Statement of

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Good afternoon, Chairman Pryor, Senator Sununu, and distinguished Members of the Subcommittee. It is my pleasure to address you today on behalf of the nation's 2800 local public health departments, who work on the front lines to protect their communities from pandemic influenza, as well as a multitude of other public health threats. I serve on the Board of Directors and am Vice-Chair of the Metro Forum of the National Association of County and City Health Officials and have had an opportunity to learn from my colleagues across the country. In Memphis and Shelby County, where I have served as health director for 12 years, I have been deeply engaged in pandemic influenza preparation and response activities. Today, I am happy to report to you on the progress made by local health departments and their community partners. I will also discuss how we believe the federal government can improve current national pandemic influenza preparedness.

The combined efforts of local health departments and our colleagues in first response will determine the initial, as well as the ultimate impact of an influenza pandemic on the people of the United States. The success of our plans relies on the crucial linkages that we are building between local public health departments and a range of governmental and community partners. Relationships among responders in many disciplines and sectors across our local communities, regardless of who their federal counterparts may be, are growing more robust and better coordinated. If we are to protect the health and well-being of our communities adequately, we have no choice but to reach out, engage, communicate and cooperate with our local partners. This activity requires a sustained effort by all partners because our job of training, exercising, and improving will never be complete.

We all recognize that pandemic influenza will not respect geographic borders. The Memphis and Shelby County Health Department is a grantee for HHS' Cities Readiness Initiative and we partner in multi-jurisdictional planning for rapidly distributing pharmaceuticals in a public health emergency. We will lead the distribution of medication to an eight-county area that includes jurisdictions in Arkansas, Mississippi and Tennessee. This initiative gives us the opportunity to strengthen our collaborative efforts with our neighbors, particularly those across state borders, something that's been long overdue

Pandemic Influenza Preparedness Must be Integrated into All-Hazards Preparedness

Local emergency preparedness is based on an 'all-hazards' approach. This approach requires communities to assure the essential capabilities necessary to respond to a wide range of emergencies including intentional or naturally occurring infectious disease outbreaks; chemical, explosive or radiologic accidents or attacks; weather-related disasters; earthquakes; or other unexplained events that affect the health of the public. .

Since 2001, with the elevated awareness of the country's vulnerability to intentional attacks with biological agents, there has developed a better understanding of public health's unique role in protecting our homeland. Regardless of the nature of the threat,

there is a core of universal public health response capabilities for which all local health departments across the country are planning, training, exercising and engaging in a process of continuous evaluation and improvement.

The Memphis, Tennessee Metropolitan Statistical Area (MSA) has a combined population of 1.25 million. We are concerned about many potential threats. Our jurisdiction is home to the world's largest and busiest cargo airport and the enormous jet fuel tanks required to service the planes, as well as a major river port, over 400 trucking companies, a refinery, and two major bridges over the Mississippi River. Public health has a role in responding to a catastrophe involving any of these, as well as a lead role in addressing pandemic influenza or any disease outbreak with the potential to cause preventable illness and death. Many of the capabilities and relationships we build as we prepare for all hazards are pertinent to our pandemic influenza preparation.

Our capabilities were tested when we helped take care of thousands of evacuees from Hurricane Katrina. Memphis and Shelby County mounted an enormous response. We mobilized our health department staff and volunteers to provide 24-hour medical and nursing care in the shelters, to keep track of available hospital beds and make proper referrals for displaced citizens who needed hospitalization, to monitor for disease outbreaks among the evacuees, to ensure pharmaceutical needs were met and to do just about anything else that needed to be done. This experience taught us, among other things, the critical importance of unified incident command and good communication among responders.

Just as there is a public health role during natural disasters, so are there roles for other responders in public health emergencies. Local health departments do not and cannot stand alone. All planning and response is and must be integrated with other local entities, most notably public safety first responders, but also state, federal and non-governmental partners. In May of this year, we conducted a large pandemic influenza tabletop exercise that brought together 86 people representing the range of community partners in preparedness, including elected officials, public safety responders, hospitals, the airport authority, schools and colleges, media, community service organizations and businesses. By working through a hypothetical scenario of an influenza outbreak, each sector had an opportunity to identify its strengths, as well as areas for improvement. For example, we're confident of our ability to coordinate centrally through our Emergency Management Agency and to utilize our well-defined disease surveillance system. Areas for improvement include outreach to businesses, the preparedness of nursing homes, and communication to culturally diverse segments of our population.

