personal protective equipment), and a train-the-trainer program.

To date, 118 of the highest priority VAMCs have received training to conduct decontamination at their local station and to train other members of their Patient Decontamination Teams. Twenty-eight of these 118 facilities have received their equipment. An additional 78 facilities have submitted action plans and ordered equipment. The Occupational Safety and Health Administration (OSHA) Best Practice Report on Hospital Based First Receivers of Victims has cited two VA facilities among seven facilities nation-wide for their accomplishments. These were Central Arkansas Veterans Healthcare System in Little Rock, Arkansas, and the Washington DC, VAMC.

Guidance, Education, and Training

Education and training is essential for sustaining an adequate level of preparedness. One of the most important tools VA has produced is the "Emergency Management Program Guidebook," which I mentioned earlier. The Guidebook, which is available both on CD-ROM and through the VA Intranet, provides the information necessary to develop a fully functional emergency management program and contains extensive examples of plans, policies, contingencies, and solutions for problems that every VAMC may face. In this way, the Guidebook supplements VA policy documents on emergency management and security, e.g., VHA Handbook 0320.2, "Veterans Health Administration Emergency Management Program Procedures"; VA Directive 0730, "Security and Law Enforcement"; the recently updated and distributed VHA Handbook 1200.6, "Control of Hazardous Agents in VA Research Laboratories"; and VHA Directive 1105.1, "Management of Radioactive Materials," which has been recently revised and will be distributed by the end of this month.

VA Directive 0730 is currently being revised. The proposed revision includes requirements for security management committees and an overall strategic security plan at each VA facility. The revision will also update pre-September 11 physical security standards; include specific instructions for the security of bio-hazardous materials in Department owned laboratories; and provide specific facility lockdown and emergency response procedures. VA's goal is to have revised Directive 0730 ready for review and concurrence in the first quarter of FY 2005.

VA Operations Plan "Safe Harbor" also provides guidance related to agency preparedness and response measures related to escalation in the Homeland Security threat level. It describes the concept of operations, organizational structures, and agency responsibilities that guide VA operations. The plan was tested in a COOP exercise on March 4-5, 2003. Participants in the exercise included key VA organizational staff and the VA CRT.

In addition, VA has produced or has in production a number of educational tools, including the following:

- personal emergency preparedness brochure for staff and patients (October 2001);
- re-broadcasts of CDC, FEMA, and DOD satellite teleconferences on weapons of mass destruction and emergency management (on going – at least monthly);
- 15 minute video/CD-ROM, "Medical Response to Weapons of Mass Destruction" for senior managers (June 2004);
- a Veterans Health Initiative (VHI) educational-based module (both printed and web-based) on "Health Effects from Chemical Biological and Radiological Weapons" (October 2003);
- a VHI Radiation Terrorism module, which is in progress following a videoconference presented January 13, 2004;
- the following five pocket cards produced with DOD:
 - Biological Terrorism (June 2002, revised August 2003)
 - Chemical Terrorism (June 2002, revised August 2003)
 - Terrorism with Ionizing Radiation (June 2002, revised August 2003)
 - Mental Health: (1) Management PTSD or Acute Stress Disorder and (2) Management of Acute Stress Reaction (December 2003); and
- a VHI Blast Injury module with major DOD input, which we expect to have completed by the end of CY 2004.

The VA Law Enforcement Training Academy also incorporates emergency management in its curriculum and is developing a new physical security specialist course. The physical security specialist training will be implemented in FY 2005 and will help improve technical expertise in this critical area.

Research

As mentioned earlier, we have asked our researchers to include terrorism and emergency management in their research portfolios. As a result, VA has increased its emergency preparedness research portfolio. In addition to adding

to the Federal government's understanding of disease mechanisms, preventive measures, and treatments, these projects address conditions that afflict VA's patient population. This year, VA investigators at 16 facilities have conducted eleven research projects focusing on diseases such as smallpox and anthrax, protective immune responses, virulence factors, and DNA-based vaccine development. These eleven projects represent a total investment of \$7.8 million; VA funding for these projects in FY 2004 is \$2.2 million. In FY 2003, VA researchers received \$1.57 million from DOD and HHS to support 15 other studies. Let me now discuss just a few examples of these projects.

Researchers at the New York Harbor Healthcare System have combined their efforts to receive a Research Enhancement Award Program (REAP) grant. This program permits skilled, interdisciplinary teams of scientists to form what are essentially centers of excellence that address a specific medical problem by integrating basic science and clinical research approaches. The team is currently identifying and characterizing antibodies present in the blood of exposed individuals that can counteract bacterial toxins. These antibodies will be developed for use as therapeutic antitoxins. Several other facilities have applied for REAP grants to support other vaccine research, and a scientific merit review board will consider the applications later this fall.

At the San Diego VAMC, researchers have used a DOD grant to develop novel compounds that can be used to produce an oral therapy for smallpox. Results have included the identification of several compounds that protected rodent models against smallpox. Two of these compounds have gone into formal drug development for the prevention and treatment of smallpox.

VA Health Services researchers at the Birmingham VAMC have taken a proactive approach to bioterrorism prevention by examining educational interventions for health care providers. This effort will develop a web-based educational approach to help physicians recognize the clinical presentation of anthrax and smallpox. The web-based educational modules will be modified and expanded, as new teaching modules are developed to broaden physicians'

awareness and recognition of other biological agents that may be used in acts of terrorism.

VA will continue its efforts to expand a research portfolio that enhances preparedness while addressing the needs of its patient population.

Activities of VBA and NCA

Mr. Chairman, up to this point, I have spoken mostly of those activities involving either VHA or the Department as a whole. While it is true that most of VA's emergency preparedness activities over the years have involved VHA, whether by itself or in concert with other Departmental administrations, both the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) also play roles in ensuring Departmental preparedness and continuity of operations.

VBA. VBA has produced a procedural manual containing standardized instructions relating to the continuity of operations and specific procedures for assessing, reporting, and restoring essential functions. A copy of this manual is kept at VBA's alternate sites. Of particular importance is the benefits payment system, which has two "redundant" systems in place at alternate locations to ensure that benefits are paid in a timely manner. There are also back-up tapes stored at several locations to ensure that data can be transmitted to the Treasury to make the payments from its alternate locations.

As of August 2004, all VBA corporate applications in operation in Austin, Texas, can be successfully recovered from the backup processing facility in less than 12 hours, and with less than 2 hours of lost data. As the Compensation and Pension replacement system, VBA's future benefits system, is implemented, it will also be recoverable within 12 hours and with less than 2 hours of lost data. In future annual disaster recovery tests, VBA will evaluate different scenarios to ensure that resources at both locations have "interchangeable" skill sets capable of recovering VBA's corporate applications seamlessly. Recently, a site visit was conducted to the Hines Information Technology Center to review existing

emergency plans and to identify areas of vulnerability in its ability to continue at an alternate location in the event of an emergency.

The Benefits Delivery Network, VBA's existing benefits system, is in the process of upgrading its hardware and operating system platform at the Hines Information Technology Center. This project is scheduled for completion in October 2004. In conjunction with the upgrade, VBA has also upgraded its BDN disaster recovery platform. The disaster recovery platform, acquired from the Department of Defense, has the capability to mirror the upgraded operating system. The disaster recovery platform will continue to reside at the Philadelphia ITC. VBA is conducting analysis for allowing the production and disaster recovery systems to automatically mirror each other. As in the corporate disaster recovery strategy, VBA's objective will be to recover in fewer than 12 hours with less than 2 hours of lost data.

VBA Central Office has also developed policies, plans, and procedures for sheltering-in-place to provide reasonable security for its personnel in case of an external event that would preempt an evacuation. VBA's CRT meets bi-weekly with team members from VA Central Office. During Code Orange alerts, it meets daily for intelligence briefings and updated information.

NCA: Soon after September 11, NCA dedicated a full-time position to ensuring the coordination of NCA's emergency preparedness activities in both central office and the field. The Emergency Preparedness Coordinator is also responsible for ensuring NCA's active participation in VA-level emergency planning. NCA has designated an alternate command site for the Under Secretary for Memorial Affairs, which will provide NCA's top management with a facility outside of Washington, D.C., from which to run system-wide national cemetery operations in the event that VA Central Office is closed.

NCA has updated its written policy guidance on emergency preparedness ensuring that all national cemeteries, including Memorial Service Network Offices and Memorial Program Service processing sites, have emergency plans. The updated guidance strengthens NCA's ability to provide assistance to

governments and private entities that act as first responders as directed by FEMA through the NRP. In the event of a mass casualty event, NCA is prepared to advise on methods for interment of fatalities and to assist in the disposition of human remains. NCA is developing an annex to VA's OPLAN Safe Harbor for handling mass casualty burials.

Evaluations and Assessments

It is important to evaluate the status of our preparedness programs continually in order to improve and enhance them. Therefore, VA has completed or initiated a number of evaluations and assessments. Among them are the following:

- Physical Vulnerability Assessments. These risk analyses use 12 threat scenarios and have identified VA's 200 most critical facilities. The assessments have cost \$2.7 million to date.
- Essential Paper Records. This is a study that looks at essential paper records needed for COOP activities as well as protection of records from fire and water damage.
- Survey of VA Medical Facilities to Assess Emergency Preparedness Capabilities. A contract to accomplish this evaluation has just been awarded.
- VA OIG Report on VA Research Laboratories. This study focused on the security measures in place at VA BSL-3 and other research and clinical laboratories. In May 2004, VA published VHA Handbook 1106.2, "Pathology and Laboratory Medicine Service Biosecurity and Biosafety Procedures." In June 2004, VA issued VHA Handbook 1200.6, "Control of Hazardous Agents in VA Research Laboratories," in June 2004. With the publication of these two Handbooks, we have addressed all VHA-focused recommendations. With the publication of the revised VA Directive 0730 mentioned above, we will have addressed the remaining recommendations. VA will then implement and certify that all corrective

actions have been addressed at each VAMC. The OIG recommendations will remain open until these certifications are completed.

- Emergency Planning, Exercise, and Evaluation Program. VA documentation related to involvement in exercises has been accomplished through detailed after action reports.

Conclusion

Mr. Chairman, VA's goal is to continue to provide needed emergency response services on a both a local and national level, as required or requested. Taken as a whole, the activities of the Department provide solid evidence of our willingness and ability to respond effectively and efficiently. This completes my statement, and my colleagues and I will be happy to answer any questions you and other members of the Committee might have.

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Statement of

**Maj. Gen. Lester Martinez-Lopez
Commanding General
U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland**

Before the

House Committee on Veterans' Affairs

Regarding

**Three Years After 9/11: Is the Nation Medically Prepared? What should VA's Role
Be in Preventing and Responding to National Medical Emergencies and Terrorist
Attacks?**

August 26, 2004

Mr. Chairman and members of the Committee, thank you for the opportunity to briefly discuss the contributions of my Command toward medical preparedness in the event of a biological attack on the Homeland and cooperative efforts and research collaborations with the Department of Veterans Affairs (VA).

USAMRMC Response to the Anthrax Letters

As Commanding General of the U.S. Army Medical Research and Materiel Command (USAMRMC) and Fort Detrick, I am responsible for delivering the best medical solutions, for today and tomorrow, to enhance, protect and treat the warfighter on point for the Nation. This responsibility includes protection against biological and chemical attacks on the battlefield and, since 9/11, has expanded to include certain responsibilities

within the homeland. My Command is actively involved in many pertinent activities, some of which involve collaboration with VA, which I will share with you today.

In the face of the 2001 anthrax attacks on our homeland, our Fort Detrick scientists at the U.S. Army Medical Research Institute of Infectious Diseases, commonly known as USAMRIID, provided a valuable National public service by utilizing their military research expertise and facilities to conduct over 250,000 biological agent detection assays on over 30,000 samples collected from potentially exposed sites, including the contaminated letters to Congress, looking for the deadly bacterium.

National Interagency Biodefense Campus

As the anthrax attacks demonstrated, the new biothreat respects no borders and knows no boundaries - our Homeland is at continual risk. After the attacks, discussions began that focused on protection of the Nation against bioterror agents. Many turned to Fort Detrick for answers because, throughout its 60-year history, Fort Detrick has contributed scientific breakthroughs and medical solutions for the Armed Forces and the Nation. In fact, for over 20 years, all Centers for Disease Control and Prevention (CDC) samples came to USAMRIID for *B. anthracis* testing.

Because of its history and leadership in biodefense, USAMRIID will be the cornerstone of the National Interagency Biodefense Campus at Fort Detrick. Through partnerships between the USAMRMC, and agencies of the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), and the Department of Agriculture (USDA), the campus will be the Nation's primary center for development of defenses against biological terrorist attacks. These agencies have complementary programs and

specific expertise that, through this interagency partnership, will contribute to this mission.

To take this campus concept from vision to reality, senior leaders from participating federal agencies met in late May of 2002. The potential for operational synergy in the area of bioresearch and National defense through establishing collocated facilities with complementary and shared infrastructure were discussed. We conducted a scientific capability assessment, performed a gap analysis, and developed a strategy to close the gaps while decreasing redundancy and maximizing efficiency. One month later, the Ft. Detrick Interagency Coordinating Committee was established with representatives from participating agencies to work on environmental, master planning, financial/business, public affairs, and scientific interaction matters.

DHS - Creation of NBACC and NBFAC at Ft. Detrick

An interagency campus master plan has been developed and construction has started. The National Institutes of Health's (NIH) National Institute for Allergy and Infectious Diseases will break ground for its new facility this year. The National Biodefense Analysis and Countermeasures Center, or NBACC, of the Department of Homeland Security, will soon release an environmental impact statement for its Fort Detrick facility. The National Bioforensic Analysis Center, a component of the NBACC, has built a laboratory inside the USAMRIID building and now conducts the forensics and confirmatory testing mission in support of the FBI and certain other government agencies formerly conducted by USAMRIID. The Department of Agriculture already has laboratories at the site.

Training of Medical Practitioners for Medical Chemical and Biological Casualties

Since 1992, my Command has been a key trainer of first responders, military and civilian care providers, and other personnel through its Medical Management of Chemical and Biological Casualties Course. In onsite, on-line and satellite-transmitted distance learning courses, we have trained 134,606 people throughout the world, including 58,301 military, 75,241 civilians and 1,064 Public Health Service personnel. Among the civilian trainees are many VA personnel. An off-site course was presented to the Baltimore VA on August 19, 2004 which trained 40 VA employees. The number of personnel trained increased dramatically during 1997-1998 due to a post-Desert Storm requirement for increased training and during 2003 due to increased military requirements and increased civilian and Public Health Service participation; these latter increases may be attributable to post-9/11 interest in the training. We have also published textbooks, handbooks, field manuals, and multiple videos that are standard teaching aids used by other government and civilian agencies conducting such training.

