LEGISLATIVE HEARING ON BIOTERRORISM, H.R. 3253 AND H.R. 3254

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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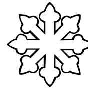

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LEGISLATIVE HEARING ON BIOTERRORISM, H.R. 3253 AND H.R. 3254

WEDNESDAY, APRIL 10, 2002

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

The subcommittee met, pursuant to notice, at 3 p.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee), presiding.

Present: Representatives Moran, Stearns, Brown, Miller, Boozman, Filner, Berkley, Rodriguez, and Lynch.

Ex officio present: Representative Evans.

Also present: Representative Buyer.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. The subcommittee will come to order. I'm glad to convene us once again. Good afternoon, everyone. I appreciate the attendance of the folks here today.

The topic before the subcommittee, what role do we want, as Members of Congress, do we want to define the VA in our national effort to combat terrorism is the issue before us. No longer is it a question of academics, or theory, but the emergency, and it's an issue that's important to all Americans.

The attacks of September 11 are vivid in our recollection, and we have entered a new phase in the United States for our role in the world with heightened concerns about personal, institutional, and national security.

In the wake of those suicide attacks on the World Trade Center and the Pentagon, and the anthrax that landed here in the halls of Congress, the Congress and the Nation have begun to ask questions about the best approaches for government to take for our Nation to prevent such future attacks.

Congress has acted rapidly in some cases, particularly last fall to approve emergency supplemental appropriations to provide funds to repair the physical damage and compensate the thousands of victims and take other actions to restore our Nation.

Since that time this committee has examined ways the Department of Veterans Affairs can deal with these urgent national needs.

Our full committee Chairman Smith will join us today, and has introduced H.R. 3253, the National Medical Emergency Preparedness Act of 2001. This Act will move the VA in a new direction in

the Nation's fight against terrorism, and Chairman Smith will be here to further describe its purpose in a few moments.

Our friend and colleague, Mr. Buyer, Chairman of the Subcommittee on Oversight and Investigations, is going to introduce H.R. 3254, the Medical Education for National Defense in the 21st Century Act. And we're pleased that Mr. Buyer joins our subcommittee here today to describe his bill and its packages.

Before we begin these matters, let me turn to my colleague, our ranking member, the gentleman from California, Mr. Filner, for any opening remarks he may wish to make.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. I thank the Chairman, and I thank you for pursuing this subject of great importance to our Nation.

I'd like to introduce to you a staff person who will be with us for 3 or 4 months. Our regular staff person is out on maternity leave. Kathleen Greve, from the Office of the VA Secretary, has experience in health matters and is going to be filling in for her.

I was going to welcome her, but she comes from the Secretary's office. I wonder if she was sent to tell the Secretary what the Democrats are doing. (Laughter.)

This is a confidential relationship—I want it on the record here, confidential and difficult. (Laughter.)

Did you get the short end by being here?

(Laughter.)

Again, Mr. Chairman, this is obviously a really important issue, and the creation of the Chairman's legislation for VA Emergency Medical Preparedness Centers is a very interesting and important proposal.

As we know, the VA, without having these organizational changes, was front and center in the aftermath of the events that took place in New York and in the other attacks.

The years of experience in treatment of post-traumatic stress disorder was extremely helpful to New York City and right here in our back yard. And we thank the VA for that.

We heard follow-up testimony from the VA about the many supportive leadership roles the department has played, and continues to play, at the local and the national level in bio-terror research, education, and, of course, homeland security.

And certainly—and I hope we continue this in the budgets that we pass—VA research has long been recognized as ground-breaking in medical, scientific, and academic circles, with benefits that extend far beyond just the VA and the community itself.

I'm very proud that a recent development was done in San Diego, in fact, where the VA has announced the development of what looks like a promising new drug to treat smallpox. The thought of a smallpox epidemic is obviously very worrisome to anybody, and it's a real bioterrorist threat to this Nation.

Dr. Carl Hostetler, of the VA in the San Diego healthcare system, has been directing this research, which is now being tested further by researchers at the U.S. Army Medical Research Institute of Infectious Diseases.

This is the kind of effort that we look to from the VA, and that it has been able to provide us. And the formation of Medical Emer-

gency Preparedness Centers of Excellence, maybe we should call them, makes good sense. We want to take advantage of the existing infrastructure and build on it.

I'm sure you will join me in this, Mr. Chairman. Any money that we devote to this has to come from other than the existing programs that we are trying to fund in the VA! We don't want to create a new program, and dilute older ones. We want to get some new money in our efforts to do that.

So I look forward to the testimony and the eventual reports pursuing this subject of great importance.

Mr. MORAN. Mr. Filner, thank you very much, and I do share your sentiments in regard to the appropriations and budget issues with regard to both of these issues.

Mr. Buyer, we appreciate you joining us today, a man of passion on these issues, and we'll be happy to have you describe for the committee your legislation.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman, and ranking member Mr. Filner. If you'll indulge me, I am going to read this statement, because it has legislation that I have authored.

And I want to thank both of you for holding the hearing today, and also let me take a moment to pause and recognize Mr. Danny Devine, who used to work for this committee, left the legislative branch, and then went into the private sector, and is now working on the executive side of the House. Where is Danny Devine? Standing in the back. Thanks for coming back into the family.

The first bill, H.R. 3253, the National Medical Emergency Preparedness Act of 2001. This is legislation introduced by our Chairman, Chris Smith, of which I'm proud to be a co-sponsor.

Chairman Smith's bill would establish at least four emergency preparedness centers at VA hospitals, and this reiterates the fourth mission of the VA. And I'm very pleased that both the ranking member and the chairman were active participants to remind everyone about the fourth mission of the VA.

The second bill, H.R. 3254, the Medical Education for National Defense in the 21st Century, is legislation that I introduced.

The purpose of my legislation is to authorize funds to enable the VA Veteran's Health Administration, and DOD's—the F. Edward Hebért School of Medicine of the Uniformed Services University of the Health Sciences to develop in partnership a series of model education and training programs.

These programs can then be made available to all healthcare professionals, students, graduate medical education trainees, and practitioners across the country about diagnosing and treating victims of biological, chemical, and radiological attacks and incidents.

The "American Association of Medical Colleges Reporter" article in December, 1998, quotes an issue of Military Medicine that says, "Even military physicians, who should be more prepared than civilian doctors, aren't sure about their capability of handling such a situation. The June, 1998 issue of Military Medicine reported that only 19 percent of military physicians were confident about providing care in NBC situations." NBC, meaning nuclear, biological, and chemical.

"The majority of those confident few—53 percent—were USUHS graduates of that military medical school."

The combination of DOD's expertise in the field of teaching and treating casualties resulting from an unconventional attack, and the VA's infrastructure of 162 medical centers, 800 outpatient clinics, extensive satellite broadcasting capabilities, and a preexisting affiliations with 107 medical schools as teaching hospitals, will enable the current and future medical professionals in this entire country to become knowledgeable and medically competent in the treatment of casualties of weapons of mass destruction and other disasters.

One of the witnesses that we will hear from today is from my own State of Indiana. We would like to extend a warm welcome to Dr. Stephen F. Wintermeyer. Dr. Wintermeyer is an Associate Professor at Indiana University School of Medicine, and chair of that school's Task Force on Bioterrorism.

