Statement for the Record

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Mr. Chairman, Congressman Dent, and Members of the Subcommittee:

I would like to take this opportunity to speak to you on behalf of the team commanders and the approximately 8,000 professionals who comprise the 107 response teams of the National Disaster Medical System (NDMS). I hope to be able to convey to you in this short time the incredible amount of work and sacrifice these members put forth in their service to our nation, and specifically, to the citizens and their families impacted by disasters, both natural and man-made.

You have asked me to address the role of Disaster Medical Assistance Team (DMAT) commanders and the coordination of the federal response teams with state and local operations. Much of what I will relay to you will be from the perspective of my own team's experiences, or the experiences that I have had working with the Management Support Team, a part of the NDMS Incident Command infrastructure that supports the teams when deployed in the field.

Since 1979, I have served in the Fire Service and Emergency Medical Services. In my role as a Fire Department EMS Captain, I recognize the need for a disaster medical resource outside the immediate state and local community at the time of a major disaster. NDMS fills that unique niche with trained, equipped and uniformed disaster medicine specialists.

I came to the position of DMAT commander 16 years ago, when the Office of Medical Readiness at Wright Patterson Air Force Base (WPAFB) in Fairborn, Ohio, came to the members of the Greater Miami Valley Emergency Medical Services Council with a request for our support in the formation of a Disaster Medical Assistance Team in the Dayton, Ohio, area. As a Federal Coordinating Center for NDMS, WPAFB was completing contingency planning in the face of thousands of potential military chemical casualties returning from the Desert Storm conflict. The reception and care of military patients is just one facet of NDMS, while the more common use of the teams has been in caring for civilian patients, animals, and the deceased following a major disaster. While DMATs comprise the greatest share of the response team assets, NDMS is significantly broader in its overall capabilities.

DMATs provide temporary medical care to the victims of disasters or public health emergencies. In addition to the standard team, which deploys as a 35-40 member unit, specialized teams and equipment are available to provide surgical capability, as well as burn, pediatric, and mental health specialties, and even teams capable of providing care in hostile Chemical, Biological or Radiological environments.

Veterinary Medical Assistance Teams (VMATs) support states in the care of animal victims of disasters. They are also an invaluable resource to DMATs, due

to their expertise in the zoonotic diseases, which represent the greatest threat to humans as potential biological weapons.

Disaster Mortuary Operational Response Teams (DMORTs) provide Disaster Portable Morgue Units (DPMU), forensic specialists, and family assistance personnel to assist local medical examiners in working with the victims of mass fatality incidents and their families.

I have told you how DMAT OH-5 started, but if you study the response teams nationally you find a variety of origins that led to their development. Teams were started by university medical schools, as the result of a specific mass casualty incident in the community, or as part of a state's emergency management planning activity to name a few. Although teams have evolved from a variety of backgrounds, NDMS has molded the various teams to be uniform in their composition, equipment, credentialing and resource-typing.

Under the early System, each individual deployment initiated a hiring process for team members, who were then terminated upon its completion. Today, team members are appointed as Federal Intermittent employees, essentially employees who are on the federal rolls "on call," who then clock in at the beginning of an assignment and clock out when they return home. These intermittent appointments provide the process to validate and maintain professional credentials, but also allow for the extensive day-to-day team

operations of training and maintaining specialized equipment to be able to deploy a team within hours of activation.

The experience of my team and its development is unique, but it parallels that of other teams. Our initial challenge was the recruitment of medical professionals and support personnel to be able to field a team capable of providing medical care in an austere environment. With the support of the Greater Dayton Area Hospital Association, we were able to staff and train a core group, and most of them still remain as members of the team today. The Veterans Affairs Medical Center (VAMC) in Dayton provided guidance on obtaining surplus medical equipment through the Defense Reutilization and Marketing Service, and gave us access to VAMC facilities to both store our equipment and conduct exercises. When we achieved the requisite staffing and readiness, we became eligible for a federal cache of medical and logistical equipment. This brought with it its own challenges to be able to transport, store and maintain the equipment. Today, as an Operational DMAT, our team has three box trucks and a 6,000 square foot warehouse where we keep our federal vehicles and equipment.

The Committee's request for my testimony today asked about the role of the DMAT Commander, and how our services are coordinated with state and local operations.

The role of the DMAT Commander has several key elements, including:

- Serving as the manager responsible for intermittent government employees under his/her command and the federal property assigned to the team.
- Representing NDMS in the local community; often serving in a leadership role in disaster planning for public health and broader emergency management functions.
- Occupying a public or private professional position in the local community: Emergency Physician, Registered Nurse, Hospital Administrator or Emergency Services Officer.

This latter local community role is the primary occupation of the team commander. This is important to keep in mind because the local position is both complementary and competitive to the role of team commander. Should a disaster or public health emergency occur locally, this individual more often that not has associated duties in that local community. This is in essence the reason for the NDMS Response Teams – the ability to bring in outside medical resources to a community with insufficient local resources during a disaster. This is further complicated because many of the NDMS teams started as a local resource, and continue to play a role in state or local emergency management plans. The disaster medical resources of this nation are limited in nature. Participation of a team member in a local employer's disaster plan, in a state or local emergency management plan, and in an NDMS Response Team presents a confusing scenario when determining how many disaster medical personnel

truly exist. An emergency planner must be careful not to count the same responder more than once.