Surveillance – Laboratory Response Network

The USAMRMC is heavily involved in the national Laboratory Response Network (LRN). Established in 1999 by the Centers for Disease Control and Prevention, the Association of Public Health Laboratories, the FBI, and USAMRIID, the network has been strengthened since the attacks on our Nation. The network builds on a longstanding, nationwide system of public health laboratories that conduct routine disease surveillance. The network ensures rapid recognition and reporting of clusters of suspicious symptoms that could indicate a biological attack. The national system links state and local public

health laboratories with other advanced-capacity clinical, military, veterinary, agricultural, water and food-testing laboratories, enhancing the U.S readiness to detect and respond to bioterrorism incidents. The first standardized protocols and reagents used by the LRN were developed with USAMRIID scientists. USAMRIID continues to serve as a national laboratory within the LRN and is assisting in the further maturation of the laboratory system. Although there are not formal agreements, under the LRN the VA can be directly supported by USAMRIID, if requested.

Surveillance - ESSENCE

Through our Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) program, we are collecting military patient encounter information into an analysis database, looking for geographic-based disease trends that would indicate a biological attack. A pharmacy component was added in 2002. The next version of the program will track military and civilian outpatient visits, over-the-counter pharmacy sales, school absenteeism and animal health data. It will also be expanded to all military treatment facilities and local civilian data in some locations. Inclusion of VA data was planned; however, VA data is now included in the BioSense program at CDC. BioSense plans to integrate DoD and VA outpatient data and over-the-counter national pharmacy information and other national data to provide a comprehensive surveillance program.

Research and Research with the VA - USAMRIID

USAMRIID is a research institute with a mission to protect military personnel from biological warfare agents. Civilian agencies are increasingly depending upon USAMRIID products or information in response to bioterrorism. The National Institute of Allergy and Infectious Diseases (NIAID) at NIH and commercial manufacturers have sought USAMRIID's biodefense medical products for civilian applications. During the past two years, USAMRIID has successfully moved products into advanced development through a partnership with NIAID. NIAID has supported the development of the next-generation anthrax vaccine, as well as multivalent vaccines for botulinum neurotoxins. NIAID is considering the development of vaccines against plague and Rift Valley fever based upon technologies developed at USAMRIID. Similarly, USAMRIID scientists are collaborating with the National Institutes of Health (NIH) to identify and develop therapeutics for a number of agents, including Ebola virus, several toxins, SARS (severe acute respiratory syndrome), and orthopoxviruses – including the virus that causes smallpox. USAMRIID has designed a novel vaccine candidate for the deadly ricin toxin that is superior to traditional approaches. USAMRIID has also collaborated with Dr. Hostetler of the San Diego VA, whom you will hear from shortly, to develop and test an oral drug to treat smallpox infection. We have had four additional agreements with VA medical centers that include transfer of materials (MTA). These include two MTA for transfer of proteins to be used in protein structure analyses, one MTA for transfer of *Francisella tularensis* DNA, and an MTA for transfer of an attenuated strain of *Bacillus anthracis*.

Research with the VA – Gulf War Illnesses

As Commander of the USAMRMC, I am also responsible for medical research that focuses upon Gulf War Illnesses and Force Health Protection for the Department of Defense. My Command began organizing and directing this research effort for the DOD in 1994. We have made enormous progress in the past decade. The best scientists in the government and renowned universities have collaborated to understand the cause and develop treatments for affected veterans.

The DOD and VA medical research programs now dovetail such that the DOD concentrates on long-term consequences of operational threats that may only emerge long after soldiers return from a deployment. VA identifies exposure risks to better prepare and protect warfighters, ultimately avoiding some of the longer-term health consequences that would appear in their hospitals. This is being accomplished through collaborative research involving both DOD and VA researchers and administrators at multiple levels. For example, researchers from at least three different VA centers are currently collaborating with DOD investigators to interview soldiers at Fort Lewis, WA, who have just returned from Iraq. This effort is part of an ambitious study jointly funded by VA and DOD to identify the most sensitive neuropsychological tests that can be used to detect early signs of a change in neurological status of soldiers following a deployment. This was one of the important diagnostic gaps identified in our Gulf War experience. Another example is the shared funding support by DoD, NIH, and VA to the neurodegenerative disease imaging center at the VA Medical Center in San Francisco. This center is developing state-of-the-art methods to use objective brain measurements to

explain subjective symptoms of chronic multi-symptom illnesses, as well as early changes that may forecast brain diseases.

Between 1994 and 2002, the US Army Medical Research and Materiel Command invested \$182 million to support 154 projects. We have pursued multiple lines of investigation to treat the Gulf War veterans. Thirty-eight of these projects continue and many of these address key questions identified in earlier projects. We supported numerous surveys of the veterans, with a focus on hazardous exposure and symptoms.

Other DOD programs, started in part because of issues raised in Gulf War illnesses, are identifying hazards to the brain, including the most susceptible neurons whose loss leads to illnesses such as Parkinson's disease and Lou Gehrig's Disease, or amyotrophic lateral sclerosis (ALS). These studies will follow up on important Gulf War illnesses studies such as the joint VA and DOD study that suggests deployed Gulf War veterans may have a higher rate of ALS than non-deployed forces. This current research effort, which includes over 100 studies, is providing new insights into the causes of Parkinson's Disease and related neurodegenerative diseases; earlier diagnostic methods; preventive measures including personal health habits; and treatments. We are moving on a wide front to address the issues that began with sick Gulf War veterans looking for an answer to their diseases. These DOD efforts are coordinated with other federal agencies through a neurodegenerative disease working group that includes Offices from the NIH and VA.

In 2002, the Assistant Secretary of Defense for Health Affairs directed transition of this program to a more forward-looking effort called Force Health Protection. The primary emphasis of the program is prospective, with a goal of protecting current and future

service-members put into operational environments. The program's scientific focus areas rely heavily on lessons learned from research on Gulf War Illnesses.

Concluding Remarks

Many agencies are working closely together to ensure our Nation is medically prepared to respond to attacks on the homeland. There is much work to be done but I am confident we are headed in the right direction.

Mr. Chairman, this concludes my remarks. I will be pleased to answer your questions.



**Testimony
Before the Committee on Veterans
Affairs
United States House of Representatives**

**Safeguarding the Nation: HHS
and VA Emergency Preparedness
Collaborations**

*Statement of
Stewart Simonson
Assistant Secretary
Office of Public Health Emergency Preparedness
U.S. Department of Health and Human Services*



For Release on Delivery
Expected at 10:00 am
Thursday, August 26, 2004

Thank you, Mr. Chairman and members of the Committee. My name is Stewart Simonson and I am the Assistant Secretary for Public Health Emergency Preparedness at the Department of Health and Human Services (HHS). I appreciate the opportunity to be here to comment on the collaboration between our Department and the Department of Veterans' Affairs (VA). It is my understanding that the Committee is particularly interested in those collaborations that are related to terrorism preparedness and response.

As you know, several aspects of HHS' mission are closely aligned with those of the VA. There is a long standing tradition of collaboration between the staffs of the two Departments. Consequently, we have shared a lengthy history in health related efforts, including emergency preparedness activities, 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 (DHS), HHS continues to partner with DHS, the Department of Defense and the VA with respect to deployment of specialty teams, patient movement and definitive care.

Following the precedent established in the Federal Response Plan, the current Interim National Response Plan continues to designate HHS as the lead agency for Emergency Support Function 8, which addresses the coordination and provision of health and medical services in a public health emergency. In such an emergency, VA will provide critical assistance that includes designating and deploying available medical, surgical, mental health and other health service support assets. Homeland Security Presidential Directive 10 designates HHS as the

lead agency for mass casualty care and directs VA, as well as other federal agencies, to support HHS in carrying out this mandate.

A particular concern since 9/11 is the possibility of a public health emergency occurring that would eclipse state and local capabilities, creating a phenomenon often identified as surge. Such an event – whether resulting from a naturally occurring or man-made disaster – might overwhelm the ability of states and local governments to respond. The approach to this challenge is to view the problem as a continuum of factors, each of which plays a contributing role, and to examine a variety of options that could be employed to mitigate consequences, optimize response, and shorten the length of recovery. My office is leading an interagency working group that is conducting an end-to-end analysis of these factors and developing what we hope will be a sound, effective action plan. VA, along with other federal agencies, is collaborating with HHS in this endeavor.

It is clear that the provision of medical care to large numbers of casualties is one of our most significant challenges. The availability of sufficient numbers of healthcare providers represents a daunting impediment to the development of this capacity. Identification and availability of providers, provision of workers' compensation, liability coverage for these providers, and verification of professional credentials/privileges so that health professionals responding to a surge can provide patient care are non-trivial obstacles that must be addressed. To that end, HHS is currently working with the Homeland Security Council and an interagency working group, including the VA, to develop options and

recommendations to address the availability of healthcare providers in a mass casualty event.

Our collaborative efforts with VA extend beyond patient care. Last year Project BioSense, a multi-department initiative, was initiated to facilitate rapid, near real-time electronic transmission of public health information from a variety of health data sources that would permit early detection of disease outbreaks resulting from either naturally occurring or terrorist-triggered events. One of the sources of information for BioSense is the VA, which transmits data electronically from its ambulatory care treatment facilities. Specifically, the VA provides diagnosis and procedures codes on a daily basis from outpatient and emergency room patient encounters. These data are received by the Centers for Disease Control and Prevention (CDC), merged with data from other sources, and analyzed by zip code to detect signals that may indicate an unusual or unexpected pattern of disease. Should such signals appear in the VA-provided data, CDC would work closely with the VA to further evaluate the information and, if appropriate, initiate a prompt investigation. To date, BioSense has received over 30 million records from VA ambulatory care treatment facilities.

The VA's National Acquisition Center (NAC) is HHS' principal federal logistics partner for emergency operations and for the Strategic National Stockpile (SNS) Program, which was transferred back to HHS from DHS on August 13. In carrying out the broad range of SNS related activities, including day-to-day operations and exercises to test the capability of state and local

health departments to receive, break down, repackage and distribute contents of the SNS, CDC has leveraged existing VA contracts to acquire personnel with specialized skills to assist in the operation and maintenance of the SNS and in the design, execution and evaluation of the deployment exercises.

CDC has also collaborated with the National Center for Post Traumatic Stress Disorder (PTSD) at the VA. Much of the collaboration includes surveillance and needs assessment as well as some work on compliance issues. CDC is co-sponsoring an upcoming conference with the National Center for PTSD that will be held at the Carter Center at the end of this month. The objective of this conference is to help us identify flashpoints that could precipitate negative collective behavior as well as mitigation strategies for behavioral issues that could emerge in the aftermath of a bioterrorist attack. In addition to this conference, CDC has participated in working groups that are examining the development of adequate infrastructure and resources for dealing with disaster-related mental health problems. CDC staff is co-editing a book with NCPTSD personnel on methodologies for addressing the issues that inevitably arise when mental health concerns intersect with public health practice in medical consequence management. CDC has also participated in developing an educational program on WMD-related mental health issues for veterans.

Beyond collaborations at the federal level, HHS, through our public health preparedness and hospital readiness programs, have strongly emphasized to state and local health agencies the importance of coordinating and integrating planning and response efforts with VA and military health facilities in their

jurisdictions. It is important to recognize that, in the case of a biological or chemical terrorism attack, or other sizable public health emergency, VA facilities and staff will undoubtedly serve as invaluable resources for the community. To underscore this point, the cooperative agreements awarded by the Health Resources and Services Administration for state and local hospital bioterrorism preparedness identify the local/regional VA facility as an institution that should be represented on the state bioterrorism preparedness advisory committee. I am pleased to report that the states have taken this recommendation seriously and are collaborating with regional VA representatives in developing public health emergency readiness plans and exploring the use of VA staff and facilities to create surge capacity.

The VA is also a critical resource for the education of our nation's health care professionals. As training sites for the majority of health professions schools, VA facilities play a prominent role in the earliest stages of medical training. Furthermore, as a result of its expertise in the treatment of victims of biological and chemical attacks, the VA is a valuable resource for supporting specialized training in this field. It is in this capacity that the VA has tremendous potential for ensuring that our physicians, nurses, paramedics and other health providers are prepared to meet the challenges of caring for casualties resulting from a biological, chemical, radiological, or nuclear attack.

As you can tell from the variety of interagency collaborations between our two Departments, HHS views VA as a very important partner in our readiness planning efforts at the federal level as well as at state and local levels. VA brings

a breadth and depth of critical expertise to bear on preparedness issues of concern to both Departments. During emergencies, whenever HHS has asked for assistance, VA has reliably responded in the affirmative. I believe that HHS' partnership with VA is one that will continue to be mutually beneficial. It enhances efforts at the federal level while strengthening the activities of our local communities. We are very pleased to have VA at the table with us as we move forward in planning for the public health security of the nation.

At this time, I will be glad to answer any questions that you may have.

**Statement
of
Dr. Neil C. Livingstone**

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House Committee on Veterans' Affairs

***Three Years After 9/11: Is the Nation Medically Prepared? What
Should VA's Role Be in Preventing and Responding to National
Medical Emergencies and Terrorist Attacks?***

August 26, 2004

GlobalOptions, Inc.

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Good morning and I want to thank you for the opportunity of testifying before the Committee today.

I am Neil C. Livingstone, CEO of GlobalOptions, Inc. I am the author of nine books on terrorism including America the Vulnerable: The Threat of Chemical/Biological Warfare. This book followed publication of my 1982 monograph, "The Poor Man's Atomic Bomb," which was, I believe, the first major publication in open sources regarding the threat posed by terrorists using chemical or biological weapons. At the time of its publication, some, even in the defense community, dismissed the growing threat of terrorists armed with chemical or biological weapons as "science fiction." Today, unfortunately, we know how wrong they were.

As I have stated publicly on many occasions, the evidence clearly indicates that it is not a question of "if", but only a matter of "when" the U.S. will suffer a major chemical or biological attack at the hands of terrorists or a rogue nation.

Let me give you some sense of what a major attack might look like based on simulation data and immunological studies.

A rogue nation could launch a biological attack simply by infecting a number of its citizens with an agent like plague (*pasteurella pestis*) and using them as vectors, or carriers. This would be done under the pretext of administering a normal inoculation to them as a requirement of traveling abroad. They would then be sent, perhaps under some humanitarian program or as a part of a visiting delegation, to the United States, where they would infect others on the plane, in the airports they pass through, and wherever they stay once they arrive.