Prior to joining the Indiana School of Medicine, Dr. Wintermeyer served in the Gulf War, and is currently a member of the medical staff at Roudebush VA Medical Center in Indianapolis. We look forward to Dr. Wintermeyer's testimony.

Last November, the VA Subcommittee on Oversight and Investigations, which I chair, held a hearing that revealed our inability to diagnose and treat casualties resulting from biological toxins, chemical agents, or radiological agents from attacks and possible other incidents.

One of the most compelling pieces of testimony we heard was from Dr. Carlos Omenaca. He was an attending physician who successfully treated the second case of inhalation anthrax in Miami, FL. Dr. Omenaca was not just a doctor. Excuse me. But he was also a specialist of internal medicine with a sub-specialty in infectious disease.

As part of his diagnosis, he referred to a 1904 text book. He said, "You do not diagnose what you do think of, and you do not think of what you do not know about."

What initially looked like a flu-like illness was later confirmed as a second case of inhalational anthrax, and the third case in 25 years in the United States. At the hearing Dr. Omenaca also stated, "Our medical personnel, including myself, do not have the training to recognize illnesses that have not occurred in this country in decades."

Since September 11, we cannot afford to assume that our country will never have to experience a massive biological, chemical, or radiological attack. We must act to ensure that if the worst of our fears are realized, our medical professionals will be ready and able to effectively respond to the fallout.

It is not the intent of this legislation to create new community standards of medical practice. We must recognize that diseases such as smallpox, botulism, and plague are not normally seen and treated except by a few clinicians in the world.

It is also imperative that in carrying out the intent of this legislation that we work with HHS to ensure that we include other Federal healthcare systems that are responsible for supporting medical research and public health.

The *Washington Post* ran an article last Sunday entitled: "U.S. Health Care System Grapples With New Role." In that article, Julie Casani, head of the Maryland Department of Health and Mental Hygiene's new Bioterrorism Division, was quoted as saying, "The CDC was hampered because of scientific understanding of how finely milled anthrax spores behave was sketchy and changed during the outbreak."

She went on to say that, "Various federal officials sometimes offered contradictory advice that confused doctors and patients." She further stated, "There was no doctor who stood up and said, 'this is what we have to do, and this is what we're going to do,' she said. 'We needed a Dr. Giuliani.'"

MEND for the 21st Century provides healthcare workers with the capability needed to identify and treat these lesser known deadly diseases to mankind.

I thank you, Mr. Chairman, for yielding me time to read my statement. I yield back the time.

[H.R. 3253 and H.R. 3254 appear on pp. 33 and 42.]

Mr. MORAN. Mr. Buyer, thank you very much, and thank you for joining us today, and for being here to support and explain your legislation.

We have our first panel in front of us, and that panel consists of the Deputy Secretary MacKay; Dr. Roswell, the Under Secretary for Health; and Dr. Koenig, and we would welcome all of you to our subcommittee, and in particular welcome Dr. Roswell for his first appearance. We look forward to a long and fruitful relationship with this subcommittee, Congress, and the Department of Veterans Affairs.

Dr. MacKay, if you would like to begin your testimony, we'd be delighted to hear from you.

STATEMENTS OF LEO S. MACKAY, JR., DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, AND KRISTI KOENIG, M.D., DIRECTOR, EMERGENCY MANAGEMENT STRATEGIC HEALTHCARE GROUP

Dr. MACKAY. Thank you, Mr. Chairman. Good morning—good afternoon, rather. I am pleased to appear before you today to discuss the Department of Veterans Affairs in its role in homeland security.

The VA plays many roles in the Nation's healthcare system. It's the largest integrated healthcare system in the country, and we have a potential to play an even greater part in procuring America's security, and we welcome that opportunity.

Our resources are significant. We are at the forefront of medical research, we're an integral part of our Nation's healthcare system, and a key member of its emergency response team.

We are the largest pre-deployed asset in our country's public healthcare arsenal, and I can assure you we will be prepared and ready to serve America wherever we are at. We will do this consistent with the evolving federal strategy on homeland security.

The two pieces of legislation under discussion this morning would substantially add to the VA's ability to help the medical

community prepare for the acts of terrorism against the United States.

Let me say that VA strongly supports the bills of both H.R. 3253 and H.R. 3254. However, we do have concerns. Chief among them is that without dedicated funding to support the proposed two missions, VA's ability to fully meet its primary responsibility to veterans may be compromised.

As you are aware, our medical care accounts are stretched to the limit. As well, I would also urge that any new spending be accommodated for in the President's overall discretionary budget.

The proposed bills would accomplish two very important goals. First, they would accelerate efforts to train VA and non VA healthcare providers. And, second, they would enhance the VA's ability to sponsor research for the prevention, containment, and treatment of injuries related chemical, biological, and radiological, or CDR warfare injuries.

It's important to note here that the pharmaceutical caches we manage for the Department of Health and Human Services provide the backbone of America's ability to respond to chemical and biological attacks.

Weapons of mass destruction have a potential to inflict serious, widespread, and sustained injury to the American population. It is therefore essential that the Nation's healthcare providers have the tools they need—that is, the education and training that they need—to successfully treat Americans who will one day be exposed to unconventional warfare agents. In response, the largest medical education and health professionals training program in the entire United States, the VA, is well-positioned to provide medical instruction of this nature.

The VA also welcomes the opportunity for an expanded role in medical preparedness research, education, and assistance. Our extensive research program has long been a vanguard on the cutting edge of medicine. In particular, our involvement with biological and chemical warfare research is significant and predates the events of September 11.

In short, the VA is well-equipped to serve the homeland security force multiplier. With our Federal partners we are already addressing broad based issues like threat assessment and incident management, medical and public health, research and development, as well as plans, training, exercises, and evaluation.

Clearly the demand for enhanced support of homeland security is one of our greatest short term challenges, and one of our greatest opportunities.

I'm confident the VA can meet the challenge and maximize the opportunities they hold not only for better national security, but for better health for all Americans. The Department of Veterans Affairs supports the proposed legislation and looks forward to sharing our expertise with the Nation at large.

Thank you, Mr. Chairman.

[The prepared statement of Dr. MacKay appears on p. 51.]

Mr. MORAN. Mr. Secretary, thank you very much. I appreciate your testimony, and I would give Mr. Filner the first opportunity to ask any questions.

Mr. FILNER. Thank you, Dr. MacKay, it's good to meet you. You, too, Dr. Roswell, and welcome to the friendly confines of this House committee. Do you have any suggestions if this bill passed? Would you give the President any suggestions for funding? Your concern was similar to mine.

Dr. MACKAY. Yes, sir. I think you said it very well.

Mr. FILNER. We're going to have to work directly with the Appropriations Committee on this because you're already stretched to the limits as far as I can see. Everywhere I look you don't have the resources to do a job that we keep giving you more to do, and the nature of your population gives you more to do.

So I think we have to work very closely with Appropriations, Mr. Chairman, and the chairman of the VA full committee is obviously very involved in that. Will he be here to talk about that?

Mr. Moran. Yes, sir.

Mr. FILNER. Because this is obviously a key issue.

You have done a lot of things before this, and this is a natural fit for you to contribute to the national effort.