Public health has learned the importance of a shared command and management framework to a coordinated community emergency response. With its strong foundation in the Incident Command System (ICS), the broader National Incident Management System (NIMS), developed under Homeland Security Presidential Directive 5, provides this common underpinning for all public health and public safety preparedness, including pandemic influenza. Adoption of NIMS is facilitating the integration of language,

organizational and service models and even certain cultural aspects of public safety by public health professionals.

Every staff member of our health department has been trained in NIMS and learned this new language and approach. We have grown accustomed to planning and exercising within an incident command system. We now understand these concepts as well as our other partners in public safety. The health department also participates in a multi-disciplinary, multi-jurisdictional Urban Areas Homeland Security Initiative (UASI) working group to enhance overall regional emergency preparedness and response capabilities.

Key Elements of Front Line Pandemic Influenza Preparedness

1. DISEASE SURVEILLANCE

The purpose of a strong disease surveillance system is early detection in order to create time in which to intervene and eliminate or mitigate threats, as well as to monitor the progress of an epidemic. In local public health, practical disease surveillance traditionally means a system by which clinicians in private practice or in hospital settings can rapidly detect and report a novel flu virus or a patient who is suspected to have a reportable disease or an unusual case presentation to a public health authority capable of receiving, interpreting and responding to such a report. Ultimately, the country may reach a point where electronic medical records and associated systems will enable universal and automatic reporting of diseases or suspicious symptoms, but such capability will be immensely challenging in our intensely diverse and complex national environment. We cannot wait, nor can we depend solely on technology when so much is at stake.

Local health departments are the ‘boots on the ground’ elements of our nation’s disease surveillance system. My health department receives and responds to thousands of infectious disease reports each year. We also use three methods of surveillance for early recognition of an illness or outbreak of disease. These include monitoring emergency room visits, school absenteeism records, and sales of over-the-counter drugs.

We receive emergency room data daily from four hospitals and upload the data into the Early Aberration Reporting System, a system developed by the Centers for Disease Control and Prevention (CDC). When the system detects a higher number of cases of a particular illness than we would expect, we begin a preliminary investigation. We are also in constant communication with infectious disease practitioners at hospitals to identify possible disease outbreaks. We plan to recruit all the hospital systems in our area to participate. During a pandemic, our epidemiologists would watch for an unusual number of people having syndromes associated with influenza.

We also search for disease outbreaks by monitoring daily electronic reports by 80 drug stores in Shelby County of sales of antidiarrheal medications and cold remedies. In

addition, Shelby County schools send us absentee records for about 47,000 students in 49 schools so that we can investigate further if there are unusual spikes in absenteeism.

These systems help us detect disease outbreaks of all kinds, in addition to their utility for detecting, tracking and stopping an influenza outbreak. Using them, we have successfully identified unreported cases of West Nile virus, meningitis, and three gastrointestinal disease outbreaks.

2. COMMUNITY AWARENESS & SELF-SUFFICIENCY

One thing that we understand about a pandemic is that there will never be enough hospital beds to take care of the sick. We can predict that we will be asking both the sick and the well to stay home to help stem the spread of pandemic influenza. But we also know that our community needs early education, rapid communication and preparation so they will understand this if a serious epidemic occurs. Reaching every Memphis and Shelby County resident in a meaningful fashion is a huge task. We can't do it all at once, but we work at it consistently through community outreach and use of the media because we believe that community understanding and cooperation will be absolutely essential in reducing the toll of a pandemic.

3. COMMUNITY INFECTION CONTROL

Over the past several years, the legal foundation required for public health to adequately protect the public in a catastrophic health emergency has been significantly strengthened in many states. Both state and local health departments have closely examined our respective responsibilities to isolate and/or quarantine persons, to control private property, or otherwise to intervene in private activities. All these would be unprecedented actions, requiring enormous pre-planning.