Because NDMS Response Teams often developed as a local resource, there is an associated local attitude of “ownership,” even though financial support and equipment is essentially federal. This has caused some states to turn to creating state disaster medical teams in order to maintain command and control over a local resource. Some of these teams then compete for the same medical professionals needed by a DMAT. Better coordination of the state and federal role of a team could minimize this duplication.

When deployed to a disaster, NDMS Response Teams truly demonstrate their expertise. Teams follow an organized rotation schedule, and several times a year pre-plan a roster of available personnel to respond as needed to disasters. If a disaster occurs, they “ramp up” in anticipation, but wait for deployment orders to activate team members. Variables like distance, the medical services required, and whether an on call team is impacted by the incident combine to determine what teams are sent on a deployment. Some events like a hurricane provide a pre-planning timetable, with the ability to pre-position teams in a response location close to the storm’s landfall, but safe from the impact of the storm. In fact, significant NDMS resources were pre-positioned prior to the landfall of Hurricanes Katrina, Rita, and Wilma, then moved to the impacted areas as needs were identified and the travel routes cleared.

Once in an assignment, the team is often positioned in a location where a hospital formerly operated, or where the demand for medical care exceeds what the local medical facility can provide. In a matter of hours, the DMAT sets up in a parking lot or standing structure, and starts to see patients. The team is designed to have sufficient logistical and medical supplies for up to 3 days. In these early hours and days, it is easy to define our role in medical care, as we are often the only option available. However, if and when the local community sees its infrastructure come back into operation, the team leadership works under the direction of the Incident Command Medical Officer and the HHS regional personnel, who in turn work with state and local officials to reach agreement when the team can withdraw. The team commander plays a key role in this decision, providing input on the number and acuity of patients seen, and what local alternative resources are available to treat patients. Incoming teams are often viewed as the "cavalry," the federal response coming to the rescue in a disaster. Teams easily take charge in this environment of chaos because they bring discipline, training, and experience. The role of the NDMS Response Team, however, is to *maintain control* in the incident without *taking control* of the incident. The teams are a temporary supplement to that local community's healthcare system.

Most of the committee members are no doubt aware of the shortage of medical personnel across the country. When the members of our teams leave for a deployment, hospitals and employers back home double-up shifts and fill in for those team members who are deployed. Although NDMS Response Team

members enjoy USERRA coverage associated with their deployment, there can still be negative feelings back home, both with employers and the co-workers who cover their shifts. Hurricanes Katrina and Rita were especially challenging in this respect because of the multiple or extended deployments of team members. Team leadership is often faced with explaining to local employers why team members are being utilized, and reassuring those same employers that their employees' NDMS service is essential to the disaster response.

While team members are deployed, family members go without hearing from their loved ones, and endure the associated media blitz detailing all the problems and dangers in the affected areas. This places stress on the family members, and needs to be addressed by the non-deployed team members with a family support structure. This was especially important for families during responses associated with the 9-11 attacks.

I would be remiss in my duty to my fellow team commanders, if I did not take this opportunity to tell the members of your committee how you can support us in our mission.

Whether it be the response to the events of 9-11, the multiple hurricane responses of the 2004 and 2005 hurricane seasons, or the vigilant preparedness of our specialized Weapons of Mass Destruction response assets, the need for our services and the time and effort expended to improve our readiness have significantly increased over the past five years. Unfortunately, we have not seen our resources increase with these demands. The NDMS program budget

specifically has remained flat since 2003. Looking forward, the Pandemic and All-Hazards Preparedness Act (P.L. 109-417) addresses new areas for which teams must prepare:

- Specific planning for the "at-risk individuals" in a disaster response.
- Specific planning for inclusion of the Medical Reserve Corps in coordinated response plans and exercises
- Additional training of team members in the National Response Plan and the National Incident Management System

The recent Pets Evacuation and Transportation Standards Act of 2006 will require VMATs to work with state governments and other national animal service agencies to define how disaster responses will coordinate veterinary and animal rescue efforts.

I know that the FY 2008 DHHS budget request calls for a modest $6 million increase in the NDMS budget. I can tell you from the perspective of the team commander that these funds and more are truly needed, and have the potential for a tremendous payback to the taxpayer. In the shadow of some of the most significant disasters this country has ever witnessed, I think we are in a unique position to argue the value of this type of preparedness.

The additional provisions of the Pandemic and All-Hazards Preparedness Act are equally important with respect to their emphasis on local planning and preparedness. NDMS Team Commanders experience first-hand the ability to

integrate operations in an impacted state where robust Department of Health and Emergency Management Agency disaster planning exist. Local preparation for known hazards is especially important for successful outcomes in the real event.

We in NDMS are an unusual entity in the federal government, in that many of us deal with citizens, one at time, whose daily lives have been shattered, either as patients, victims, or affected family members. This provides us with a unique hands-on perspective in disaster medicine, and provides the federal government with an unusual personal role in their care. Providing the best care possible in these conditions is our passion, and it is what drives us to train and prepare for the call. We are grateful for the opportunity to serve.

I thank you, Mr. Chairman, and the Members of your Subcommittee for your attention. I hope I have been able to provide you with a clear picture of the role and duties of an NDMS Team Commander.

This concludes my testimony. I would be happy to answer your questions.