I can't resist putting a little dig in here. You referenced today a very comprehensive homeland security policy. I wish the Director would come to Congress and talk to us about it!

We need to work together if we're going to do this. To figure out where the money is coming from because we can't add this on to you without the resources, and I think we need to keep that in mind, Mr. Chairman.

Mr. RODRIGUEZ. Will the gentleman yield?

Mr. FILNER. Please.

Mr. RODRIGUEZ. Mr. Chairman, I apologize I have no comment for the committee meeting at the present, but I would like to submit some written comments for the record if possible.

Mr. MORAN. Without objection, so ordered.

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

[The prepared statement of Congressman Rodriguez appears on p. 46.]

Mr. MORAN. Mr. Stearns.

OPENING STATEMENT OF HON. CLIFF STEARNS

Mr. STEARNS. Thank you, Mr. Chairman, I'm delighted to be here, and of course I was just recently out in Snowmass, Colorado with Dr. Roswell meeting with the Disabled Veterans Sports Clinic. And both he and I addressed roughly 400 veterans, amputees, spinal cord injury, and veterans who were out there to compete and sweat and to provide tremendous inspiration for both Dr. Roswell and I.

And I urge all my fellow colleagues if they can to go out once a year and see the disabled veterans tackle the ski slopes, and to come down successfully. It's an inspiration. I think, first of all, Mr. Chairman, I just want to make my opening statement as part of the record quickly.

[The prepared statement of Congressman Stearns appears on p. 46.]

Mr. MORAN. Without objection, so ordered.

Mr. STEARNS. And, of course, I want to congratulate Dr. Roswell on his Under Secretary appointmentship. He was, of course, the di-

rector in Florida, and that is a very challenging job to satisfy people in Florida because there is always new people coming down from north and northeast, the west, and so forth, so that Florida has a challenge for accommodating all of the veterans' services that are required.

Dr. MacKay, refresh my memory. How much do you think this is going to cost out of discretionary funding for these bills? Can we just run through that again, definitively how much the first year, the second, so forth?

Dr. MACKAY. We had a—in the testimony, we have a first year estimate of about five and a half million dollars for 3254. And roughly about five and a half million dollars a year, for a 10-year total of about $55 million, Congressman.

And the bill itself, 3253, has provisions for $20 million a year, and also provisions for us to be able to reprogram money out of other accounts at the discretion of the Secretary to bolster, or fill out these efforts. We are working on a detailed estimate for 3253, and we don't have a complete estimate for that at this time.

Mr. STEARNS. So 3254 is going to cost $20 million——

Dr. MACKAY. Five and a half million a year in funding over 10 years.

Mr. STEARNS. Where does the $20 million come from?

Dr. MACKAY. The $20 million is mentioned in the language of H.R. 3253.

Mr. STEARNS. Okay. So the bills together would cost?

Dr. MACKAY. Twenty-five million, to $26 million a year.

Mr. STEARNS. So that would be roughly a quarter of a billion dollars over 10 years.

How much, Dr. Roswell—I know you're just on the job, but, you know, it's always been a problem getting payments on loans, and getting outstanding debts that are due to Veterans. That's been one area that we've always tried to tweak to try to get more money back.

Is that an area that would be helpful to get this funding for those two bills?

Dr. MACKAY. I'm not sure that that type of recovered funds could be reprogrammed, but it's certainly something that we would be happy to look into as a source of some funds.

Mr. STEARNS. These recovered funds have always been enormous, and they have been—you know, unsuccessful in getting payment back. And I'd just—I think everyone on the Vets Committee wants to see these bills, but they don't want you folks to come up and say, oh, yes, we like the idea, but it's going nowhere because we don't have the money.

And I think many of us would like to see if we internally what could be done within the Veterans' Affairs to increase productivity, lower expense, and provide a better service.

And so, in turn, on a $50 billion budget, to come up with some of this money to take on this. So what your offices will always say is we like the idea, but it costs too much money, and the bill goes nowhere.

And so the sponsors of this, including my own healthcare bill, we all sit here and let the bills pass, but we don't get the funding for it. So it's a disappointment for us. So, you know, it would be nice

if you folks would also come up here and give us ideas on how we could fund this.

So, Mr. Chairman, my comment really is to throw the ball back at them because they're throwing it on us and saying, well, you've got to fund it, Congress, and we like the idea, but there's no funding. So we're not sure if we can do that. I would throw it back at them and say if they come up with some areas that they could show us where they could increase productivity, decrease expenses, and help fund this themselves.

Mr. MORAN. Thank you, Mr. Stearns. We're glad to have Mr. Evans, the ranking member of our full committee, with us. Lane, welcome.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate your holding this hearing; it's very appropriate that we air these issues. But it also concerns me that perhaps this Nation's people think that the VA itself is under that current state of increased funding for its core programs. The VA, of course, provides medical assistance, but does not have the resources to do more than its core program. The VA has been involved, of course, with its medical system and other resources, along with the DOD and the military. And I think all we can do is press our government to move as quickly as possible with the resources that it can apply to this situation, and try to improve it, so we can get this done. I'm concerned about it, and I appreciate your coming up here to testify before Congress.

[The prepared statement of Congressman Evans appears on p. 47.]

Mr. FILNER. If the ranking member would yield.

My good friend, Mr. Stearns, and I represent the differences in the way the two sides of the aisle view the situation. For me, it's always waste, fraud and abuse. And, of course, the Democrats always want to spend more. We've been dealing with the VA budget for quite some years together, and we have given them increased responsibilities. Your very good Millennium Healthcare Act, adds very great responsibilities. And yet the budget has gone down in real terms over a decade. We've managed to get it up a little bit over the last couple of years, and now it's flat lined again.

And as I understand it—Craig, tell me if I'm right on this, Dr. MacKay, Dr. Roswell. That there is a provision in the new supplemental for the VA. Is there money that the President is requesting in the supplemental? Several hundred million? What is that figure?

Dr. MACKAY. It's $142 million that's——

Mr. FILNER. That's requested. Well, I see figures anywhere between $400 million and $800 million that you're really out of synch with in your existing budget.

And so we can't even give the veterans who have served us the proper care now. And you know from, your chairmanship of this committee, Mr. Stearns, better than anybody, what the needs are, and what we want to do, and should do. And yet the money is not there. But to think that they are going to try to find more money by, only looking for waste and abuse is mistake. If I went into your

office I'd find a few minutes that some staff member was goofing off——

You haven't seen Stearns' office! We could find abuse anywhere. You know, we could—but they're under incredible pressure that we have helped put them under. And, of course, the aging population that they're serving, I think we have to give them some credit for trying to do more with less over the last decade.

I think it's up to us to come up with the money, and not assume that there is somehow money in there.

I know you're very anxious, Mr. Stearns, so I'll yield to you.

Mr. STEARNS. I thank the gentleman. But, you know, the many years I have served on the Veterans Committee rarely have I have heard either administration come forward with a plan to provide extra money because of higher productivity, or because of cutting of waste, or duplication, or repetition.

And so——

Mr. FILNER. Actually, they have. They have come forth.

Mr. STEARNS. Well, I would say it's not the routine. And so, you know, like any government agency it's always good to try and urge them to come forward with an initiative which shows how they could save money.

