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Statement of

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On behalf of the

National Association of County and City Health Officials

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Hearing on "Beyond the Checklist: Addressing Shortfalls in National Pandemic Influenza Preparedness"

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Good Morning Chairman Langevin, Representative McCaul, and distinguished Members of the Committee. 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 am a Past President of the National Association of County and City Health Officials and I have had an opportunity to learn from my colleagues across the country. I have had the privilege of representing our local public health departments by participation in focus groups for the development of standards for Fusion Centers to capture, coordinate, and rapidly communicate intelligence among all levels of government. In my home County of Dutchess in New York, I have been deeply engaged in pandemic influenza preparations under the leadership of our County Executive William R. Steinhaus. Today, I am happy to report to you on the progress made by local health departments and their community partners. I will also point out areas of concern that we have identified as shortfalls in 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. I will describe how local health departments are planning our response to a worldwide influenza outbreak, with an emphasis on how the success of those plans relies on the crucial linkages that have been built 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 our communities adequately, we have no choice but to reach out, engage, communicate and cooperate with our local partners.

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: intentional or naturally occurring infectious disease outbreaks; chemical, explosive or radiologic accident or attack; weather-related disaster; or other emergency.

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. Whether the communicable disease threat is a novel influenza virus, smallpox, anthrax, West Nile Virus, SARS, or other emerging pathogen capable of causing widespread illness and death, 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.

However, our 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. Fundamental to such integration is a shared command and management framework. 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. Adoption of NIMS is facilitating the integration of language, mental models and even certain cultural aspects of public safety by public health professionals.

Just this past week, I spent three full days in Poughkeepsie, NY completing the ICS-300 training with colleague emergency response partners which included local police, fire, EMS, water-plant operators, state emergency management officials, state troopers, public health nurses and many other disciplines mandated to be trained. These mandates, while burdensome, provide many important benefits, including opportunities to meet and work with the very individuals who we will likely meet in the Emergency Operations Center (EOC) during a real emergency. I have always said that the EOC should be the last place for exchanging business cards of introduction with your critical partners.

In Dutchess County, the staff of our health department have learned this new language and approach. They have grown accustomed to planning and exercising within an incident command system. We practice this in many ways. For instance, we use incident command for our seasonal influenza vaccination clinics, so that we will know exactly how to address a need for mass vaccination. We have worked closely with the local police to address traffic and safety issues in planning our system of PODS, or points of mass distribution sites, which we would need to distribute medication during a pandemic or other public health emergency.

Through these opportunities to strengthen relationships, our county emergency management agency now understands and uses the expertise that our health department offers in epidemiologic surveillance, environmental health, and medicine. We work side-by-side on planning, education and evaluation. The health department is now included in emergency drills undertaken by other county agencies and organizations. This enables us to uncover and address discrepancies between the emergency plans of individual organizations, so that the expectations of every responding agency are universally understood.

Key Elements of Front Line Pandemic Influenza Preparedness

1. DISEASE SURVEILLANCE

The purpose of a strong surveillance system is to create time in which to intervene and to eliminate or mitigate threats. In local public health, practical disease surveillance means a system by which clinicians in private practice or in hospital settings can 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 automatic reporting of

diseases or suspicious symptoms, but such capability will be immensely challenging in this intensely diverse and complex national environment. We cannot wait, nor can we depend solely on technology when so much is at stake.

Our greatest strength is in our American workforce—our astute clinicians, our trained healthcare professionals, our alert hospitals—and the effective partnerships that are forged between these entities and capable local public health departments. It is important not to underestimate the immediate and important utility of this model of disease surveillance. As we recently witnessed with the case of the mismanagement of the internationally traveling groom with multi-drug resistant tuberculosis, all electronic monitoring efforts can be thwarted by just one human error. All of our new multi-billion dollar monitoring systems must be complemented with continued vigilance, training, testing and evaluation of our front line agencies and their workers.

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. In preparation for pandemic influenza, we have determined that syndromic surveillance must accompany traditional methods of case reporting. Syndromic surveillance will allow prompt identification of potential communicable disease clusters and trigger response long before laboratory confirmation is received.

After 9/11, our county hospitals' emergency departments began reporting individual patient's symptomatology to the state and local health departments via the HERDS (Hospital Emergency Response Data System) data base. In addition to this statewide effort, our local health department makes direct phone contact daily with each emergency room to identify clusters of illness or unusual presentations. This ongoing networking effort with local emergency departments and infection control staff has proved to be crucial in the early identification and response to infectious disease. We have also partnered with select community health care providers and veterinarians to function as sentinel sites for syndrome and emergent infectious disease identification.

Our most recent effort for improving our surveillance capacity is to work with schools, particularly school nurses. We are training them in the basic principles of epidemiology and disease surveillance and asking them to report absences due to sickness to us more frequently. It is our intention to expand these syndromic surveillance efforts to local colleges and major businesses soon. We are actively engaged in cross-training the majority of environmental sanitarians and public health nurses in the basics of outbreak response so they can assist in case investigation, contact tracing and outbreak control efforts should a large scale event occur.

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. Therefore, in Dutchess County we are placing a great emphasis on community education and have reached out to the schools, the business community, law enforcement, emergency services and home care agencies. Reaching every Dutchess resident in a meaningful fashion is a huge task. We can't do it all at once, but we work at it consistently because we believe that community understanding and cooperation will be absolutely essential in reducing the toll of a pandemic.

Our county's home care agencies are developing a unified emergency preparedness home care plan. This will enable our residents to know that there will be people available to deliver some medical and nursing care in their homes if they get sick.

There is a tremendous desire for information regarding pandemic influenza across all sectors and a there is a great deal of work ahead for local health departments in spreading the word. This effort will be worth the return if we can reduce panic and increase creative response options when the need arises, which it will.

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 health department has worked with the County Attorney's office to educate legal, law enforcement, and emergency medical professionals about isolation and quarantine. We also conducted a "tabletop" exercise to test our knowledge and we will be continuing to follow-up on these efforts.

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.

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 department gave 5800 doses in two days to our most vulnerable populations. (Dutchess County has a population of 300,000.)

Yet again, we could not have managed this mobilization without the full support of our public safety partners, who provided security, traffic control and emergency medical care. These are no minor feats in a mass setting, especially in a real life situation where emotions are running high and the chance of panic is never far away. The public already has benefited greatly from the collaboration between public health and public safety agencies. Only through a highly coordinated and very broad approach will we achieve maximum homeland security in the face of an influenza pandemic.

Another example of the ongoing efforts to enhance inclusiveness and communications between agencies is that I was invited and am now a member of our Dutchess County Chiefs of Police Association. When I entered public health school and when I began my position as Commissioner of Health back in 1994, I could not have imagined being a member of the Chiefs of Police Association. Times have changed and so have our thinking and response to new and emerging threats.

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. In Dutchess County, we have established two new positions for public health preparedness. We have no large cadre of new staff. However, our entire health department staff, from the clerical staff to the Commissioner, have received and will continue to receive training in the ICS system.

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 county 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 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 local funding for all-hazards public health preparedness has been eroding steadily.

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. As I described above, pandemic influenza response will require much more than medical care and hospital beds.

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.

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 in 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, for your concern and leadership.