Rodents, fleas, birds, and arthropods, to cite just a few examples, might also be used as vectors. Certain bacteria could also be released in aerosol form. There are countless ways that an epidemic might be introduced into the United States.

Depending on the agent and incubation period, cases would soon start to appear. Plague, for example, has an incubation period of approximately three days, whereas Q-fever can take up to three weeks.

Depending on how contagious the agent is, soon doctors and emergency rooms would begin to receive patients and local health officials would declare an emergency. Depending on the morbidity and lethality of the agent, panic would soon sweep the affected city or region. People would try to flee the city and authorities would have to address the issue of whether or not to impose an area-wide quarantine, including suspension of all travel in-and-out of the city. And here's where some of the really thorny issues arise: for example, should federal troops or the National Guard be used to seal a city off from the rest of the world? If people challenge the quarantine, should lethal force be used to stop them? What about people trying to get into the city to help their families?

Hospitals will have to set up elaborate triage systems to address thousands of potential victims, probably in their parking lots, even in inclement weather. How will they protect other patients from those infected by the agent? Will there be enough vaccine to inoculate health care

professionals and other key workers like police and firefighters? How will they dispose of the bodies of those who expire as a result of the infection?

The situation would likely get totally out-of-control with tens of thousands of stricken people, some armed, flocking to hospitals and demanding treatment. What then?

This is why it is imperative that the U.S. be adequately prepared, with all contingencies fully explored and appropriate policies, procedures, facilities, personnel, and supplies in place to address any biowar attack that could conceivably occur.

It is in this context that I would like to focus on the role of the Veterans Administration (VA) in response to a mass casualty biowar terrorist attack.

Hundreds, if not thousands or even tens of thousands, of Americans are likely to be afflicted by such an attack, especially if the terrorists use a contagious agent rather than a toxin.

The VA is the nation's largest direct provider of health care services. It maintains more than 1,300 facilities, including 163 hospitals and 850 ambulatory care and community-based outpatient clinics. By comparison, the Defense Department oversees 75 hospitals and about 460 medical clinics.

The VA also is the nation's largest pharmaceutical purchaser and boasts the largest health professionals training program in the United States. Each year the Agency trains 85,000 health care professionals and is affiliated with almost 1,400 medical and other schools.

Since the Veterans Administration is the closest thing this nation has to a national health care delivery system, it can be anticipated that the VA will play a major role in addressing any biowar crisis.

By contrast to military hospitals, which are often located on restricted reserves and in rural areas, the VA maintains hospitals and clinics in virtually every major urban area in the United States. In many respects, the VA is the healthcare equivalent to the National Guard, standing by to be mobilized in the event of a major disaster.

But is the VA able to respond effectively in the event of a major biological attack? Sadly, the answer is no.

The VA plays a supporting role in the National Disaster Medical System (NDMS), which coordinates federal medical resources to assist state and local authorities when health care facilities are overwhelmed following an emergency. In the event of an attack, VA hospitals are available to provide medical assistance as part of a local health care network. In the aftermath of the 9/11 attacks, the VA has improved its emergency response and continuity of operations. Training has been provided to staff, as well as decontamination equipment and medical supplies.

In 2002, legislation was signed by President Bush to establish four research centers at VA hospitals to develop responses to biological, chemical, and radiological attacks. The new law also created an Assistant Secretary for Operations, Security, and Preparedness within the VA, and it directed the Agency to develop bioterrorism medical response education programs.

While \$100 million was authorized to implement the new law, no funds have been appropriated since then. The Agency has not been able to move forward with the research centers, although it has developed and distributed medical educational materials on bioterrorism.

The hesitancy to fund the research centers stems, in part, from a concern about the VA's primary mission, which is to provide care for our veterans. There is a fear this mission may be diluted if the Agency becomes too involved in bioterrorism preparedness.

As a result, the basic role of the VA has changed very little since the 9/11 attacks and the creation of the Department of Homeland Security.

Restricting the VA's role to providing health care for our veterans may appear laudable, but in practicality it is a disaster waiting to happen – no pun intended.

In the event of a biological terrorist attack, local hospitals – including VA facilities – will likely be overwhelmed with patients. Some bioterrorism scenarios predict more than 100,000 casualties.

It is critical that we actively prepare now for a bioterrorism attack. “Most hospitals across the country,” according to the General Accounting Office (GAO), “lack the capacity to respond to large-scale infectious disease outbreaks.” Few hospitals have adequate equipment to handle a large increase in patients. As of July 2004, no state has the ability to respond to an epidemic involving at least 500 beds.

While most hospital staff has received training on biological agents, fewer than half has participated in an exercise related to bioterrorism.¹ Major gaps remain in disease surveillance systems and laboratory facilities. GAO reports there are also major deficiencies in regional planning and coordination. Some states have yet to negotiate basic agreements just to share physicians.

The federal government has plans to deploy medical teams to disaster sites to supplement care. But more is required. As previously mentioned, in a bio attack, there will be widespread panic, with victims demanding emergency care at local hospitals, while others seek to flee the city.

ER-One Project

Several years ago, my company, GlobalOptions, worked with the Washington Hospital Center on the ER-One project, to design the emergency room and related facilities and capabilities of

¹ “SARS Outbreak: Improvements to Public Health Capacity are Needed for Responding to Bioterrorism and Emerging Infectious Diseases. General Accounting Office. May 7, 2003.

the future. As part of the project, we examined the challenges hospitals will face from a mass casualty attack.

In a major event involving chemical agents, the first task for hospitals will be to triage casualties before they are decontaminated and moved into a facility for emergency care. The purpose of triage is to prioritize the injured and determine the best use of available resources, with the purpose of saving as many lives as possible.

In a biological attack, the first responders will most likely be health care professionals at a hospital or clinic. Based on early symptoms, it may not be apparent that patients have been contaminated with an infectious disease. But once diagnosed, vaccines and antibiotics will need to be quickly administered and patient isolation will be essential.

Most hospitals are poorly equipped to deal with an infectious agent, and do not have air filtration and over-pressure air flow systems to prevent contamination. At best, sections in a hospital can be quarantined, with medical staff protected by gowns and masks. Many hospital rooms do not even have double-paned windows to prevent the escape of an infectious agent.

Another key issue for hospitals in preparing for a chemical, biological or radiological attack is ensuring the availability of safe, potable drinking water. Few facilities have water purification systems. In a water emergency, the standard procedure is to rely on tanker trucks to bring potable water to a hospital. But this option is problematic in a terrorist attack. The source of water for the tanker trucks also may be contaminated. In the chaos that would follow an attack, trucks may have difficulty reaching hospitals, and once they do, distributing the water becomes a burdensome process.

Another issue often overlooked at hospitals is security. Crowd control is essential. After the 9/11 attacks in New York, hospitals were inundated by people looking for family members. Workers who escaped from the towers were treated in more than 100 different hospitals, and family members roamed from hospital to hospital looking for their kin.

In a biological attack, people will be desperate for medical care. Hundreds of people may descend on hospitals to demand treatment and could even threaten violence to gain access to care. Hospitals must have security systems in place to protect staff without compromising the efficient and compassionate delivery of health care services.

Retrofitting every hospital to respond to a bioterrorism attack would be financially prohibitive. But as new hospitals are constructed, preparing for such scenarios should be a consideration.

Very early detection and isolation is the most effective strategy to contain a bioterrorism attack. If thousands of people are contaminated before an infectious disease is diagnosed, it will already be too late to manage the crisis by isolating victims in hospitals equipped with the most modern technology. But if we are able to detect an attack in its earliest stages, such facilities will be critical to preventing a pandemic and treating victims.

Recommended Changes

Everyone agrees the VA's primary mission should remain unaltered – providing quality health care for our veterans. But this role would not be jeopardized by utilizing the VA's national health care network and educational resources to prepare for a biowar attack so long as additional resources are made available to get the job done.

Organizing our vast health care system to respond to a biological attack is a daunting task. Much work remains unfinished.

Enhancing the VA's role in communities where VA facilities already exist could be a far more cost-effective and efficient answer to the biowar threat than relying on the present structure where local communities are expected to address such emergencies until they are overwhelmed and federal resources mobilized.

As the nation's largest health care network, the VA has broad reach into our communities and established relationships with medical professionals. The Agency is actively training health professionals and is in a unique position to assist in bioterrorism preparedness. Consideration should be given to enhancing the VA's role in training and coordinating medical resources to respond to a biowar attack.

Funding the four research centers at VA hospitals to develop responses to biological, chemical, and radiological attacks would further enhance the Agency's expertise and ability to assist communities in preparing for, and responding to, a biowar attack.

The VA's national health care network is an underutilized resource that can be readily harnessed to focus, enhance, and accelerate our preparedness. By elevating the Agency's national role in bioterrorism, needed resources can be uniformly deployed throughout the United States in an expeditious and cost-effective manner to protect communities from a biowar attack.

Conclusion

Time is running out. A biological, chemical or radiological catastrophe will happen; it's inevitable. It may come from abroad or conceivably even from a domestic hate group. There have been, after all, dozens of incidents where domestic terrorists have attempted to acquire chem/bio weapons, including ricin, anthrax, and various viruses.

Twenty years ago followers of the Bhagwan Shree Rajneesh sought to infect local politicians and voters in The Dalles, Oregon, with salmonella and other pathogens. In Japan, the Aum Shinrikyo, which was responsible for the 1995 sarin attack in the Tokyo subway system that killed a dozen people and sent 5,000 to the hospital, was actively trying to perfect an anthrax weapon and even acquire a filovirus (Marburg, Ebola) culture.

And even if it is not a hostile act, with the advent of modern jet travel and global commerce, we must be prepared for the emergence of new diseases, often viruses, that dwell in the deep

recesses of primeval forests and other remote places that could break out of their environments as the result of a mutation or if the appropriate host appears.

The threat of germ weapons being unleashed on unsuspecting populations is real and growing. While we are constantly developing new vaccines and detection systems, far more needs to be done to protect America, and the Veterans Administration is one of the few institutions with the knowledge, facilities, laboratories, and personnel necessary to defend this nation.

It is time to make the VA the frontline troops in this potential war against an invisible enemy. As Judith Miller, Stephen Engelberg, and William Broad conclude in their study, Germ: Biological Weapons and America's Secret War, "We remain woefully unprepared for a calamity that would be unlike any this country has ever experienced."²⁰

GlobalOptions is a multidisciplinary international risk management and business solutions company headquartered in Washington, D.C. Among our previous government clients, we have provided services for the U.S. Department of Energy, Department of Defense, Veterans Affairs Department, and District of Columbia Emergency Management Agency.

² Judith Miller, Stephen Engelberg, and William Broad, Germ: Biological Weapons and America's Secret War, (New York: Simon & Schuster, 2001), p. 320.

**STATEMENT OF
JERRY L. MOTHERSHEAD, MD FACEP
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

AUGUST 26, 2004

Mr. Chairman, members of the committee, distinguished guests:

My name is Jerry Mothershead. I am an Emergency Physician. I am an assistant professor at the Uniformed Services University of the Health Sciences and a Physician Advisor for Battelle Memorial Institute. I am a retired Naval Officer with over 15 years experience in disaster medicine, biodefense, and homeland security. For the past several years, I have served as a technical advisor to the Department of Veteran's Affairs Emergency Management Strategic Healthcare Group Technical Advisory Committee. I am honored by this opportunity to discuss my personal views on the health and medical sector role in preparedness and response to bioterrorism attacks, and what part in these initiatives VA might play in support of the overall national effort.

I would like to provide three general observations concerning disasters, disaster preparedness, and the current state of healthcare in the United States

America's Healthcare Experience with Large Scale Disasters producing Mass Casualties is Limited

Disasters in America have typically been non-progressive, sudden impact, defined scene events characterized by property and economic losses far out of proportion to injuries and deaths. Only a handful of events occur annually that result in total casualty counts in excess of 50. Most victims have minor injuries not requiring hospitalization. Of those seriously injured but salvageable, over 95% are rescued by local volunteers and responders and treated within 24 hours. Less than 15% of all victims are admitted to hospitals. With notable exceptions, resources of most U.S. health care facilities have not been exceeded, few suffered staff shortages, and fewer still reported supply shortages. Most facilities have been able to return to normal or near-normal operations within 48 hours of the disaster.

The disasters currently contemplated - resulting in large numbers of casualties that would exceed our health care capacity include pandemic contagious disease such as influenza, some types of bioterrorism such as a large aerosol release of anthrax, nuclear detonation, or release of large amounts of radiological material, toxic industrial materials, large magnitude earthquakes, or weaponized chemical agents. In terms of the ability to produce live, treatable casualties, these events are orders of magnitude greater than this country has witnessed in over 100 years. In even small scale events of these types, we could see thousands of deaths, tens of thousands of casualties requiring both acute and long term care, unfathomable numbers of psychological casualties, displaced populations, and loss of health care facilities and providers. The only non-combat related public health emergency in this country that has approached this magnitude was the Spanish influenza pandemic of 1918. Over 500,000 Americans died in four months. Approximately 1 in 3 Americans were affected. In Philadelphia, 3,000 died and 12,000 became ill in one week.

No community or collection of communities in America has the resources to absorb the surge in patients produced by these types of catastrophes, and a tiered national response including

local/regional, state, and federal resources, will be required, acutely and quite likely for a sustained period of time.

Health care in the United States is already in crisis.

Burgeoning costs of per capita services, reduced reimbursements and an increasing uninsured population effectively cut any fat from the health care industry. We have shifted a great many services from the in-patient to the out-patient setting. Over 500 hospitals (10%) and 1,000 Emergency Departments, (25%) have closed in the past decade. During that time, visits to Emergency Departments have grown nearly 20%. ED overcrowding is most severe in areas with large populations, where 1 in 10 hospitals report diversion 20 percent of the time. Waiting times in Emergency Departments may at times exceed 24 hours, and it is not uncommon to see admitted patients "boarded" in the departments because of lack of inpatient rooms.

Market forces have affected federal institutions as well, with closure of military facilities in excess of those linked to the Base Realignment and Closure, and many beneficiary services have been shifted to the local economy. The VA Capital Asset Realignment for Enhanced Services program (CARES) may result in similar closure of many of its facilities.

The net result is that we have little true sustainable national excess capacity and cash-strapped hospital systems have few surplus funds to invest in disaster preparedness. Without significant change, this will most likely worsen in the future. It is my contention that medical disaster preparedness and response must be recognized as a public safety function, and therefore is a governmental responsibility which must be appropriately subsidized. Until public policy changes to address this reality, we have little chance of adequate preparedness.