Mr. FILNER. I agree, I see I'm defending *your* administration!

Mr. MORAN. Thank you. Mr. Evans? Mr. Miller?

Mr. Miller. Thank you, Mr. Chairman. I do have a statement that I would like to enter into the record, and at this time will waive any questions.

[The prepared statement of Congressman Miller appears on p. 47.]

Mr. MORAN. Without objection, so ordered. Mr. Lynch.

OPENING STATEMENT OF HON. STEPHEN F. LYNCH

Mr. LYNCH. Thank you, Mr. Chairman. Mr. Chairman, I just want to commend you on your good work on behalf of our veterans, and also I do want to say that I am supportive of both these legislations that are being offered today.

However, I am concerned, as has been voiced earlier by the ranking member on our side, about whether or not we would also be looking at additional money, or whether we are simply trying to do something with resources that are currently dedicated toward the core, the other three missions, I guess, of the VA.

And if I could be satisfied that we were not going to draw from those other core missions of the VA, I would be most happy to support this—these pieces of legislation.

And I guess just as a general question to our guests, I would ask what specific proposals do you have in terms of I think undertaking a more vigorous pursuit of the VA's fourth mission?

Dr. MACKAY. I will begin to answer you, Congressman, and then I'll invite the Under Secretary.

We are working very closely with the Office of Homeland Security and the White House. In fact, we are part of the effort to provide the homeland security strategy which hopefully will be delivered to the President in July.

Gen. McKickliter, who has been—is actually our representative to the process. I sit on, of course, the Deputy's committee of the

homeland security process. That has served a senior review group for many of the policies and other planning that's gone on. So we have been very much involved.

We are also part of policy coordinating agreements for medical and public health, research and development for exercises and plans, and also for domestic response and incident management. So we're fully involved in the homeland security process.

Additionally, we have taken a number of steps on our own. We have identified funding that would—is very top priority funding, and made those needs known to the Office of Homeland Security.

On our own recognizance we have formed a consolidated office of operations, security and preparedness. A centralized place where all our planning and execution for these types of things happen inside the department.

I'll let Dr. Roswell continue, but just some of the things that we have done; an emergency management academy that had been contemplated even before September 11 has been started where we deliver education and training over our own internal knowledge network to both our own, but also partner agencies that have access to that network.

We have initiated a new telecommunications plan, and a new cyber security plan that will give us a robustness to resist cyber attacks. We have also revamped, and refreshed our continuation of continuity of operations for our continuity of government.

We have more robust, hardier, and more numerous operation centers and plans so that we would be a harder target, and we would be better in the face of a terrorist incident in delivering benefits and services to the veterans that come to us. And also in safeguarding our own employees.

So we have not been still. We have not been static. We have done things that we could within our own resources. We have identified very modest, but also, we hope, very effective pharmaceutical caches that have been positioned in some 20 facilities around the VHA network. These are all, you know, to protect our own employees and veterans that come to us.

We have exercised our decontamination capabilities, and we also had a very real world exercise with regard to the Olympics that were held out in Salt Lake City. The Olympic Stadium was about 1,500 yards from the Salt Lake City VMAC, and during that—the course of the Olympics, the Salt Lake City VMAC was the headquarters for the bulk of the Federal forces that were deployed there.

In fact, one building was taken over by one federal entity that had overall responsibility for coordinating the federal effort out there.

So we were an integral part of that. We have a 24 by 7 capability now in our operation center that constantly keeps the Secretary and myself apprised of events that are going on around the network and heightens our ability to respond and protect our assets, our veterans and employees.

I don't think I've left much time for you, Mr. Under Secretary.

Dr. ROSWELL. Thank you. If I may, Dr. MacKay has given a very exhaustive list of some our responses. I think the point here is that our role is inevitable. With, or without funding, with our without

these bills. Our role in a significant domestic terrorist event is inevitable.

Literally within hours of the first diagnosis of anthrax in south Florida the VA was responding. The VA was using its extensive communication capability to send out clinical guidance to over 15,000 physicians throughout our health system.

Within days we had distributed guidance from the Department of Defense, the Army Surgeon General's guidance, the CDC guidance. We were able to disseminate that to all 1,300 locations of care nationwide.

When patients were evaluated by the Centers for Disease Control in the West Palm Beach area and Fort Lauderdale area, they were referred to the VA for assistance with CIPRO, a prophylactic medication and the antibiotic necessary to treat anthrax.

So we had a major response early on. Our role is inevitable.

With regard to Mr. Stearns' earlier statement about funding, these are national programs. They should be national programs. If I'm not mistaken, I believe there is a statutory requirement for monies collected by the Department of Veterans in private insurance to be retained at the facility where it's collected.

So I certainly don't mean to abrogate on our obligation, or absolute requirement to improve the efficiency with which we deliver care. We are doing that, and are making concerted efforts. But by the same token I think a national program such as this should not be funded from the MCCF collection program.

Mr. LYNCH. May I just ask one follow-up question?

Mr. MORAN. Yes, Mr. Lynch.

Mr. LYNCH. Dr. Roswell, you mentioned the work that you're doing so far. Is there some coordination with local first responders and the Emergency Management Academy?

Dr. ROSWELL. Yes.

Mr. LYNCH. I mean the local first respondents?

Dr. ROSWELL. The VA's role is not a first responder role, but we do coordinate with community and State officials. We have a very effective role in coordinating that response.

Dr. Koenig, our consultant of emergency medicine, can describe very briefly that—how that response is activated, and how it was activated in New York and Washington and report.

Dr. KOENIG. To answer your question directly, the Emergency Management Academy was set up first and foremost to train VA providers across the entire Nation as a cost effective way of using satellite broadcasts and web based training.

So it is not currently used for first responders, although that infrastructure could be expanded for that role if we have the appropriate authorization and funding to do so.

We do coordinate on the local levels, as Dr. Roswell said, with all healthcare providers, including first responders.

Mr. LYNCH. Thank you. Thank you, Mr. Chairman.

Mr. MORAN. Thank you, Mr. Lynch. Mr. Brown.

Mr. BROWN. Mr. Chairman, I don't have any questions, but I do have an opening statement I would like to turn in.

[The prepared statement of Congressman Brown appears on p. 48.]

Mr. MORAN. Without objection, so ordered. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you, Mr. Chairman, and thank you for being here. I'm sorry that I didn't hear the bulk of your testimony, but I'm sure my staff member is going to advise me. She was briefing me while we were sitting here.

Let me tell you my concern, because it's—I represent a district where we don't have a VA hospital. Our clinic is getting condemned because of structural damage—and, by the way, the—it was first built and dedicated in 1997.

I don't have a cemetery, I don't have an old age home, I don't have a nursing care facility, and half of my homeless are veterans that are lining the streets with no place to go. Now, it concerns me that there is yet another mission for the VA when, quite frankly, they're not doing much of a mission and not fulfilling the mission you've got for my veterans. And, as everybody knows here, I've got the fastest-growing veterans population in the United States.

I don't know where these monies are going, but I feel a little bit awkward going back to my vets and saying you've got no hospital, you've got to go to Long Beach. You—we're closing the clinic, we're going to have you throughout the city in various facilities because we don't have a place for you to go for the basic needs that you have.