Our department is currently working with CDC, Homeland Security, the county airport authority and state and local public health authorities to address how we would deal with a situation where incoming passengers would need to be quarantined. Our first challenge is to identify a location for sheltering those in quarantine, and we expect to use our Hurricane Katrina experience in planning how best to care for passengers.

4. MASS DISTRIBUTION OF VACCINES AND MEDICATIONS

Timely development of an effective vaccine, in sufficient quantity to immunize the population against a novel virus, is a huge challenge that the Federal government has taken important steps to confront. Local health departments are responsible on the ground for accepting delivery of the Strategic National Stockpile in which such a vaccine or anti-viral medications would be stored. Mindful that we do not now have the ability to manufacture sufficient quantities of such countermeasures, we must still have in place all of the planning, staffing and public information systems necessary to promptly distribute them to all priority populations in the county. In Memphis and Shelby County, we have a detailed plan for using 20 Points of Distribution (PODS) to distribute antiviral or

antibiotic medications in a public health emergency. The plan has roles for schools, fire departments, police departments, emergency medical systems, hospitals, Medical Reserve Corps volunteers, and the local transportation authority.

While we've not experienced a pandemic flu, local health departments have had parallel experiences and exercises that have tested our ability to provide mass vaccine and medication distribution. During the 2004 seasonal flu vaccine shortage, with delayed shipments causing the public to become extremely anxious to get their flu shots, our health department administered 2,875 doses to seniors and other vulnerable citizens in two days, using both staff and Medical Reserve Corps volunteers.

People are Key to Preparedness

Prior to 9/11, many local health departments were open only during conventional business hours. Unlike fire or police departments, there was no tradition, structure, or funding for operating 24/7. That has changed. Now we all have 24/7 coverage and an ability to call out our staff regardless of the hour. But we do it mostly by increasing expectations for existing staff.

One characteristic of all the operational capacities needed for effective pandemic influenza planning I have described above is that they are labor-intensive. While we do need to make certain capital purchases in public health, such as communication equipment and personal protective gear, the bulk of our costs are for people. It is people who do the collaborative planning in the cities and counties and work closely with their state counterparts. It is people who learn new skills for their new roles in preparedness. It is people who educate the community. It is people who reach out to hospitals, businesses, schools, and all the non-governmental organizations whose help we need to prepare our communities for a pandemic.

The structure and funding of the nation's pandemic influenza preparedness efforts simply do not recognize this reality. A NACCHO survey showed that the average grant received by local health departments nationally for all-hazards public health preparedness declined by 20% from FY 2005 to FY 2006. Supplemental federal funds for state and local health department work specifically in pandemic influenza preparedness will terminate in August 2008. We are deeply worried that, as federal priorities change, our ability to sustain the workforce that must continue the complex job of preparedness will diminish. Our funding for all-hazards public health preparedness has been eroding steadily.

Volunteers in Preparedness

In Memphis and Shelby County we are particularly proud of our progress in developing a trained cadre of volunteers who would help us in a pandemic or other emergency. We have a Medical Reserve Corps of more than 2,700 registered volunteers, including physicians, nurses, pharmacists, dentists, mental health professionals, and many others. MRC members have a variety of skills and fill many roles. All trained volunteers have picture identification cards and have received basic orientation and preparedness training.

We have used them in our Katrina response and mass influenza vaccination drives. Each volunteer is familiar with our basic response plan and understands where to report in an actual activation. Our MRC volunteers also fill non-emergency roles to help us serve our community – as "buddies" for seniors applying for Medicare Part D, in community health fairs, and most recently during this summer's heat crisis.

The MRC program, a project of the Office of the U.S. Surgeon General, is an invaluable resource not just in Memphis and Shelby County, but also in communities nationwide. Following the tragic bridge collapse in Minnesota, three local MRC units provided psychological first aid and support to families of the missing. In Indiana, a local MRC assisted the local health department with a lead screening clinic in response to the recent mass recall of contaminated toys. Following the severe weather this spring in Kansas, three MRC units spent more than 250 hours helping the local health department deliver more than 2,000 tetanus shots to community residents. Today, there are more than 700 MRC units and 145,000 medical and non-medical volunteers organized and trained to address a wide range of challenges from public health education to disaster response.