Disasters are low probability-high consequence events. Pre-event actions are an insurance policy. However, there is a cost involved, and resources expended in pursuit of disaster preparedness are no longer available for current, day-to-day issues that collectively also have consequences. I would therefore respectfully suggest that any mandates for change be accompanied by the appropriate resources to accomplish those changes.

Efforts to improve bioterrorism and disaster preparedness have accelerated, but much remains to be done.

The past three years have witnessed the greatest reorganization of the executive branch of the federal government since World War II. Bioterrorism-related funding, executive orders, and legislation have increased exponentially as well. Many existing programs and departments, from the federal to local level, have been bolstered. Many new programs have been developed, and virtually every health related organization and agency at all levels have established new offices directly linked to homeland security. Comparatively speaking, massive amounts of money have been earmarked for biodefense research and technological development, including vaccines, medical surveillance, supplies, pharmaceuticals, and other materials, training programs, protective equipment, and personnel. There is no doubt in my mind that, as a nation, we have definitely increased our efforts to improve health and medical capabilities to respond to catastrophic disasters.

We still face many challenges. Many programs have not yet reached full maturity. We have yet to implement environmental and epidemiological surveillance systems with the requisite sensitivities to ensure the earliest possible detection of attack. Much research remains to field pharmaceuticals and vaccines against the greatest threat agents. We have virtually no reserve capacity for acute or long term health care and mental health services for the potential numbers

of surviving victims of large scale attacks by weapons of mass destruction or severe pandemics. Education and training in disaster medicine and the clinical aspects of bioterrorism has still not been universally institutionalized. We have yet to solve the post attack environmental surety problem. And the list goes on. Although funding for governmental and non-government hospitals has improved, it by no means has solved the fiscal dilemmas.

The role of the Department of Veterans Affairs in bioterrorism preparedness and response could be expanded

VA, DoD, and DHHS facilities and health professionals represent a national asset in the Global War on Terrorism and for response to disasters of any sort that reach the threshold of a national emergency. With over 150 hospitals, 900 additional clinics, domiciliaries, and other facilities, and full and part time staff numbering well over 200,000, VA operates the largest integrated health care system in the United States. VA facilities exist in every state and several of the territories. If DoD and DHHS health and medical resources are included, practically no community is far removed from a significant federal health footprint.

All disasters are local events. If you accept the premise that, faced with an overwhelming disaster, emergency responders should utilize all available resources, then VA facilities must be considered local assets that should be utilized for the good of the community as a whole.

Many VA facilities have already collaborated with other health care systems. At the local level, federal facilities must be allowed to more fully integrate into the entire health care system during disasters. Today, most federal health care facilities do not even participate in their local trauma systems. The cooperative trauma system that exists between the City of San Antonio, TX, Brooke Army Medical Center, and Wilford Hall Air Force Medical Center is a model of federal-civilian collaboration that should be studied for more wide-spread application.

- In those locations where the Metropolitan Medical Response Systems are operational, federal facilities must be full and active partners.
- In those communities without such systems, federal facilities should assume a leadership role in development of similar unified health care systems approaches to disaster response.
- Epidemiological data must also be integrated across jurisdictional lines if such initiatives as syndromic surveillance are to achieve their full potential for early identification of outbreaks and accurate epidemiological projection. Lack of information sharing between VA, DOD, and civilian facilities within the same community hampers this tool's potential value.
- In general, federal healthcare facilities are more physically secure than their civilian counterparts. Regional disaster cache storage or the staging, storage and distribution of national stockpiles at secure VA facilities should be considered. Many VA facilities already store additional caches for department use, and through partnerships with the Strategic National Stockpile Program, have developed logistical and maintenance procedures applicable to regional or local stocks as well.

The National Disaster Medical System (NDMS) combines Federal (DoD, VA, DHHS, and DHS/FEMA) and non-Federal medical resources into a unified response that is designed to meet peacetime disaster needs as well as combat casualties from a conventional armed conflict. VA's principal role in the NDMS is the management of the Federal Coordinating Centers (FCC). Of note is that membership in NDMS is restricted to civilian hospitals. Federal facilities may in general receive eligible beneficiaries only. There are 66 FCCs and approximately 1500 member hospitals, covering less than 10% of the geography and including only about 30% of the hospitals in the United States. In addition to expanding the roles of FCCs to provide better situational awareness of medical threats, vulnerabilities and capabilities for their areas of responsibility, increasing their numbers, enlarging geographic coverage, and

inclusion of more civilian facilities, may be worth pursuing. Initiatives such as these will require close collaboration with state public health and emergency management agencies.

The federal government has an interest in assisting community medical systems in all phases of emergency management. Headquarters level involvement can be directive, facilitative, supportive, or interactive. Some areas for consideration include:

- Standardization
 - Education and training. VA already has a defined role in medical education and training, of both its staff and of health professional students and residents. Significant amounts of training are currently being performed. I would observe that the other federal health and medical partners, academic institutions and professional organizations have also independently developed training, and much of this is remarkably similar. Three years after 9-11 and we still do not have a competency-based, tiered national standard curriculum for education in the clinical and operational medical management of victims of terrorism and weapons of mass destruction, nor do we have an organized national education program. It is time that we develop such a program and institute it nationally. DHS, VA, DOD and DHHS should collectively serve as the leadership backbone for this initiative.
 - Standards of performance. Lack of explicit standards and benchmarks allows a great deal of subjectivity to drive decision making processes. Unpublished data suggest that hospitals may in general overestimate their readiness capability significantly as compared to outside objective criteria, even when those criteria are known to them. It is the responsibility of leadership to institute standards of performance and measures of effectiveness for programs it oversees. Although there are many stakeholders in the standards-setting process, certainly the federal health sector has a duty to be part of that process.
- Leveraging purchasing power. As the largest provider of health care in the United States, the VA has an immense purchasing power, currently being used in the Strategic National Stockpile Program. Extension of this program to provide conduits for community health care systems may conserve limited local funds and promote standardization.
- Response team development. If one looks at a table of mobile response teams, medical or otherwise, it is a veritable alphabet soup of acronyms. NDMS has DMATs and DMORTS, DoD has SPRINTS, SMARTS and BATs, the VA has the MERRT and EMRTs. Each agency has its own concept of response team size, composition, roles, responsibilities, and operations. Collective review of these teams in emergency response may be in order. Certainly the VA would have an important role in such a venture. Certainly, with the need for redundancy and geographic placement of these teams, VA should consider expanding its limited participation to date. This will of course require incentives for increased enrollment in the Disaster Emergency Medical Personnel System, which has not achieved its full potential.
- Development of programs and job aids to help VA facilities do their jobs better. While the VA is doing this, it could potentially do more. An example would be in exercise support. The VA already participates in national and regional exercises. Exercise design, development, scheduling, logistics, execution, and evaluation can be greatly enhanced through the establishment of a Comprehensive Public Health and Medical Emergency Exercise Program. I view this also as a headquarters responsibility.

These are but some of the areas in which the VA may progress toward enhancing its capabilities and roles in bioterrorism and disaster preparedness and response. I would finally say that further, more intimate collaboration with the other principle federal health sector partners at all levels and on all common issues would facilitate a more cohesive, integrated health and medical strategy and which would strengthen our defensive and response posture.

Jerry Lynn Mothershead, MD, FACEP

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Current Position

Battelle Memorial Institute Physician Advisor Medical Readiness and Response Group	Columbus, OH 2002 - Present
Uniformed Services University of the Health Sciences Adjunct Associate Professor, Department of Operational and Emergency Medicine	Bethesda, MD 2004 - Present
Veteran's Health Administration Advisor, Technical Advisory Committee Emergency Management Strategic Healthcare Group	Washington, DC 2001 - Present

Previous Positions

Navy Bureau of Medicine and Surgery, Washington DC Senior Medical Consultant, Office of Homeland Security Specialty Advisor, Emergency Medical Services	2001 - 2002 1996 - 2002
Navy Environmental Health Center, Norfolk, VA	1998 - 2002
Naval Medical Center Portsmouth, VA Staff, Emergency Medicine Department Operational Medical Director Head, Disaster Committee	1994 - 2002
United States Central Command Head, Resuscitation & Stabilization Team ONE	1990 - 1991
National Naval Medical Center, Bethesda, MD Head, Military Medicine Department Staff, Emergency Medicine Department Hospitalist	1987 - 1991
Naval Safety Center, Norfolk, VA Aeromedical Safety Officer Aviation Mishap Investigator	1985 - 1987
Naval Air Test Center, Patuxent River, MD Head, Emergency Medicine Department, Naval Hospital Head, Aerospace Medicine Department, Naval Hospital	1982 - 1985

Education

Christ Hospital & Medical Center Oak Lawn, IL	Residency – Emergency Medicine	1991 – 1994
Naval Regional Medical Center San Diego, CA	Internship – General Surgery	1980 – 1981
University of Missouri Columbia, MO	Doctor of Medicine	1976 – 1980
U. S. Naval Academy Annapolis, MD	Bachelor of Science – Physics	1970 – 1974

Licenses

Virginia Active

Professional Memberships

American College of Emergency Physicians - Fellow
National EMS Committee (1996 – 2002)
EMS Section
Disaster Medicine Section
Government Services Chapter

National Association of EMS Physicians
Standards and Practice Committee

Accreditations & Certifications

Diplomate	American Board of Emergency Medicine	1995
Diplomate	National Board of Medical Examiners	1981
Graduate	Special Events Contingency Planning, Emergency Management Institute	2002
Graduate	Incident Command System Self-Study Course, United States Fire Administration	2000
Graduate	Combined Humanitarian Assistance Response Team Course	1999
Graduate	Military Operations Other Than War Course	1999
Graduate	Medical Effects of Ionizing Radiation Course, Armed Forces Radiobiology Research Institute	1999
Graduate	Medical Management of Chemical & Biological Casualties Course	1998
Graduate	National Emergency Medical Services Medical Director Course	1997
Graduate	Counter Narcotics & Terrorism Operational Medical Support Course	1991

Military Awards

Navy Meritorious Service Medal	2002
Navy Commendation Medal (two awards)	1998, 1999
Presidential Unit Citation	1991
Combat Action Ribbon	
Southwest Asia Defense Award (dual awards)	
Armed Forces Expeditionary Forces Medal	
Navy Unit Citation	1984
National Defense Ribbon	1970, 1991

Jerry L. Mothershead

Publications

Managing Editor, *eMedicine* "Emergency Medicine" Text and "AAEM Emergency Medical and Family Health Guide." BMJ Publications, Boston, MA (Internet On-Line Emergency Medicine Text) (chapters on chemical and biological agents and defense).

"Disaster Planning" in *Emedicine*, BMJ Publications, Boston, MA.

"Biological Warfare Mass Casualty Management" in *Emedicine*, BMJ Publications, Boston, MA.

"Medical Management of Biological Terrorist Events" *Emedicine*, BMJ Publications, Boston, MA.

"Physicians in Prehospital Care" *Prehospital Immediate Care*, Vol.1.No.4. Dec 1997. Pp. 879-884.

Army Field Manual 8-284 "Medical Management of Biological Warfare Agent Casualties" Joint Service Publication, April 2000.

Multi-Service Techniques, Tactics, and Procedures Manual "Consequence Management in Chemical, Biological, Radiological, and Nuclear Environments" December 2000.

"General Principles of Response to Biological Terrorism" *Hazardous Materials Advanced Life Support* text. (with Robert Darling, MD FACEP) University of Arizona. 2001.

Specific Biological Agents *Hazardous Materials Advanced Life Support* text. (with Robert Darling, MD) University of Arizona. 2001

Co-Editor, Emergency Medicine Clinics of North America "Biological Warfare and Terrorism" (May 2002)

"Medical Treatment Facility Preparedness for Bioterrorism" for Emergency Medicine Clinics of North America, WB Saunders, Inc. (with Carl Schultz, MD, FACEP, and Morris Field, DO) (May 2002)

"Community Preparedness for Bioterrorist Events" for Emergency Medicine Clinics of North American, WB Saunders, Inc. (with Lynn Flowers, MD FACEP and Tom Blackwell, MD FACEP) (May 2002)

"State, Local, and Federal Response to Bioterrorism" for Emergency Medicine Clinics of North American, WB Saunders, Inc. (with Kevin Tonat, PhD, and Kristi Koenig, MD, FACEP) (May 2002)

"Weapons of Mass Destruction" for Third Edition of Prehospital Systems & Medical Oversight, National Association of Emergency Medical Services Physicians. (Spring 2002)

"Military Emergency Medical Services" for Third Edition of Prehospital Systems & Medical Oversight, National Association of Emergency Medical Services Physicians. (Spring 2002)

"EMS Research" for American College of Emergency Physicians publication Medical Oversight in Emergency Medical Services. (Fall 2002)

"Biotechnology and Biosensors" Chapter in *Disaster Nursing and Emergency Preparedness for Chemical, Biological and Radiological Terrorism and Other Hazards*. Veenema, TG, ed. Springer Publishing Company, New York. 2003.

"Weapons of Mass Effect" and "Preparedness and Planning" Chapters in *Response to Terrorism: Preparing Healthcare Leaders for Our New Reality*, McGlown, J., ed. ACHE Press, Chicago. 2004.

Disclosure Statement

19 August 2004

During the period from July 2002 to the present, I have worked as a subcontractor for or an employee of several government contractors who provide services primarily to agencies of the executive branch of the federal government. With the exception of remuneration of \$2500 from the US Coast Guard for legal review of a malpractice case, I have received no remuneration directly from any Federal agency.

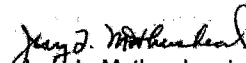
My income from all contractors for these services during this time was approximately:

\$ 30,000 (2002)
\$200,000 (2003)
\$ 90,000 (2004 to date)

Principal clients have been:

Department of Defense, including component services
Department of Justice
Department of Health and Human Services
Department of Homeland Security
Department of Agriculture

I have received no remuneration for any services performed for the Department of Veterans Affairs.


Jerry L. Mothershead

Battaglia Report October 2001

Finding 1. VA's medical preparedness to respond to casualties of chemical or biological attack is significantly lower than it should be.

Recommendation Summary: 8 recommendations: Plan and execute a comprehensive education, training and exercise program to ensure all personnel are trained in emergency response plans and procedures.

Finding 2. A callup of Reserve or National Guard units, or other events causing fear that staff may not report to work, would result in a severe medical care staffing shortage.

Recommendation Summary: 4 recommendations: Design local emergency plans to identify backup sources of staffing.