I don't have a cemetery. There is no long term care, so if you get really sick and you've got no family, I don't know what the heck you're going to do. And half of my homeless are lying down in the streets with no place to go, and we've cut the funding for the homeless, even though we passed the Heather French Homeless Act last year.

So tell me what I can go back and tell my veterans, because this bioterrorism, I don't know, I have a whole bunch of—my sheriffs, my FBI, and the hospitals and everything else, the VA wasn't there. And I'm not sure that that should be your role if we're not fulfilling the role the we've got already, with all due respect.

How do I go back and tell my vets I'm supporting this more money for another mission for the VA?

Dr. MACKAY. Congresswoman, I think you—though I can tell you better—we share your concern about the veterans' health, and we absolutely promise you that in the Department of Veterans Affairs——

Ms. BERKLEY. You know what, after 3 years of sitting on this committee and being in Congress, my vets don't want to hear that you feel their pain. They want to see something productive from the VA, and so far we don't see anything.

And I'm uncomfortable voting for more funds for yet another mission when the VA doesn't seem to be fulfilling any of the basic missions that it has for the veterans I represent. So——

Dr. MACKAY. I can only reiterate that the veterans' healthcare is job number one in the Department of Veterans Affairs. And we have been very clear, my testimony is very clear, the Secretary has been very clear, that over and above missions—and this would be an over and above mission, it's not currently within the scope of the things that the department does—requires over and above funding. So we are absolutely and a hundred percent in accordance with you about the primacy of that issue.

With regard to the situation, and it is an unfortunate situation in Las Vegas with the clinic. I know you and the Secretary have had many conversations about this.

You know, that we have been monitoring very closely the situation with the structural integrity of the unit. That we are planning actively. As you know, medical care in that region of the country is fully subscribed, as you have accurately characterized.

We are going to find an alternate facility. We are going to move the veterans to that alternate clinic, and we are going to execute our CARES process—capital asset realignment for enhanced services—we're going to look at situations that have demographic drivers like in Las Vegas and Nevada. And we are going to shift our resources to accommodate them.

You know, these are dynamic demographics within the medical community. I have no qualm, I have no problem with anything you said. You have made some very accurate statements. Some of them are hurtful, but I understand the truth of the things you said.

You have the Secretary's commitment. I know that you have our commitment, the whole department commitment that we know, we understand, and we are working as hard as possible to alleviate both the immediate situation you have with respect to the clinic issue. And the long term situation you have with respect to the growing veteran population.

You are absolutely correct, and I could add nothing more to what you have said, only our commitment. We do understand you.

Ms. BERKLEY. Well, let me ask you something. If I'm not mistaken, you're going to want—you want funding for this additional mission for the VA.

How can I vote for that when I need the additional funding to do the work that you already aren't doing in my district?

Mr. FILNER. They're being nice here in their testimonies. You know, they probably want to say what you just said.

Ms. BERKLEY. Okay. Then let me address this to you.

Mr. FILNER. That would be good.

Ms. BERKLEY. Why are we giving them an additional mission if they can't fulfill the mission they've already got?

Mr. FILNER. Ask Mr. Buyer. It's his bill.

Ms. BERKLEY. And help me out here to understand whey we're burdening them with more when they can't do what they've already been assigned to do, and what we've already promised our veterans for years, and years, and years that we will provide for them.

Not that I don't think all of this stuff is very important, but even a train stops. Where are we going to get it? Where are we going to get the additional funds? If I'm being told by the VA we don't have funds for a clinic, we don't have funds for a hospital, we don't have funds for a long term facility, we don't have funds for the homeless, but we're going to find funds for bioterrorism.

Mr. BUYER. Ms. Berkley, when I was the chairman of the Personnel Committee on House Armed Services, I had jurisdiction over the military health delivery system. I have been at Nellis.

The picture that you just drew is completely different from the picture that I saw when I was at Nellis. I met with district commanders, the veterans' service organizations. They described a dif-

ferent scene and a different picture than you just described in your testimony.

So, I was sort of taken aback. I'm not going to dispute you, because it's your district. I just know what I saw when I was there and I spoke to the district commanders.

So, I cannot concur with what you just said.

Ms. BERKLEY. Well, then let me—come out to my district, because you don't know what you're talking about. I'm telling you what's happening on the ground in Vegas.

Mr. MORAN. The gentlewoman's time has expired. I believe that concludes this panel. Oh, I'm sorry, Mr. Buyer.

Mr. BUYER. Thank you. Now to answer your question. I can only convey to you, ma'am, what was told to me by your district commanders that I had met with in Vegas. So I'm a little sensitive to your personal attack toward me.

The second thing, did you vote for the bioterrorism bill that went to the House floor? Did you? You did? Then you have voted for this provision. So you should go back and defend your vote, because you've already voted for this.

This bill, the reason we're bringing it before this committee, is that—we've got several things going on here at once, and this is Steve Buyer's blueprint. You aren't going to read it anywhere, but you have the prosecution of the war on terrorism going on.

We have preventive measures that we have to do, i.e., homeland defense. We have consequence management that we have to do, and then we have a judicial function which comes under the military commissions in how we treat terrorists.

So Ms. Berkley, you're right. We're doing all those other things, and they're suppressed in doing those things, but on top of it, the country has turned to us, being the responsible individuals, to address America being attacked and how are we going to prevent future attacks. And how are we going to prepare first responders. What are the consequences if those acts occur, and other things.

So when we coordinated with DOD, with the AMA, with medical universities, with the Veterans Committee, with the Congressional Committee, jurisdiction was waived from DOD and VA, and this piece was put in the bioterrorism bill that passed the House, and is presently in committee.

It was moving—everything, if you recall last fall, was moving fast. And we didn't know if these anthrax attacks were going to occur, if there was going to be another wave coming; we didn't know.

And the President was putting together his request for funding for the bioterrorism package, and I sent this over to the Senate, but, you know, the Senate is a little different. And they didn't get their opportunity to chill it, I guess, and do their own approach to it. So they left it out and it's presently at conference.

Now that we've had some time, what I want to make sure is that we don't put it together in haste. Yes, we took 5, 6 weeks to put this together, but we also have some time now.

CDC is going to be testifying today, and they've got their ideas. In their testimony the VA just said, "we like this idea that you've put together, is it in complement thereof."

The funding mechanisms are in place. What I have asked this committee today is to mark up this bill separately. In the House, we've sent a very strong message to the conferees, who have already been assigned to bioterrorism, and that conference is already occurring, to keep the education piece in the bioterrorism bill.

And what's unfortunate here is, to all my colleagues is, I thank you for permitting me to be a part of your subcommittee, and I wish I could explain that ahead of time to all of you, but I had to go last in my remarks.

And I am very eager to have a conversation, a sidebar, with you, ma'am. Julia Carson and I chair the oversight and investigations subcommittee of this committee. We are sensitive to what's occurring in this population shift to southern Nevada, and whether or not they're being responsive to your veterans. That's what brought me out there.

You know, Johnson took me and said you've got to see this. And if the picture is changing that rapidly, I want to know about it because when I was there it was 4 years ago. You're saying, Steve, what happened 4 years ago, today is so much different. Please, I want to have that conversation with you and if we need to go out there and see some things and be responsive, ma'am, that's what the oversight function of this subcommittee is for.