Federal Leadership

It is a positive step that so many in this country are paying attention to pandemic influenza before we find that threat a reality. We often tend to focus on the last event, but in this case the focus has been on being proactive—a fact which is evidenced by the very existence of this hearing. Your leadership on this issue is appreciated.

However, there doesn't always appear to be cooperation and coordination between preparedness planners at the Federal level and those working at the local and state levels. In addition, the Department of Homeland Security (DHS) has made progress in understanding and integrating public health in fits and starts. Initial efforts toward fulfilling HSPD-8 showed limited understanding of what public health even was and how it would mount a response in an incident.

NACCHO has long been concerned that DHS planners, unlike their state and local counterparts, have little appreciation for the local public health role in pandemic influenza response and for the kinds of local operational realities I have described above. The vast assortment of DHS committees and task forces have only a smattering of public health representation and the opportunities for meaningful input have been scant. We respectfully suggest that, while including representation from the Department of Health and Human Services in DHS work is important, it is not an effective substitute for gaining the input of public health departments who are doing the operational planning every day.

For example, we share the frustration of many local and state officials about their lack of representation in the revision process for the National Response Plan (NRP), which will govern response to pandemic influenza, as well as all other national emergencies. DHS tasked 12 workgroups to focus on specific issue areas of the NRP. One of these workgroups focused on 'State and Local Roles and Responsibilities," but had only six

state government representatives and no local government representatives, compared to a group of approximately 40 federal representatives. None of the state representatives were public health officials. If DHS intends the new National Response Framework to address pandemic influenza effectively, local and state governmental public health experts should be engaged at the beginning, not during a comment period at the very end.

The input of local responders in public health and every other discipline of public safety must be brought to bear on DHS plans and guidance in a manner that enables serious listening and timely input. That is the only way to bridge the federal gulf between traditional emergency response and public health emergency response. At the local level, we believe that public health and its public safety partners understand the true meaning of "all-hazards" preparedness, as well as the special place that pandemic influenza planning has within that context. We strongly urge improvements in this regard at the federal level.

Federal agencies need to collaborate in sending coordinated and reinforcing messages to all grantees at state and local levels that multidisciplinary cooperation is a high priority. Through the structure of grant programs and the guidance provided, DHS and HHS can either facilitate local efforts in that regard or hinder them with inconsistent guidance. HHS guidance for public health emergency preparedness has been incorporating many dimensions of the NRP, such as required training in the National Incident Management System. In general, however, federal agencies are developing and disseminating uncoordinated, fragmented, and dissimilar plans for addressing pandemic influenza.

For instance, recently released HHS/CDC guidance for state and local preparedness lists eight required critical tasks to prepare for isolation and quarantine and HHS is working on performance metrics. DHS has a published a Target Capabilities List for Isolation and Quarantine that includes over 60 critical tasks, with associated performance measures. The result is a mixed message to local planners.

In addition, the HHS 2007 grant guidance for pandemic influenza includes specific requirements for health departments. The 2007 DHS guidance for state and local emergency management offices does not address pandemic influenza. Joint, fully consistent requirements for planning and exercising by DHS and HHS grantees for pandemic influenza would be a more useful approach.

Finally, while much time is spent asking local and state emergency personnel to understand how the national response plan is structured, we need to remember that no matter how serious the emergency, the response always begins locally. And in the case of pandemic influenza, the effectiveness of that early response will determine how the emergency unfolds. Standardization is important to the extent that it can be realized, but national plans also must support a response that is right for every corner of this diverse country. A top-down, one-size-fits-all approach simply will not be successful.

Whether pandemic influenza or some other disaster afflicts our nation, there is no shortage of dedicated Americans at every level of government working hard on homeland security. Continuing to promote, support, and build local partnerships among public health, health care, public safety, emergency management, and a host of private sector partners will only improve our ability to protect the health and safety of our communities.

Thank you, on behalf of all the nation's local health departments and the citizens we serve, for your concern and leadership.