Finding 3. VA's contingency planning for PTSD counseling is not adequate to treat all who would need counseling in the event of a sustained conflict involving significant casualties.

Recommendation: Train all mental health clinicians to provide acute care to combatants, civilian casualties of terrorism, and family members.

Finding 4. VA security forces are not adequate in number or training to manage a domestic crisis or to protect key VA personnel, facilities, and systems.

Recommendation Summary: 3 recommendations: Train personnel, address vulnerabilities (not specified but presumably extensive), and plan to obtain backup personnel.

Finding 5. In the event of chemical or biological attack, the VA lacks sufficient equipment and pharmaceuticals to address medical needs.

Recommendation Summary: 2 recommendations: Each VISN must stockpile key drugs and supplies. Devise a means for national oversight of stockpiles so that VA can move needed items in an emergency.

Finding 6. In the event of CBW attack, VA medical centers are not equipped and trained to address issues of decontamination.

Recommendation Summary: 3 recommendations: Purchase necessary decontamination equipment and train personnel in its use.

Finding 7. VA hasn't used all of its trained assets to meet emergency staffing needs.

Recommendation: Develop plans and training with OIG employees to augment other VA organizational elements in times of emergency.

Finding 8. VA is not equipped or prepared to assist employees in the event of a CBR exposure.

Recommendation Summary: 3 recommendations: Establish an emergency medical care capability at VA headquarters.

Finding 9. VA cannot maintain a high degree of readiness during emergencies because it lacks an effective, reliable and centralized communications system, and its headquarters computer site it is below ground and could be flooded.

Recommendation Summary: 4 recommendations: Move the computer site and acquire an emergency communications system.

Finding 10. VA doesn't have sensors to detect a CBR attack. This lack is especially critical at VA medical centers.

Recommendation Summary: 3 recommendations: Develop a feasible plan to acquire CBR detection systems.

Finding 11. Cyber attacks on government and commercial data are real and ongoing, but VA lacks a centralized command and control mechanism for its data and communications assets.

Recommendation Summary. 2 recommendations: Establish a centralized security operations center and a global secure network operations center for VA communication and information technology assets.

Finding 12. The National Cemetery Administration does not have a comprehensive plan to meet an unexpected increase in workload.

Recommendation Summary: 3 recommendations: Establish contingency plans that would allow for appropriate but rapid interment.

Finding 13. The Veterans Benefits Administration three technology centers have never tested their back-up systems and strategies.

Recommendation Summary: 3 recommendations: Immediately test and evaluate back-up capability and establish redundant email and internet systems.

Finding 14. VA has arrangements with only one Treasury Disbursing Center to issue payments to veterans, their families, VA employees and vendors.

Recommendation: VA and Treasury need to work out a back-up plan to ensure uninterrupted payments.

Finding 15. VBA headquarters cannot reconstitute itself outside of its current location.

Recommendation Summary: 2 recommendations: In consultation with GSA, VBA needs a plan to reconstitute its headquarters functions in the event its current location becomes unusable.

Finding 16. VBA needs a better plan to relocate on a short-term temporary basis.

Recommendation Summary: 3 recommendations: Develop a better plan with the ability to relocate key personnel and replicate files and services currently provided at current headquarters location.

Finding 17. In the event of large-scale warfare, VA and DOD lack adequate plans to coordinate transition to VA of disabled service persons.

Recommendation Summary: 3 recommendations: Update procedures and policies to activate VA casualty assistance teams and establish critical communication links with DOD.

Finding 18. VA does not have procedures to suspend or write-off debts of persons called to active duty or who become victims of terrorism.

Recommendation: VA should establish procedures to stop efforts to collect debts owed by persons on active duty or persons who are victims of terrorism.

Finding 19. The current plan to move essential headquarters personnel and functions to secondary sites in the event of a CBR attack is unlikely to work.

Recommendation Summary: 5 recommendations: Expand facilities at existing alternate site and develop plans to relocate vital records and data. Train alternate leadership personnel to exercise headquarters function.

Finding 20. The attacks of 9/11 point out the need for a more robust headquarters operation center and better emergency planning and procedures.

Recommendation Summary: 3 recommendations: Establish an emergency operations division, a round-the-clock headquarters command center, and conduct exercises to assure contingency plans would work.

Congressman Evans to the Honorable Gordon Mansfield, Deputy Secretary,
Department of Veterans Affairs

**Questions for the Record
From The Honorable Lane Evans,
Ranking Democratic Member
House Committee on Veterans Affairs
August 26, 2004**

Hearing on Emergency Preparedness

Question 1: After you left the hearing, Jerry Mothershead told the Committee that most emergency preparedness plans that have been developed stop at the emergency rooms, and that many preparedness plans fail to follow through to other areas of the hospital such as operating rooms, for example. Has the VA planned beyond the initial point of contact with possible casualties, and developed plans that involve other areas and departments within its hospitals, clinics, etc?

Response: Yes. To effectively plan to "surge" to meet demands of a mass-casualty situation or other unexpected demand on a hospital (for example, a disease epidemic), the overall capabilities and capacity of the hospital, not just its emergency department, must be evaluated and incorporated into the facility's Emergency Operations Plan (EOP). All VA EOPs incorporate this level and degree of detail into their planning. Moreover, our VA medical centers have had extensive experience with planning to meet "surge" requirements given the planning that has been necessary to meet potential Department of Defense medical care requirements for active-duty patients under Public Law 97-174.

Question 2: Mr. Mansfield, you committed to taking the recommendation of rolling into CARES, the four emergency preparedness centers, as authorized by Congress in November 2002. This would not only help in further developing VA's preparedness, but also help make the best case scenario for funding these centers. What is the status of this recommendation? Will the Secretary consider this in the further development of CARES?

Response: The primary mission of the CARES initiative is to modernize VA's aging infrastructure, with a particular focus on renovating and modernizing VA's health care system. On the other hand, implementation of significant portions of the medical emergency preparedness centers would require linkages with academic medical centers and schools of public health, as well as training or responding to local, state, and other Federal needs in emergency preparedness. Thus, we believe that funding the four centers on medical emergency preparedness using resources identified through the CARES process would not be an appropriate or effective use of those resources.

Question 3: What is the standardization requirement for on-site Decontamination Unit [leader] training, organization practice requirement [a percent of the organization's employees] and Decon-kit inventory requirements?

Response: While VA's role is not to function as "first responder", the goals of VA "Emergency Mass Casualty Decontamination Program" are to: 1) protect VA medical facilities, staff and veteran patients, 2) ensure continuity of health care to patients, and 3) provide emergency care to local casualties when existing local civilian and community emergency capabilities are overwhelmed.

VA recognizes that a well-trained staff is essential to an effective hospital emergency mass-casualty decontamination program. Thus, this training program combines existing VA emergency decontamination programs into a comprehensive week-long training course for VA staff, called the "Emergency Mass-Casualty Decontamination Training Course." Its purpose is to train VA employees who have been nominated for this responsibility by their medical facility management. Each trainee can return home and provide the basic decontamination training to 5 to 30 staff at his or her facility.

The course content includes three days of basic decontamination training and two days of "train-the-trainer" course work. The course is taught in modules listed in the table below. The course includes written exams, practical exercise and equipment review. The train-the-trainer section covers effective training presentations and provides practice sessions. The VA Employee Education System (EES) provides and maintains certificates of attendance.

From March 2003 through October 2004, EES has trained over 500 students in emergency decontamination operations for 133 VA Medical Centers. Students must be medically cleared to use level C Personal Protective Equipment (PPE) by their Occupational Health Unit, according to OSHA Respiratory Protection Standard 29 CFR 1910.134.

Topics of modules covered in VA's Emergency Mass-Casualty Decontamination Training Program	
Regulations relating to federal safety, health and environmental standards	Hazard recognition
Toxicology of various classes of chemical, radiological and biological agents that may be encountered	Response plan implementation
Risk assessment and hospital planning	Bioterrorism
Chemical warfare agents including clinical aspects of examining and triaging potential casualties	Industrial chemicals emergencies
Radiological emergencies	Personal protective equipment (PPE) and environmental factors
VA's medical cache program	Portable decontamination equipment specifications
Donning and doffing PPE	Train-the-trainer section

Each participating VA medical center nominates four students from their facility for this training, who have backgrounds as clinical, safety and health, and emergency managers (other backgrounds may also be acceptable), and who can pass the relevant OSHA physical requirements. At least one of the four students is required to be a Health/Safety/Emergency Coordinators. Classes typically have students from 5 to 7 medical centers, or 20 to 28 students.

After VA staff complete the course and return to their home medical facility, they, together with their hospital management request the type and number of tent-based shower-shelter systems and PPE needed. Requests are reviewed by VA Central Office, and upon approval the equipment is supplied to the facility. The centers are responsible for training additional staff; obtaining materials used in regular exercises and drills; and ensuring compliance with all relevant Joint Commission on Accreditation of Healthcare Organizations (JCAHO), OSHA, and EPA regulations.

Medical centers that participate in the VA Emergency Mass-Casualty Decontamination program basic training must agree to complete the program. To be compliant with VA requirements, each hospital must identify and train additional required staff, implement a regular drilling and exercise program, and document their activities to VA Central Office.

VA has developed specific policies and guidelines to address long-term sustainability and certification of a facility's capacity to provide protection and continuity of operations in the event of a terrorist attack. Details are in the document, "VAMC Notification and Decontamination Implementation Checklist Memo -- February 3, 2003, available from (www.va.gov/EnvironAgents). Certification of complete program implementation occurs when the medical center director can document that the staff has been fully trained and have successfully completed emergency drills.

VA is also developing a new position of Medical Center Safety Officer (MCSO), to be located at VA facilities. The MCSO will provide the necessary experience and skills to provide day-to-day on-site management of the VA's emergency mass-casualty decontamination program. Among other duties, the MCSO will have responsibility for maintaining the Decon-kit inventory.

Question 4: A coordinated domestic terrorist attack -- for example, a derailed railcar containing chlorine in a populated area near a water source, could cause hundreds of thousands of injuries. How is the VA coping with the increased potential of such an event when the number of available beds in VA has decreased since 9/11?

Response: VA medical facilities do not plan for these types of events independently but as part of a community-wide response. It should be noted that

the question posed applies equally to the community-at-large, since the decline in VA beds mirrors what has been occurring within the private sector. Therefore, it is reasonable to assume that community resources alone cannot adequately address the scenario presented by the question, even in a very large city. This necessitates coordinated public/private sector planning on a national level, as represented by the National Disaster Medical System (NDMS), the National Response Plan (NRP), and the Catastrophic Incident Supplement to the NRP. VA has been actively involved in this planning effort and will continue to be a fully engaged participant to address these concerns in a coordinated manner at the local, state, regional, and national levels.

Question 5: Has the failure of the CoreFLS system in Florida caused any problems in maintaining the Inventory of the VA pharmaceutical caches? At a Committee hearing in October 2001, GAO recommended additional steps to further tighten the stockpile security. What has been done since then? Are you sure that the problems uncovered by the GAO have been fixed?

Response:

CoreFLS

The problems that VA experienced in the implementation of the CoreFLS system have not had any adverse impact on the VA Pharmaceutical Cache Program. The VA Pharmaceutical Cache Program uses the iDynaMed software on an independent server to maintain the cache inventory. While the iDynaMed software is indeed one of the three components in the CoreFLS system, the cache program is using only this component and is using it in an isolated environment unconnected to any of the CoreFLS activities or systems. The iDynaMed software is an inventory system that was designed specifically for healthcare applications and has a proven track record with other clients. The iDynaMed software has met and continues to meet the inventory management and readiness needs of the VA Pharmaceutical Cache Program.

October 2001 GAO Testimony

Below are the GAO recommendations and the actions taken by VA to ensure compliance with them. All of the problems noted by GAO have been corrected.

Recommendation: Finalizing and implementing approved operating plans.

VA Actions and Status: VA is in compliance with the Interagency Agreement between VA and the Federal Emergency Management Agency (FEMA), which requires VA to submit updated Operations Plans for each storage facility to FEMA within 30 days of acceptance of the Interagency Agreement. The plans were approved in 2001 and again in 2004 and are in place at each storage site.

Recommendation: Ensuring compliance with operating plans through periodic reviews.

VA Actions and Status: The site specific Operations Plans are reviewed twice a year during cache site visits conducted by VA and FEMA. The plans are followed during each cache deployment and exercise. VA and FEMA review compliance with the plans as part of the analysis of each exercise.

Question 6: VA operates a network of 140 treatment programs for post-traumatic stress disorder (PTSD) and is recognized as the leading expert on PTSD diagnosis and treatment. How has VA prepared for the possible numbers of victims needing mental health services following a terrorist attack? Please explain how VA would provide mental health support under the Interim national Response Plan.

Response: As authorized by Public Law 107-287, VA is creating a comprehensive curriculum for VA staff on care for survivors of attacks by Weapons of Mass Destruction (WMD). This curriculum includes modules on management of casualties of blast, chemical, biological and radiological/ nuclear attack, and incorporates a module on the mental health approach to survivors as well. The Mental Health module describes evidence-based practices in the joint VA/ DoD PTSD Clinical Practice Guideline (January 2004) and employs pocket cards from this Guideline. Topics covered include assessment and management of survivors in a manner that provides education about common post-event responses and is designed to avoid "over pathologizing" the survivors. Most survivors will have some short term adaptive emotional responses to an attack, but only a minority (10-20%) will be expected to develop long term mental disorders. Coping with problems and resilience to stress are key goals of the mental health approach to survivors. The concepts of rehabilitation (emphasizing strengths as well as problems) and recovery (engaging the patient and significant others as partners in the clinical care) characterize the approach to those who do have mental disorders. It is important to recognize that our clinicians are being taught that not only PTSD but also other mental disorders including other anxiety disorders, depression, and substance use disorders may arise in response to the stress of an attack.

Currently, VA mental health staffs have skills in management of PTSD and other mental disorders. Many of them, especially staff of VA's Readjustment Counseling Service (RCS), are also schooled and experienced in response to disasters both natural and man-made. Clinicians in Veterans Integrated Service Network (VISN) 3, have a training program that incorporates care concepts described in the Mental Health WMD module. Mental health leadership has been integrated into all facility Emergency Management teams, including the VISN level team. VISN 3 mental health staff participates in Emergency Management drills and are involved with local Red Cross for partnering opportunities. VISN 3 includes the New York City area, and staffs from VISN 3 were members of the

writing team for the Mental Health WMD module, contributing key sections on the service interface between VA and the non-VA community in times of disaster/ attack based on their post 9/11 experiences. Other existing support materials include the VA/DOD Iraq War Guide (revised May 2004), and the National Center for PTSD disaster web page, which received thousands of "hits" after 9/11. In many ways, the clinical approach to civilian survivors of a terrorist attack is similar to the management of returning troops from Global War on Terror. The need to pay attention to emotional and mental health needs of those who have been wounded in an attack is one example. VA's Office of Public Health and Environmental Hazards keeps a list of trained mental health volunteers for disaster response. Mental health clinicians including psychologists and social workers comprise over 11 percent of the 1,815 volunteers currently on the Disaster Emergency Medical Personnel System (DEMPS) list.