Mr. FILNER. But, Mr. Buyer, could you yield for a second?

Mr. BUYER. Sure.

Mr. FILNER. What Ms. Berkley was painting of her district is, because of the demographic changes, much more dramatic in her district. But the same is true in every district in terms of veterans not getting proper treatment and care.

They're waiting months for appointments. You know, and on, and on, and on.

Mr. BUYER. Well, I understand.

Mr. FILNER. So you tried to dismiss her situation as if you haven't been on this committee for a decade.

Mr. BUYER. I find that insulting. I reclaim my time.

I would like to know, in your preparation for the Olympics, the coordination that you had with CDC in the training of first responders, what occurred? Can you tell us what occurred out there in the field?

Dr. ROSWELL. Yes. The Bay Pines VA Medical Center in Florida operates a hazardous material decontamination team. That team was mobilized at the request of the Secretary's office to provide a contingent decontamination capability.

The HAZMAT team deployed, and set up on the grounds of our Salt Lake VA Medical Center for the opening ceremonies of the Olympics and was prepared to receive casualties in the event that there had been some type of chemical, or biological warfare attack at the opening ceremonies.

This was not an exercise. They were deployed and prepared to execute their mission. The team then redeployed for the closing ceremonies, and also was prepared to execute—in the event of any actual casualties.

So this was a response that took advantage of expertise and capability in the Department of Veterans Affairs. It was supported by our VA Medical Center in Salt Lake City.

If I could add, Mr. Buyer, that our emergency management infrastructure is extensive. In fact, our very ability to respond to structural deficiencies for the southern Nevada healthcare system exercised our emergency management response, and our ability to validate comprehensive plan to relocate the staff and patients at that clinic in the Congresswoman's district was in large measure a result of the emergency management infrastructure that we have in the VA healthcare system.

So, again, I would submit to you that our role, albeit unfunded at present, is an inevitable one, and we will be a participant when called to task.

Dr. MACKAY. And it's unfortunate that Congressman Stearns isn't here. We took the opportunity when we deployed the decontamination team from Bay Pines—which is the senior decontamination unit, to exercise with a team that was there in Salt Lake City.

I was actually on site when the exercise occurred, and watched the learning between the two teams. And the Salt Lake team, which is just being started, learned from the Florida decontamination teams. They went back to redeploy for the closing ceremony, but they also left in place a residual capability. In Salt Lake the decontamination team was much better off for being able to exercise with and learn from a team that had been together and had developed and garnered expertise for a long time.

Mr. BUYER. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Filner.

Mr. FILNER. Ms. Berkley, I think, put a very important question before us, and whether or not we voted for the Bioterrorism Act, as Mr. Buyer said, we have had now 6 months to see if we're working out the details, or we're seeing what can happen if, those details get enacted.

And her question I think has to be dealt with by this committee as we move forward. She said are we going to add a new mission when we have—we're not doing the present mission, the primary mission, satisfactorily. And, again, this is because we haven't had the resources to do that.

And that's the question. There's no wrong or right on it. It's something this committee has to grapple with, and that's the purpose of these hearings, it's the purpose of the mark-ups.

Because we voted for one act doesn't mean that the consequences of that act have been presented to us. We have to deal with it and fund it properly.

So we have to work together on this, and I thank the gentle lady for bringing up this issue. She has been a very firm advocate for her district, and we should applaud that, because what she's actually saying is for all our districts as we all feel the same thing in some way, or another.

So it's an issue, and we appreciate your testimony. And if you want to address the issue as Mr. Berkley put it, please do.

Dr. ROSWELL. Healthcare has changed significantly in this country since September 11. We're a healthcare provider. We're a predeployed Federal healthcare provider. But we have already of necessity spent scarce resources, which I fully admit are scarce, to maintain the integrity of our ability to provide and respond to the

needs of our veteran patients should this country have another terrorist attack.

We have already, with appropriated funds, purchased pharmaceutical caches that Dr. MacKay spoke of to safeguard our employees and the patients they treat at all of the locations around this country.

What I'm saying, sir, is that healthcare is different today. It's not a choice of accepting the mission, we can't continue to do our current mission of providing comfort and healthcare veterans in this new environment, post 9/11, without additional resources.

So it's really not a choice of accepting a new mission. It's whether or not we choose to fund a mission that is an essential part of delivering healthcare in the 21st century, and it's an inevitable role that the VA will play as the largest Federal pre-deployed healthcare responder in this Nation.

Mr. FILNER. I appreciate it, that was a very good statement of the issue. This is for funding.

Mr. BUYER. Mr. Chairman.

Mr. MORAN. Mr. Buyer.

Mr. BUYER. As I understand, when we passed the bioterrorism bill, and what has gone into conference, what was going to be worked out is between $3 billion and $4 billion.

That's money that we have already sent. All right. So if this piece stays in the bioterrorism bill, then future funding comes out of the HHS appropriations. If this piece is not in the bioterrorism bill, and this becomes a stand alone through us, then the funding is by us.

That's what I wanted to share here.

Mr. MORAN. Thank you, panel, very much for giving us the opportunity to make a number of statements and have debate among ourselves, and we appreciate your time with us, Mr. Secretary.

We'll call for the second panel. Thank you.

Dr. MACKAY. Thank you.

Mr. MORAN. Dr. Kevin Yeskey, Director of Bioterrorism Preparedness and Response Centers for Disease Control and Prevention, also Dr. Deborah Powell, who is the Executive Dean of the University of Kansas School of Medicine, and Dr. Stephen Wintermeyer, the Associate Professor of Clinical Medicine at Indiana University.

Dr. Wintermeyer is a Persian Gulf veteran, and a leader of the bioterrorism task force. So the subcommittee has a special privilege in welcoming him, and we appreciate the testimony of all our expert witnesses today. And I would call Dr. Yeskey.

STATEMENT OF KEVIN YESKEY, M.D., DIRECTOR, BIOTERRORISM PREPAREDNESS AND RESPONSE PROGRAM, CENTERS FOR DISEASE CONTROL AND PREVENTION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY MAUREEN LICHTVELD, M.D., ASSOCIATE DIRECTOR, PUBLIC HEALTH PRACTICE AND PROGRAM OFFICE, DEBORAH POWELL, M.D., EXECUTIVE DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF KANSAS, AND STEPHEN F. WINTERMEYER, M.D., M.P.H., ASSOCIATE PROFESSOR OF CLINICAL MEDICINE, INDIANA UNIVERSITY

Dr. YESKEY. Thank you, sir. Good afternoon, Mr. Chairman, and members of the committee. I'm Dr. Kevin Yeskey, Director of the bioterrorism preparedness and response program in the National Center of Infectious Diseases of the CDC.

I'm also a graduate and longtime adjunct faculty member of the Uniformed Services University School of Medicine.

With me today is Dr. Maureen Lichtveld, Associate Director of the workforce development of the Public Health Practice and Program office of the CDC.

Thank you for this opportunity to discuss CDC's public health response to the threat of bioterrorism. Recent events highlight the need for increased vigilance and preparedness of unexplained illnesses and injuries as an essential part of the public health network to protect the American people against bioterrorism.