In summary, VA has mental health clinicians trained in management of emotional and mental responses of attack and is initiating the roll out of an educational plan in these approaches through the WMD curriculum that will span all elements of our health care system. This new training, building on existing skills of our staff, will strengthen VA's role in supporting the nation in times of need as described in the Interim National Response Plan.

Question 7: Each year VA medical centers estimate the number of beds that could potentially be made available to receive returning military casualties. Estimates of VA contingency beds are also gathered from VA medical centers quarterly. Since most injuries experienced in disasters are addressed on an ambulatory basis, do you agree that counting beds is a poor measure of capacity in wide-scale emergencies? Why are you not more focused on VA's current lack of adequate trauma centers and decontamination equipment?

Response: VA fully concurs that "patient treatment capacity," as opposed to "beds," is a much better measure of a health care system's, or community's ability to respond to a mass casualty event. First, due to advances in technology and increased treatment capability, shorter hospital stays, and capacity for care of patients on an outpatient basis, "beds" is no longer a true indicator of the capability and capacity to care for patients. Secondly, simply counting hospital "beds" ignores the medical capability and patient capacity that exists in free-standing clinics and other ambulatory settings. While hospitals were once referred to as the "physician's workplace," we now find sophisticated diagnostic testing, treatment, and surgery being performed outside of the traditional hospital setting. Regarding the second part of the question, VA's focus has been and continues to remain on meeting the needs of our veteran patients. Accordingly, VA feels that we have sufficient trauma centers and are working to complete having the decontamination capability (staffed, trained, and fully-equipped decontamination teams) to meet both veterans' medical needs and protect our infrastructure in a terrorist attack. VA can, if necessary and as authorized, shift

these resources to provide emergency care to the non-veteran population in a disaster or terrorist event.

Question 8: Your previous Chief for EMSHG left VA July of this year. What are VA's plans for replacing her and when do you anticipate having a leader in place?

Response: The position of Chief Consultant, EMSHG, was announced nationally and the closing date of the announcement was October 29, 2004. The list of applicants will be examined rigorously and a short list of candidates from this list will be interviewed with the selection of a best qualified candidate. We hope to fill this position within 6 months.

Question 9: The Committee asked VA for a comprehensive listing of facility level agreements related to VA medical centers' participation in local and regional disaster response planning and activities. We were told that VHA did not have that information 'readily available' and that there were thousands of different agreements that would take an extensive survey to compile. It gives the sense that EMSHG regional managers do not really have a thorough knowledge of what's going on in the field. Please explain.

Response: It is true that to gather the information on all MOUs that VA medical facilities have that are related to local and regional disaster response planning and activities would take an extensive survey to compile. These are not available from EMSHG since they do not have the responsibility to track these either at the local or National level. EMSHG, through its field staff of Area Emergency Managers, does track MOUs that VA Federal Coordinating Centers (FCCs) have with private sector hospitals participating in the National Disaster Medical System (NDMS). A listing of these MOU's was made available to the Committee in October following the hearing. We are providing it again as an attachment to these responses.

Question 10: If the VA was actively supporting a moderate number of war-related casualties and a major domestic event [terrorist or natural disaster] were to occur, what would drive the VA's priorities if a large number of beds were requested under the NDMS or other system? Is a prioritization listed in writing anywhere that would address this hypothetical situation?

Response: Under 38 U.S.C. § 8111A, VA may give a priority for furnishing care to active-duty casualties in wartime or in a national emergency, second only to that of furnishing care to veterans with service-connected disabilities. Under the specific scenario provided in the question, there is no written prioritization to guide VA, other than that just mentioned for active-duty personnel. In such a scenario, however, local VA medical facility directors are authorized to provide emergency treatment to otherwise non-eligible personnel. Also at the national level, under the Stafford Act, the President could direct VA to provide resources,

including beds, to support non-veteran/non-active-duty casualties. VA would do whatever it would be asked to do by the President at the National level, and as dictated by the situation at the local level to care for patients requiring immediate treatment. In addition, NDMS is a coordinated effort among VA, DOD, DHS/FEMA, and HHS, in collaboration with the States and other appropriate public and private entities. If VA and DOD were unable to respond to a request for a large number of beds because of war related casualties, the private sector would be expected to fill the community need. Therefore we would not expect the hypothetical situation to arise.

Question 11: Section 3 of Public Law 107-287 provided funding for the Secretary to carry out a program to develop and disseminate a series of model education and training programs on medical responses to the consequences of terrorist activities. What is the status of these educational training programs as specified in this law? How much has VA spent thus far and on what? How does VA track the number of individuals participating in emergency preparedness education programs?

Response: Under Section 3 of Public Law 107-287, VA has developed and disseminated several education and training modules and products. These products include continuing medical education (CME) accredited module on Health Effects from Chemical, Biological and radiological weapons; general guidance pocket cards on management of patients due to exposures to biological, chemical, radiological and blast/explosive agents used in acts of terrorism; modules and general guidance pocket cards on health issues and management of Post Traumatic Acute Stress Reaction (ASR) and Disorder (ASD); a short (about 15 minutes long) training video and CD-ROM titled "Medical Response to WMDs" aimed for senior managers and clinical leadership at the facilities; a video titled "When Terrorists Strike: Blast Injury Triage," which deals with the management of blast and explosion injuries; and brochures including disaster preparedness as part of daily life; emergency preparedness and decontamination in Washington D.C.; and employee awareness of the WMDs. In addition, Emergency Management Program Guidebook, which pre-dates JCAHO standards and prepares VAMCs to meet JCAHO requirements, is being updated. VA has spent \$0.5 million on these efforts. In order to obtain credits and continuing education (CE) hours, participants have to register in these courses. Thus, VA keeps track of the number individuals who elect to register in the education/training programs for credits and CE hours.

Question 12: The ability to receive and exchange medical records, including imagery, among Federal agencies could prove to be a tremendous asset in times of crisis. How far along are we in this regard?

Response: VA has made significant progress with the development of electronic medical record exchange technologies. Through close collaboration with the Department of Defense (DOD), VA has identified several technologies to support

the exchange of medical record data. Where VA serves as the contingent provider of medical care to DOD in times of national crisis, VA and DOD are major catalysts in moving the industry toward use of interoperable health information technologies that will improve health care delivery, patient safety, and support the provision of care in times of crisis. Within the Departments, the focus of this work has been on the creation of a seamless transition for those military service members who separate from service and seek care from VA.

In April 2002, the Departments adopted a strategy to develop interoperable electronic health records in 2005. This cross-cutting initiative, the VA/DoD Joint Electronic Health Records Interoperability Plan - HealthPeople (Federal), brings together the common adoption of standards, the development of interoperable data repositories, and joint or collaborative development of software applications to build a model of data exchange technologies.

As part of this Plan, the Departments are planning a series of progressive data exchange initiatives. In May of 2002, the Departments began the electronic transfer of clinical information from DOD to VA on separated or retired service members. As of November 2004, DOD has transferred clinical information on over 2.27 million prior service members to VA through the Federal Health Information Exchange (FHIE). FHIE continues to transfer clinical information from the DoD Composite Healthcare System (CHCS) to the FHIE Data Repository, where it is available for viewing by VA clinicians using VA's Computerized Patient Record System (CPRS). VA claims examiners also may access FHIE data using the Compensation and Pension Records Interchange system. The data available include laboratory results, outpatient government and retail pharmacy prescriptions, allergy information, radiology reports, admission, disposition and transfer messages, discharge summaries, consult reports, and outpatient coding elements from the Standard Ambulatory Data Record.

The Departments are presently engaged in the next step of their data exchange work, development of a real time bidirectional exchange of select data sets for shared patients. The DoD/VA Bidirectional Health Information Exchange (BHIE) leverages already developed joint DoD/VA infrastructure, IT investments, VA/DoD test facilities, and existing personnel resources to quickly create a real-time, bidirectional interface. BHIE permits a Military Treatment Facility to share clinical data capable of computational actions with any VA medical center where a shared patient presents for care. In October 2004, VA and DOD successfully implemented BHIE at the first shared site, Madigan Army Medical Center and VA Puget Sound Health Care.

Beyond bidirectional data exchange of text data in present systems, the Departments also are developing an interface between the DoD Clinical Data Repository of the Composite Health Care System II (CHCS II) and the VA Health Data Repository of HealthVet-VistA. This initiative, known as "CHDR" (Clinical

Data Repository/Health Data Repository) will support the real time bi-directional exchange of computable health data by October 2005. In September 2004, VA and DOD demonstrated this functionality using a pharmacy prototype in a lab environment. Also in September 2004, the Departments awarded a contract to assist the Departments in developing production phase CHDR to enable its use in clinical settings.

VA is also a lead participant with the Department of Health and Human Services (HHS) and DOD in the federal Consolidated Health Informatics (CHI) initiative. Pursuant to CHI, VA and other CHI participants have achieved the common adoption of 20 health data standards. VA and DOD are actively working on implementation of an initial set of messaging, pharmacy, and laboratory standards as part of their current data exchange projects. VA and DOD have established an initial joint strategy for data standards, including the completion of a target list of VA/DoD standards, which focuses on maximizing the utilization of the CHI standards in future systems development and acquisitions and influencing Standards Development Organizations (SDOs) in further standards work. This Federal government effort has the potential to catalyze industry to adopt common terminologies and standards, thereby promoting the proliferation of interoperable software technologies to support medical record sharing.

One of the standards adopted in the CHI initiative is for Digital Imaging and Communications in Medicine (DICOM) developed by the American College of Radiology and the National Electrical Manufacturing Association. DICOM delineates how images are sent, stored and how they are associated with information about the patient. Both VA and DOD have adopted DICOM standards for the storage and transmission of images. VA has medical imaging deployed throughout the country and will be providing remote access to imaging in the future. The adoption of the standards related to imaging will facilitate the sharing of medical images in the future and further enhance the clinical information necessary to effectively and efficiently provide health care.

In addition to the technological requirements to exchange medical records between VA and DOD, an important element of interoperability concerns the security and privacy of shared data. Therefore, in accordance with the various confidentiality statutes and regulations governing these records, safeguards have been implemented to ensure that the privacy of individuals is protected throughout these collaborative projects. The confidentiality statutes and regulations include the Privacy Act, HIPAA Privacy Rule, and several agency-specific authorities. In order for the Departments to have a common understanding of the authorities that allow data-sharing, a Data Sharing Memorandum of Understanding (MOU) has been constructed. This MOU, once signed, will provide a formal agreement that outlines the applicability of the HIPAA Privacy Rule and Privacy Act requirements to the sharing of medical records between VA and DOD, while protecting the privacy of the data.

Hearing Date: August 26, 2004
Committee: Veterans Affairs Committee
Member: Representative Evans
Witness: MG Lester Martinez-Lopez
Question # 1

Question: The ability to retrieve and exchange electronic medical records, including imagery, among Federal agencies could prove to be a tremendous asset in times of crisis. How far along are we in this regard?

Answer:

The Federal Health Information Exchange (FHIE) supports the transfer of electronic health information from the Department of Defense (DoD) to the Department of Veterans Affairs (VA) at the point of a Service member's separation. Data transferred includes: laboratory and radiology results, outpatient pharmacy data, allergy information, discharge summaries, admission, disposition, and transfer information, consult reports, and patient demographics. Through fourth quarter FY 04, DoD has transferred records for 2.3 million unique patients to the FHIE repository for use by VA clinicians and claims adjudicators. This increases monthly as data from newly separated Service members is added to the repository.

The Bi-directional Health Information Exchange (BHIE) will provide secure, near real-time, bi-directional access to electronic health information on DoD and VA shared patients. The initial data shared, in the first quarter of fiscal year 2005, will be patient demographic data, DoD and VA outpatient pharmacy data, and allergy information. Additional data elements that will be added in fiscal year 2005 are DoD mail order pharmacy and retail pharmacy network data, laboratory results, and radiology results. This product is currently in development and testing as part of the Fiscal Year 2003 National Defense Authorization Act Demonstration Site projects.

Recognizing the importance of medical imagery, the Departments have both adopted the Digital Imaging and Communications in Medicine (DICOM) as the imagery standard. DoD and VA are jointly developing DICOM implementation guidelines to be used across both Departments for new imagery acquisitions and developments to ensure future interagency imagery exchange.

Hearing Date: August 26, 2004
Committee: Veterans Affairs Committee
Member: Representative Evans
Witness: MG Lester Martinez-Lopez
Question # 2

Question: After you left the hearing, Jerry Mothershead told the Committee that most emergency preparedness plans that have been developed stop at the emergency rooms, and that many preparedness plans fail to follow through to other areas of the hospital such as operating rooms, for example. Has DOD planned beyond the initial point of contact with possible casualties, and developed plans that involve other areas and departments within its hospitals?

Answer:

DOD military treatment facilities (hospitals and clinics) have comprehensive, hospital-wide plans that are routinely exercised for receipt and treatment of large numbers of casualties resulting from an emergency, such as a homeland security incident, military contingency or natural disaster. All MTFs are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and meet their emergency management standards. JCAHO requires health care organizations that offer emergency services or are designated as disaster receiving stations to have an emergency preparedness program that addresses both external and internal disasters. In addition, all organizations must have an emergency management program (also known as a disaster plan) so that patient care can be continued effectively in the event of a disaster.

The Surgeons General offices of the Air Force, Navy and Army have developed extensive emergency preparedness and response policies and programs that meet and surpass JCAHO requirements.

The Air Force Medical Service uses Air Force Instruction (AFI) 41-106 "Medical Readiness Planning and Training" as their guidance for procedures pertaining to medical readiness planning, training, medical policy and local procedures for response to natural or man-made contingencies. Air Force MTFs are routinely assessed by their Surgeon General's office for mandatory compliance and include a myriad of emergency preparedness and response criteria involving all MTF departments. These include management of casualty triage and flow within the facility, facility usage, logistic and supply inventory management, and departmental teams that are ready to respond and support a mass influx of patients. Memoranda of Understanding for mutual support between Air Force MTFs and their surrounding locale are required, and the Air Force Medical Department have formed medical units that can be mobilized for response within the Installation or in support of a local community event.

The Army medical department also has a robust emergency preparedness and disaster response program, described in MEDCOM Regulation 525-4, 11 December 2000. Through the Regional Medical Centers and the Army's MTFs, policies, Emergency Medical Management Committees with hospital-wide participation, plans and standard operating procedures have been developed to manage consequences of disasters and other emergencies, and receive large numbers of casualties for care. Their preparedness and response program includes all hospital departments and emphasizes vulnerability assessments, common command structure (e.g. Emergency Operations Center), communication, management of supplies/equipment, health care provider and support personnel training, cross utilization of their providers, emergency hospital-wide drills, and annual readiness evaluation. Memoranda of Understanding have been coordinated with local operations plans for patient reception within Army MTFs and for community distribution if support is needed. The Army's Surgeon General's office has also developed Special Medical Augmentation Response Teams (SMART) that can be deployed to support an MTF or be deployed within the local community to support local response to a disaster. These include Emergency Medical Response, Nuclear, Biological, Chemical, Medical Command, Communication & Control and Telemedicine, Stress Management, Health Systems and Assessment, Burn, Aero-Medical Isolation, Pastoral Care, Veterinarian, Preventive Medicine, and Logistics SMART Teams. Army Medical Command has also incorporated the use of the National Disaster Medical System - deployable Disaster Medical Assistance Teams, Disaster

Mortuary Teams and Veterinary Medical Assistance Teams in its planning, to augment military healthcare providers in the event of a large-scale event.

A review of the JCAHO results for the past five years indicates that none of the Army's Medical Command MTFs have ever received a recommendation for improvement in any of the areas below. Several of their MTFs have received commendable comments for their efforts in Emergency Management plans and cooperation/agreements with the local civilian population have also been met and are continuously sustained. The requisite number of JCAHO mandated local MTF emergency management drills are also always met and participation in civilian initiated emergency management training endeavors receive a high priority.

Additionally, training was provided to all Army Medical Command Senior Leaders in CY 2002 on Homeland Security and Emergency Management. Training is also provided in this area each year by JCAHO staff, at the JCAHO Headquarters in Chicago, on all aspects of revised standards implementation and a significant part of the training includes Emergency Management requirements. Within the last five years, 220 Army MEDCOM staff attended this training. JCAHO Standards implementation is also taught at the majority of the courses offered at the AMEDD Center and School.

The Navy Medicine Department uses its Disaster-preparedness, vulnerability, assessment, training, & exercise (DVATEX) program, a rapid, post 9/11 effort to provide a snapshot picture of their readiness status, provide training, and conduct detailed vulnerability assessments of their hospitals and major clinics. It identifies system-wide and individual command deficiencies, thus guiding investment for further improvements. Naval MTF emergency preparedness/disaster plans involve the entire hospital staff and hospital-wide departments to receive and care for mass casualties, task organize for the requirements of the incident, and are well coordinated into the local disaster plans involving the civilian community. Depending on the MTF, this can include participation at local city, county, state, and federal levels including support for military contingencies, natural disasters, humanitarian assistance, or man-made events. Current Bureau of Medicine and Surgery doctrine for disaster planning is NAVMEDCOM Instruction 3440.4, Activity Disaster Preparedness Plans and Material for Disaster Preparedness Teams, 28 Mar 89.

Additionally, the Navy Surgeon General's Office is transforming its approach to mass casualty support through establishment of the Navy Installation Emergency Management Program (EMP). Policy will be based on 14 program standards (DODI 2000.18, SECNAV Inst 3400.17, OPNAVINST 3440.17 (draft), CNI Inst 3440.xx (draft), BUMED Inst 3440.xx (draft) that include the five phases of the National Information Management System (NIMS) (Preparedness, Prevention, Mitigation, Response, and Recovery); the DOTLMPF approach (Doctrine, Organization, Training, Leadership, Material, Personnel, and Facilities); a tiered response that incorporates risk management methodology for optimizing limited resources, and phased implementation. The EMP aligns Navy emergency management with civilian statutory code, regulations, and guidelines. This ensures Navy personnel will be OSHA certified and will be able to respond in NIOSH-approved equipment to incidents both on military installations and off-base through local immediate response or Military Assistance to Civil Authority (DODD 3025.15). Navy will also leverage heavily on the Joint Program Manager Guardian Installation Protection Program for its implementation program to provide initial equipment and training for its personnel. The Navy Surgeon General's office is developing the health service support, safety, and occupational safety and health policy for this program. Additionally, they intend to codify specific requirements based from the hospitals and clinics which will be viewed as homeland security operational platforms providing these capabilities, monitoring them through a medical consolidated assessment and status tool that will give leaders visibility of response resources and a picture of "readiness" on capabilities that Navy Medicine can provide to a military or civilian mass casualty incident.

Additionally, the three Services co-developed the Emergency Medical Preparedness and Response Course (EMPRC), a 10-12 hour Chemical Biological, Radiological, Nuclear and High Explosive (CBRNE) distance learning tool that is required of all military medical personnel, and is designated as the baseline training course. It provides the majority of didactic learning for OSHA certification for DOD health care providers. Initiated by Navy Medicine Office of Homeland Security through the Naval Medical Education Training Center, and chaired by Defense Medical Readiness Training Institute, the Tri-service CBRNE Training Committee has established training requirements, positional competencies, and learning objectives for military medicine.

**Questions from Honorable Lane Evans
To Honorable Stewart Simonson
Assistant Secretary for Public Health Emergency Preparedness
Department of Health & Human Services
Before the Full Committee Hearing on August 26, 2004
Three Years After 9/11: Is VA Prepared?**

1. What other data sources besides VA does CDC receive data on disease outbreaks for Project BioSense? Please explain the process of evaluating the information received from VA and others. What kinds of information would prompt further investigation? Are there precursors in place that help flag 'questionable' data?

Response

The CDC, through BioSense, receives ambulatory care data from VA and DoD and test orders from Laboratory Corporation of America. We are in negotiations to receive nurse call-line and pharmaceutical prescription data as well. We will soon be announcing RFPs for the provisioning of additional regional and/or local data sources.

The evaluation of data signals is based upon two algorithms designed to assess whether the number of records received exceeds the number of expected records. This analysis is performed by date, syndrome category and zip code or region. Algorithm results are monitored on an ongoing basis by staff in CDC's BioIntelligence Center (BIC).

Further investigation of "suspected" signals include database queries to compare anomalies with other data sources, calls to health departments, and calls to the data source provider as necessary.

Questionable data are flagged using the following criteria:

- Data does not meet the minimum set of data quality standards (e.g. timeliness, validity, and format). If an excessive number of these records occur, BIC staff will contact the data provider to resolve the problem.
- Data contains indicators of the possible presence of a "specific infection." If identified, these data are further investigated for validity.

We are currently developing a new component in the BioSense interface to present these analyses to the user(s) and to provide drill-down capability for revealing more detailed information.

2. Why was the Strategic National Stockpile (SNS) just recently transferred from DHS, back to HHS?

Response

After more than a year of experience operating the SNS as a joint institution between DHS and HHS, it was clear that some changes to the SNS were necessary to accommodate its evolving mission. For example, when it was created the SNS was focused on licensed pharmaceuticals and off-the-shelf items (e.g., bandages, airways, etc.) used in responding to a conventional disaster. Under Project BioShield, the SNS mission became substantially more complex. The SNS took on responsibility for handling BioShield products, like the new anthrax vaccine. When these new products enter the SNS, they will not be licensed and will require very special care in order to ensure that they can be licensed at the appropriate time. Since this is an area of expertise for HHS, it was only logical that HHS would assume more responsibility for the SNS.

3. In March 1992 at an oversight subcommittee hearing on the VA/DoD Contingency Hospital System and related issues, the HHS witness, Director of the Office of Emergency Preparedness/National Disaster Medical System, Mr. Thomas Reutershan, defined the worst case scenario as,

“an 8.3 earthquake somewhere in this country that might instantaneously, within a matter of minutes, produce 100,000 seriously injured people requiring hospitalization.”

What is the worst-case scenario you plan for today?

Response

The worst-case scenario we plan for today is an outbreak of a highly lethal and highly communicable disease – such as a naturally occurring pandemic influenza or a terrorist-perpetrated release of smallpox virus. Such an event could require hospitalization of 100,000 or more individuals and overwhelm local healthcare resources. HHS is addressing this challenge with a three-part strategy: enhancing local and state preparedness with awards to help hospitals and other healthcare entities increase their surge capacity, developing a stockpile of deployable healthcare stations that to augment local resources, and linking the local/state and national capabilities within a common concept of operations so as to ensure that they complement one another both conceptually and operationally.

4. Since the threat of that 8.3 earthquake is still there, do we have the capacity to hospitalize 100,000 seriously injured people?

Response

At present, no major metropolitan area or geographic region has sufficient organic capacity to hospitalize 100,000 victims of a natural disaster or a terrorist attack. HHS funding for local and state preparedness seeks to help hospitals and other healthcare entities achieve the capability to accommodate a surge of 500 patients per million population. This equates to accommodating a surge of patients to about 15% above normal levels. Because this level of local preparedness is necessary but not sufficient, HHS simultaneously is developing a stockpile of deployable healthcare stations that can be sent to affected areas to help establish

temporary healthcare facilities (e.g., in venues such as a civic center or indoor sports arena). The goal is to ensure that the combination of local/state resources and federal government assets are sufficient to accommodate 100,000 casualties.

*Question to Neil Livingstone:
Question Number 1*

A number of federal watchdog agencies have expressed concern regarding the security of select agents in America's BSL level 3 and 4 laboratories. The GAO and the Inspector General have issued reports expressing the need for improvement in this area. Physical security, transportation, and background checks as a prelude for access were all indicated as problems. Are Federal labs a potential threat?

Yes, federal laboratories present a potential risk if security measures are inadequate.

To determine if security at the labs is sufficient, it is necessary to regularly conduct security assessments of each facility.

In 2002, the Office of Inspector General (OIG) at the U.S. Department of Agriculture assessed security at 124 laboratories, some of which were BSL Level 3. Based on the audit, security was deemed inadequate at "nearly half" of the laboratories. Among the deficiencies, many laboratories did not keep an inventory – or kept an inaccurate inventory of – biological agents. At some facilities, access control measures were deficient. And scientists were being allowed access to labs prior to receiving clearances.

In 2004, the OIG reexamined 16 laboratories where security problems had been identified. Four of the laboratories were BSL Level 3. While security at these facilities has improved, according to a March 2004 report, it appears recommended security system upgrades may not yet be completed, posing security risks.

Because security is a dynamic process, security assessments must be conducted regularly. It is also important to periodically review threats and security requirements at laboratories to ensure they are adequate.

Finally, it would be useful to have third parties conduct security assessments of selected BSL Level 3 laboratories to validate the overall process. In our experience, security assessments by private companies can yield far different results than by government agencies.

For example, GlobalOptions was tasked by the U.S. Department of Energy to assess security at selected civilian nuclear facilities in Russia as part of the Materials, Protection, Control & Accounting Program. Our assessments uncovered major deficiencies that had been overlooked.

***Question to Neil Livingstone:
Question Number 2***

The Committee had previously asked VA for a comprehensive listing of facility level agreements related to VAMCs participation in local and regional disaster response planning and activities. We were told that VHA did not have that information "readily available" and that there were thousands of different agreements that would take an extensive survey to complete. On page 5 of your statement you discuss "VAs role in communities...." Please explain why "the devil" may be in the detail.

In a discussion with the VA about facility level agreements, it is my understanding that the agency is compiling the requested information and it will be forwarded soon to the Committee or may already have been delivered.

The VA is a signatory to a very large number of sharing agreements with local authorities involving everything from food to laundry, which are pertinent in local and regional disaster response planning and activities. All of these agreements, the VA explained, are not readily available.

However, in subsequent discussions with the Committee, it was learned that only broader agreements specific to emergency preparedness were of interest and these documents have been compiled and will be delivered to the Committee.

**Questions from Honorable Lane Evans
To Dr. Jerry Mothershead
Former Senior Medical Consultant
Before the Full Committee Hearing on August 25, 2004
Three Years After 9/11: Is VA Prepared?**

1. **A number of federal watchdog agencies have expressed concern regarding the security of select agents in America's BSL Level 3 and 4 laboratories. The GAO and Inspectors General have issued reports expressing the need for improvement in this area. Physical security, transportation, and background checks as a prelude for access were all indicated as problems. Are Federal labs a potential threat?**

As a preface, I have no first-hand knowledge of security levels or procedures at national FLS laboratories. That being said, it is reasonable to assume that these national laboratories may represent potential targets of terrorism, considering the potential collections of biological pathogens contained within them. If one accepts this premise, one must be concerned about threats from without, and from within.

I would defer to security experts to identify the necessary administrative and physical controls necessary to assure a reasonable degree of safety and security of BSL pathogens. I would opine, however, that special attention needs to be paid to the scientists and other employees of these laboratories, as both potential targets of terrorists and as intentional or unintentional terrorism collaborators:

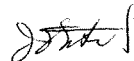
- Certainly, any individual could be the subject of hostage taking attacks. Scientists at BSL laboratories possess rather unique knowledge and experience in handling these highly pathogenic microorganisms, and the potential for kidnapping with the intent of extracting this knowledge cannot be overlooked. Information on security methods could be extracted from employees, under threat of harm or through extortion. It would be prudent to provide all BSL employees with antiterrorism training, and to ensure hiring procedures call for meticulous scrutiny of individual's backgrounds for information that could be used in blackmail schemes.
- Several cases involving national laboratories, such as Los Alamos, highlight the need to ensure that all employees are fully and regularly briefed on security and the safeguarding of information and technologies. Sloppiness of habit, and intentional or unintentional leakage, must be avoided at all costs.

2. **In your testimony you emphasized that a 'measure' of preparedness is need to determine how prepared we are. Please elaborate and give 6-8 examples of priority areas which you believe should be measured or be a standard of preparedness.**

Inasmuch as the subject testimony was focused on the Veteran's Administration, and predominantly the Veteran's Health administration, I will restrict my examples to those related to healthcare systems. Again, as a preface, certain "standards" already exist. Organizations such as the National Fire Protection Association, the Joint Commission on the Accreditation of Healthcare Organizations, and the American Society for Testing and Materials have for years developed "standards" that might be considered directly to indirectly related to homeland security and the healthcare systems participation in this venture. However, one great problem with most of these standards is that they are to a great degree subjective or are process related. Compliance with such standards thus becomes highly dependent on the evaluator's perspective.