The CDC outlined necessary steps for strengthening public health and healthcare capacity to protect the Nation against bioterrorist threats in its April 21, 2001, Morbidity and Mortality Weekly Report release of Biological and Chemical Terrorism: Strategic Planning for preparedness and response, Recommendations of the CDC's strategic planning work group.

This report reinforces the work CDC has been contributing to this effort since 1988, and lays a framework from which to enhance public health infrastructure. In keeping with the message of the report, five key focus areas have been identified which provide the foundation for local, State, and Federal planning efforts; preparedness and prevention, detection and surveillance, diagnosis and characterization of biological and chemical agents, response, and communications. These areas capture the goal of CDC's bioterrorism preparedness and response program for general bioterrorism preparedness.

My written statement details the ongoing efforts of these five areas, and so I would like to spend the balance of my time highlighting some of our current focus areas.

In the area of preparedness and prevention, CDC has been working to ensure that all levels of the public health community, Federal, State, and local, are prepared to work in coordination with the medical emergency response communities to address the public health consequences of biological and chemical terrorism.

CDC has created diagnostic and epidemiological guidance for State and local health departments, and will continue to help States conduct drills and exercises to assess local readiness for bioterrorism.

The next area is detection and surveillance. Since the initial detection of a biological terrorist attack will most likely occur at the

local level, CDC is providing terrorism related training to epidemiologists, laboratories, infection control personnel, emergency responders, emergency department personnel, and other front line healthcare providers, as well as health and safety personnel.

The CDC is also working with partners such as Johns Hopkins Center for Civilian Biodefense Studies and the Infectious Diseases Society of America to develop training and education materials for incorporation into medical and public health graduate and post-graduate curricula.

Third, CDC continues to invest in the public health communications infrastructure through the Health Alert Network, or HAN. HAN is a nationwide program to establish the communications, information, distance-learning, and organizational infrastructure for a new level of defense against health threats, including bioterrorism.

For response to events another integral component of the public health preparedness, CDC has developed a national pharmaceutical stockpile. The CDC maintains an interagency agreement with the National Acquisitions Center for the Department of Veterans Affairs in order to facilitate the procurement of pharmaceuticals, medical supplies, and antidotes that comprise the NPS.

This partnership allows CDC to take advantage of a four billion dollar annual pharmaceutical buying power of the VA to analyze various markets and then develop the need and very favorable contractual agreements for the stockpile program.

These contracts provide the acquisition of pharmaceuticals and other material, inventory rotation, and maintenance, and emergency transport. CDC's partnership with the VA also permits the stockpile program to access the VA's current vendor for pharmaceuticals and medical/surgical supplies under very favorable terms.

CDC's goal in education and training is for the entire public health system to maintain a public health work force fully capable of delivering the essential public health services during routine and emergency operations. As one of the Nation's largest providers of health care, the VA is a partner in CDC's efforts.

CDC and the VA collaborate through a number of different training and education mechanisms, including: the Public Health Training Network, laboratory training activities, and the Association of American Medical Colleges, or AAMC, their bioterrorism initiative First Contact, First Response.

Since October, of 2000, 79 VA Medical Centers have participated as satellite down link sites of PHTN presentations. The National Laboratory Training Network provides clinical, environmental, and public health laboratory training forces with six regional offices to identify training needs, deliver courses, and evaluate NLTN training programs.

Last year alone, the NLTN delivered more than 226 courses to an audience of more than 6,200 students. Since 1997, NLTN has trained 359 students from the VA. In the year 2000, CDC established a national system of Centers for Public Health Preparedness to strengthen State and local work force capacity to respond to bioterrorism and to support CDC prevention programs in general.

The Centers have developed over 180 bioterrorism-related training programs, short courses, seminars, public meetings, media

interviews, and national satellite broadcasts to address local and regional concerns of preparedness.

The AAMC designed an educational plan with CDC to address the preparedness of the work force in both the near and distant futures by including specific educational experiences for medical students, resident physicians and practice physicians. Specifically, regional medicine-public health education centers will be established to facilitate this preparedness education activities and foster collaboration between medical schools and State and local public health agencies.

CDC will collaborate with the VA, Department of Defense, FEMA, FDA and other Federal partners, State and local governmental agencies, as well as medical societies, and national professional organizations in implementing the Centers for Preparedness and other education and training programs targeting clinicians and other public health and healthcare professionals.

In conclusion, CDC continues to work with other Federal agencies and partners, as well as State and local public health departments to ensure the health and medical care of our citizens. A strong and flexible public health infrastructure is the best defense against any disease outbreak.

Thank you very much for the invitation to present today. I'll be happy to answer any questions you may have.

[The prepared statement of Dr. Yeskey appears on p. 56.]

Mr. MORAN. Thank you, Doctor, very much. Dr. Powell, the University of Kansas, I especially welcome my—your home town, at least home state. Thank you very much for joining us here today.

Dr. POWELL. Thank you, Mr. Chairman, for giving me the opportunity to testify today and strongly support H.R. 3253 and H.R. 3254. The University of Kansas VA affiliation is one of the oldest VA affiliations in the country, and they're somewhat unusual because they're affiliated with four VA Medical Centers within our VISN: Kansas City, Wichita, Topeka, and Leavenworth.

We also are unusual in that our primary VA Hospital, 15 minutes away from our medical school, is in Kansas City, MO. We have a bi-state partnership with the VA.

The Veterans' Affairs Medical Centers are a critical part of our educational efforts for our 700 medical students, and almost 400 resident physicians in training, and the VA provides almost a hundred residency positions in primary care and specialty fields to the University of Kansas School of Medicine.

I believe today I'm speaking in support of the second very important mission of the VA, which is the educational partnerships with the School of Medicine. And the events that the Chairman referred to of September 11 has made medical schools acutely aware of the gap in our curriculum, and the need to fill those gaps, and it's entirely appropriate that the Department of Veterans Affairs and the Department of Defense take a leadership role in partnering with us to address the needs.

I wanted to just summarize a few points, and not read my testimony. The first point I'd like to make is that I think these initiatives should be ones of partnership and inclusivity. I hope that the important partnership of the VA and the AAMC will not be deducted. The CDC has already referred to the exciting new collabo-

rations with the AAMC and CDC to establish medical school of public health regional education centers, which I think could be very important collaborative units for the VA in this partnership.

But the partnership can't be confined to medical schools alone. All health professionals have to be educated to recognize and treat the results of terrorist activities. So the partnership has to extend beyond the schools of medicine and public health to include schools of pharmacy, dentistry, nursing, and allied health through our academic health centers.

It also must include our resident physicians, who have a somewhat different, but real educational needs, and our practicing physicians throughout the country who have educational needs as well, particularly through the American Board of Medical Specialties and continuing medical education.

A second point I would like to make is that those of us in medical education are struggling with information overload, and how to teach our students to access, rather than memorize information. It is impossible in 4 years of medical school and 3 to 7 years in residency for a practitioner to learn all that they are going to require in 40 plus years of practice.

So all of the educational materials that have come out of this proposed legislation should be designed with the idea of providing accessible information that can be readily accessed by practitioners of all different levels.