Without claiming that the following should be the standards set (this would require consensus approval from appropriate stakeholders and subject matter experts), the following examples are provided:

1. Education and training: Rather than having a standard mandating a certain number of hours of training (as is done by CFR 1910 concerning hazardous materials), educational standards should be competency based, and an appropriate standard would be based on demonstrated competency. For example: The



individual will be able to don and operate Level A Personal Protective Equipment within 3 minutes. Another example, related to laboratory technicians, might be: The individual will be able to identify, from a set of 10 unknown properly prepared microscopic specimens, gram positive bacillus, and will be able to list all pathogens that have this morphology.

2. Detection: The hospital system will have in place an epidemiological monitoring system that will be able to determine an increase in the number of cases of (upper respiratory track infections/rashes with fever/etc.) of greater than 5% as compared to historical records, and will be able to determine this variation within 12 hours of its onset.
3. Facility security: Within 15 minutes of notification, the hospital facility will be able to secure all access points against non-forceful foot traffic.
4. Decontamination: The facility will be able to activate decontamination capabilities, including staff, within 15 minutes of notification, and will be able to conduct sustained decontamination of ambulatory and non-ambulatory victims at a rate of 20 patients/hour continuously for 8 hours without outside augmentation.
5. Evacuation: Within 1 hour of notification, the facility will be able to evacuate all staff, patients, and visitors from the physical premises of the facility. Within 4 hours of notification, all patients will have been evacuated to temporary or permanent facilities capable of maintaining healthcare operations.
6. Surge capacity: The facility will be able to increase total internal in-patient bed capacity (define as both physical space and appropriate staff) by 15% within two hours of notification, and will be able to increase total bed capacity (by a combination of internal and external resources) by 50% within 6 hours of notification of need.

The key to such standards are that they define a function or capability, and they may be objectively measures.

Concerning standards, I would like to make several additional points:

- Standards are best applied to a system, and that system must take into account all functions and participants. The requirements for decontamination of patients at hospitals will be highly dependent on the ability of first responder organizations at the scene to contain the hazard and sequester victims for on-scene decontamination.
- One critical failure of the current approach to national preparedness is the failure to clearly define jurisdictions and link expected capabilities and capacities to those jurisdictions. A jurisdiction may be defined by geography, legal order, population density, etc. and possibly the best method of defining emergency response jurisdictions would be through a formula that takes all of these into account. Once this type of jurisdictions defined, overall jurisdictional standards can be more easily set. Total hazardous materials mitigation capabilities should not be expected to be the same in Chicago as they are in New York City. However, these capabilities and capacity could be defined based on total potential population, or maximum credible event, within the jurisdiction.
- Additionally, the criticality and potential threat level within a jurisdiction should be factored in during standards development. The Navy, for example, identifies its installations by a tiered level, with higher standards required for the most critical tiers.

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9. Section 505 (adds new Sec. 5510) Annual reports. As part of the Annual Benefits Report of the Veterans Benefits Administration or the Secretary's Annual Performance and Accountability Report, detailed information on the numbers, types of benefits, and amounts paid to various categories of beneficiaries and fiduciaries is required. The annual report also must contain details on the number of misuse cases and the final disposition of such cases, to include the number of such cases referred to the Office of the Inspector General and the total amount of money recovered by the government.

10. Section 506. Annual adjustment in benefits thresholds. Provides for annual adjustment in the dollar limitations in sections 5507 and 5508 in conjunction with the annual adjustment in benefit thresholds.

11. Section 507. Effective dates. The fiduciary provisions relating to determinations of misuse and reissuance of benefits (sections 6106 and 6107) and provisions relating to reporting (section 5510) became effective the date of enactment of the Act, December 10, 2004. Interim instructions for sections 6106 and 6107 will be forthcoming. Data collection and reporting procedures are also being developed. The other fiduciary provisions become effective on the first day of the seventh month beginning after the date of the enactment of the Act, July 1, 2005.

Implementation of Statutory Changes

Although regulations will be published, it is not necessary for changes in the regulations to be completed to apply the provisions of the Act. They should be put into effect immediately unless they have a delayed effective date.

Questions?

Questions regarding these changes should be submitted to the Q&A mailbox at VAVBAWAS/CO/21Q&A by the station Question Coordinator (see Fast Letter 02-04).

This letter is rescinded January 1, 2006.

/s/

Renée L. Szybala, Director
Compensation and Pension

Service

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Attachments (3)

**ATTACHMENT 1
LANGUAGE FOR TRANSITIONAL BENEFIT AWARD
LETTERS**

Public Law 108-454 has created a new two-year benefit for surviving spouses entitled to Dependency and Indemnity Compensation (DIC) who have children under the age of 18. Your award includes an additional \$250 per month for each month beginning on or after January 1, 2005, that is part of your first two years of benefits. Your entitlement to the additional \$250 monthly benefit ceases whenever the first of the following events occurs

- two years have passed since you began getting DIC benefits, or
- your last minor child turns age 18, or
- your last minor child is removed from your award.

ATTACHMENT 2

Sample Letter to Retired Pay Center

Refer to: VA Method A Calculation Request

Payment Center:

The Department of Veterans Affairs has found [insert name, claim number, and social security number] 100% disabled from [insert effective date].

Evidence in our records indicates [insert name] is a medically retired service member with 20 or more years of service for retirement purposes. Please tell us the gross amount of monthly retired pay the veteran is entitled to and the amount he is entitled to based **solely** on longevity for all periods beginning (insert January 1, 2005, or the effective date of the new or increased award, whichever is later). This information will be used to determine the amount, if any, of retroactive benefits payable.

Please fax a response to this fax to VA Regional Office (insert name) at (insert fax number) attention (insert the name of the appropriate employee).

Name
Service Center Manager

ATTACHMENT 3**Veterans Benefits Improvement Act of 2004 (PL 108-454)**

The following provisions, while not directly affecting compensation or pension programs, are provided for your information and the use of your staff working in the Public Contact Team and in TAP, DTAP, and other outreach activities.

Title I: Veterans Earn and Learn Act***Modification of benefit entitlement charges for certain on-job training programs***

Section 102: Modifies the computation of on-job training and apprenticeship benefit entitlements under the Veterans' Educational Assistance program (chapter 34) and the Survivors' and Dependents' Educational Assistance program (chapter 35) to be the same as the entitlement charged under the Montgomery GI Bill (MGIB)-Active Duty program (chapter 30) and the Post-Vietnam Era Veterans Educational Assistance program (chapter 32) of that title, as well as under the Selected Reserve MGIB (chapter 1606 of title 10, U.S.C.) program. This amendment authorizes VA to charge the entitlement proportionately based on the monthly benefit rate paid rather than one full month of entitlement for each month of training. This provides needed uniformity in calculating use of entitlement for such training regardless of the benefit chapter under which a student is eligible, resulting in greater equity for veterans. This amendment is effective with respect to months beginning after September 30, 2005.

Increase in benefit for individuals pursuing apprenticeship or on-job training

Section 103: Temporarily increases by 10 the percentage of the full-time monthly institutional rate of educational assistance allowance that is payable for apprenticeship or other on-job training under the MGIB-Active Duty and Selected Reserve programs and the chapter 32 program. It further increases the educational assistance allowance for such training under chapter 35 for the first six months of training from \$574 to \$650; for the second six months of training from \$429 to \$507; and for the third six months of training from \$285 to \$366. This amendment is effective for months beginning on or after October 1, 2005, and before January 1, 2008.

Authority for competency-based apprenticeship programs

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Section 104: Codifies VA's authority to pay education benefits for competency-based apprenticeships. This section allows State approving agencies (SAAs) to approve apprenticeship programs that are competency-based and of variable length. It requires SAAs to take into consideration the approximate term of the program recommended in registered apprenticeship program standards recognized by the Secretary of Labor. Apprenticeships offered in industries that choose not to register with the Secretary of Labor, and that are approved for veterans' training by a State approving agency, will continue to be available. It also authorizes VA to use up to \$3 million to develop the computer systems and procedures needed to carry out the above provisions of the bill. Prior law permitted approval of only time-based, fixed-length apprenticeships. The 1990's saw a steady move away from time-based apprenticeships toward competency-based apprenticeships.

Availability of education benefits for payment for national admissions exams and national exams for credit at institutions of higher education

Section 106: Authorizes use of education benefits under chapters 30, 32, and 35 to pay for national admissions examinations (e.g., the Scholastic Aptitude Test, law School Admission Test, Graduate Record Exam, and Graduate Management Admission Test) and national tests for course credit at institutions of higher learning, such as the Advanced Placement exam and the College-Level Examination Program. The benefit payment is the amount of the fee charged for the test, not to exceed the individual's remaining entitlement. The number of months of entitlement charged is equal to the amount charged for the test or examination divided by the full-time basic benefit. However, in calculating the amount of MGIB entitlement to charge for this benefit, chapter 32 kickers and the additional contribution (buy-up) amount are not included.

Pilot program to provide on-job benefits to train Department of Veterans Affairs' claims adjudicators

Section 108: Permits eligible individuals to receive VA education benefits under a pilot program established by VA to furnish on-the-job training to VA employees to become claims adjudicators in VA's disability compensation, dependency and indemnity (DIC), and pension programs. The pilot program would permit on-the-job training programs of up to 3 years.

Collection of payment for educational assistance under Montgomery GI Bill from members of the Selected Reserve called to active duty

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Section 109: Directs the Department of Defense (DOD) to collect from members of the Selected Reserve who are called to active duty \$1,200 as a precondition to such member's entitlement to educational benefits under the Montgomery GI Bill (MGIB). Prior law required that the \$1,200 be collected by basic pay reduction when the reservist first enters on active duty. This section gives DOD the authority to collect the \$1,200 by any means (not just a pay reduction) within 1 year after the reservist completes the 2 years of service on active duty that is the basis for entitlement. VA notes that DOD's collection responsibility under this bill extends to members of the Coast Guard Reserve, which is under the jurisdiction of the Secretary of Homeland Security.

Title II: Employment Matters

Two-year period of continuation of employer-sponsored health care coverage

Section 201: Amends section 4317 to extend from 18 months to 24 months the period for which a person may continue coverage under an employer-provided health care plan if they are absent from employment due to service in the uniformed services.

Requirement for employers to provide notice of rights and duties under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

Section 203: Adds a new section 4334, which requires employers to post a notice regarding the rights, benefits, and obligations of persons and employers under chapter 43, pertaining to employment and reemployment rights of members of the uniformed services.

Note: The United States Department of Labor assists persons claiming rights under USERRA. The Department of Labor has posted extensive information about the USERRA and other matters relating to veterans' reemployment rights on the website: <http://www.dol.gov/vets/welcome.html>.

Title IV: Housing Matters

Increase in maximum amount of home loan guaranty for construction and purchase of homes and annual indexing amount

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Section 403: Increases the maximum VA housing loan guaranty from \$60,000 to 25 percent of the Freddie Mac conforming single-family loan limit, as adjusted annually. Effective January 1, 2005, Freddie Mac rate is \$359,650, except in Alaska, Hawaii, Guam, and the Virgin Islands, where it is 50 percent higher. The current Freddie Mac produces a guaranty of \$89,912. VA's guaranty will be automatically adjusted annually in tandem with the Freddie Mac limit.

Extension of authority for guarantee of adjustable rate mortgages

Section 404: Revives the Adjustable Rate Mortgage (ARM) program authorized by section 3707 with a sunset date of September 30, 2008.

Extension and improvement of authority for guarantee of hybrid adjustable rate mortgages

Section 405: Modifies the current Hybrid ARM program authorized by section 3707A.

Subsection (a) extends the sunset for this program from September 30, 2005, until September 30, 2008.

Subsection (b) modifies the rules for interest rate adjustments on Hybrid ARMs. On such loans where the interest rate remains fixed for an initial term of 5 or more years, VA is granted the authority to specify the maximum initial rate adjustment. This section also allows the Secretary to specify the maximum lifetime interest adjustment.

Termination of collection of loan fees from veterans rated eligible for compensation at pre-discharge rating examinations

Section 406: Waives the loan fee for any veteran who has been rated eligible to receive compensation as a result of a pre-discharge disability examination. Prior law waived the fee only if the veteran was actually receiving compensation or would be entitled to compensation but for the receipt of retirement pay. The prior law did not waive the fee for service-connected disabled personnel who received such a rating but purchased a home while awaiting formal discharge.

Three-year extension of Native American veteran housing loan pilot program

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Section 407: Extends the sunset for the Native American Veteran Direct Loan program, sections 3761 - 3764, from December 31, 2005, to December 31, 2008.

Title VII: Improvements to Servicemembers Civil Relief Act

Clarification of meaning of "judgment" as used in the Act

Section 701: Amends section 101 of the Servicemembers Civil Relief Act (SCRA), 50 U.S.C. § App. 511, by adding a definition of the word "judgment." This term, for purposes of the SCRA, is defined as "any judgment, decree, order, or ruling, final or temporary."

Requirements relating to waiver of rights under Act

Section 702: Amends section 107 of the SCRA, 50 U.S.C. App. § 517, to require that, to be effective, any written waiver of rights under the SCRA concerning modification, termination, or cancellation of a contract, lease, or secured obligation must be in writing and in an instrument separate from the obligation or liability to which it applies. This provision also adds a new section 107(c) to the SCRA requiring that any waiver of a right or protection under that statute applicable to a contract, lease, or similar legal instrument must appear in at least 12-point type.

Right of servicemember plaintiffs to request stay of civil proceedings

Section 703: Amends section 202(a) of the SCRA, 50 U.S.C. App. § 522(a) to enable servicemembers who are plaintiffs in litigation to seek a stay of judicial proceedings as authorized under the SCRA. Previously, the law provided only servicemembers who were defendants the opportunity to obtain such a stay.

Termination of leases

Section 704: Amends section 305(a) of the SCRA, 50 U.S.C. App. § 535(a) to clarify that when a servicemember terminates a residential or motor vehicle lease entered into jointly with a dependent, the obligations of both the servicemember and the dependent are terminated. This provision also amends section 305(b) of the SCRA to clarify provisions governing the termination of a motor vehicle lease upon a servicemembers' change of station and to provide for termination of a residential or motor vehicle lease upon an individual as well as a unit deployment.

NOTE: The Department of Defense (DoD) is the Federal agency primarily responsible for these provisions of the

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SCRA. Veterans who raise questions pertaining to possible violations of these provisions should be encouraged to contact DoD.