Thirdly, I would like to just mention the need in these times of national crisis to develop systems for rapid information sharing. We need to develop systems to share data, and to build information linkages across boundaries such as State lines, to our medical centers, hospitals, health departments, et cetera.

We need to start with our emergency rooms and urgent treatment centers since these are the primary access to our systems by individuals.

The VA has been a leader in medical information systems, but we need to find better ways to link our systems to the VA, and to each other across State lines and regions, and this is the challenge of all of us.

Finally, I think we cannot neglect agriculture. Kansas is one of only six State nationally which operates a combined department of health and environment. And we have active collaborations with our Land Grant Institution at Kansas State University.

Issues of bioterrorism in many forms also involve the agricultural community, and we must find ways to connect with them as well.

Finally, I just want to say that I am extremely supportive of any effort that can be found to strengthen the historic partnerships between the Veterans' Affairs Medical Centers and our health professional schools, particularly our schools of medicine. These historic partnerships could be re-strengthened and re-energized in this time of national crisis, and I think this represents an opportunity the University of Kansas will be very happy to play whatever role we can in assuring the success of these partnerships and initiatives.

[The prepared statement of Dr. Powell appears on p. 70.]

Mr. MORAN. Thank you, Doctor. Dr. Wintermeyer.

Dr. WINTERMEYER. Chairman Moran, members of the committee, good afternoon. I am Dr. Stephen Wintermeyer, Associate Professor

of Clinical Medicine in the Division of Pulmonary, Allergy, Critical Care and Occupational Medicine at the Indiana University School of Medicine. Dean D. Craig Brater of the IU School of Medicine has asked me to represent the school at the hearing today.

Let me speak briefly about myself and the IU School of Medicine. I know the VA system well. I have been a medical student in a VA hospital. I have served as a resident and fellow in a VA hospital. I am presently a member of the medical staff at the Richard L. Roudebush Veterans' Affairs Medical Center in Indianapolis.

Equally important, I have been a patient in the VA, and I have been a family member of a patient in the VA. I have tremendous respect for the VA health system.

I also know something about biological, chemical, and nuclear weapons. As a physician on active duty in the U.S. Army for 6 years I was deployed to the Middle East for 6 months during Operations Desert Shield and Desert Storm. As chief of medicine and ambulatory care for the 46th Combat Support Hospital during these operations, among other things I made a decision along with my hospital commander to start our troops on pyridostigmine, a nerve agent prophylactic medication.

At the present time, in addition to giving talks on bioterrorism, I am the Associate Chair of the IU School of Medicine Task Force on Bioterrorism.

The IU School of Medicine is the second largest medical school in the country. At IU, we enjoy a mutually beneficial and appreciated affiliation with the Richard L. Roudebush Veterans' Affairs Medical Center. Our school's primary effort regarding bioterrorism is our Task Force on Bioterrorism, created by Dean Brater right after the 9/11 tragedy.

This task force is chaired by Dr. Rose Fife, our Associate Dean for Research, and includes members from our Schools of Medicine, Nursing, Dentistry, the VA Medical Center, including several faculty members who are also veterans; our County and State Departments of Health, the Indiana Poison Control Center, the University environmental health and safety department, and other primary teaching hospitals.

I should like to emphasize that the VA is a very important participant on this task force. We have been dealing with issues of training, personnel mobilization, emergency transport, general education, and so on. As an example of one area of immediate interest for the task force, I enclose with my testimony a draft course outline for a "crash course" that we are developing on emergency preparedness for medical students, nursing students, residents, and other trainees and faculty.

The group developing the course includes members of our County Department of Health, the Indiana Poison Control Center, and full-time School of Medicine faculty members for the Departments of Emergency Medicine, Medicine, and Obstetrics/Gynecology.

Additionally, Dr. Fife and other members of the school's task force, including our VA representative, serve on a task force organized by the Mayor of Indianapolis to deal with disaster preparedness. This group has been working on innovative measures, including emergency credentialing of physicians and hospitals other their home hospital in the event of disasters to ensure that medical per-

sonnel will be distributed throughout the city, and, indeed, region as needed.

They have also been dealing with issues such as networking among hospitals such as building a common electronic medical record, emergency transportation, quarantine facilities, access to drugs, and care of mass casualties, to list a few.

The activities of the task force are examples of what can and should be done cooperatively among hospitals and institutions to improve our ability to withstand any future attacks or other disasters. The VA's participation as a major member of this task force ensures that programs developed by the VA in this arena can be readily deployed throughout the community.

I am here today to speak in support of both H.R. 3253, the National Medical Emergency Preparedness Act of 2001, and H.R. 3254, the Medical Education for National Defense in the 21st Century Act. H.R. 3253 establishes emergency preparedness centers within the VA. Such centers would involve strong collaboration with qualified medical schools, public health schools, and other research and educational entities.

With the VA's national network and affiliations with medical schools, such as ours, and its recent integral role in educating both the medical and lay communities about bioterrorism, VA hospitals are in an excellent position to work with these medical schools to expand research in medical emergency preparedness and to further enhance the training of healthcare professionals in this area.

H.R. 3254 creates a joint program between the Department of Veterans Affairs and the Department of Defense in which a series of model education and training programs on the medical response to the consequences of terrorist activities are developed and disseminated. Again, the long history of collaboration between VA hospitals and medical schools puts the VA in an excellent position to get this valuable job done.

H.R. 32543 and H.R. 3254 are valuable initiatives that work in synergy to address critically important educational and research needs in the area of emergency preparedness. This synergy is leveraged even more through partnering with the Uniform Services University of Health Sciences, and VA affiliated medical schools.

In closing, let me reinforce our support for these laudatory initiatives, but also emphasize that they will require new resources for the VA system. Existing resources should not be reassigned for this proposal, rather additional resources should be added for to this specific program. To do otherwise would jeopardize other valuable VA programs. Indeed, the programs that would be created by these two pieces of legislation require a stable foundation on which to build. The stable foundation is a solid and vibrant VA medical health system.

I thank you for this opportunity to present to you today.

[The prepared statement of Dr. Wintermeyer, with attachment, appears on p. 75.]

Mr. MORAN. Doctor, thank you very much for your testimony. I thank the entire panel.

Dr. Powell, you have the opportunity to at least explain to me in a way that I can understand it, because I'm familiar with the University of Kansas School of Medicine. I'm familiar with the

Kansas/Missouri line. I'm familiar with our VA hospitals in Kansas City and Leavenworth, and Topeka and Wichita.

And if you could just generally help me understand the consequences of this legislation? If it's passed, what would change, how would things be different, and in addition to that would you—since September the eleventh have the—has the University of Kansas School of Medicine, and other schools of medicine changed their curriculum? Is there continuing medical education for physicians that's now different? What is it that we're doing today, and what would this legislation help us accomplish?

Dr. POWELL. Well, I think, Congressman, what we are—we have made some attempts to introduce new topics related to bioterrorism and chemical warfare and radiological terrorism into our curriculum, but our faculties are not well prepared to do this in many instances.

In the fourth year of our school of medicine, we have a required course called The Health of the Public, and this is the venue for us to introduce the course materials for the medical students.

But this legislation, I believe, would help in the generation of new courses, such as being—are being put in place by the Uniformed Services University, which would provide us with expertise that may be lacking in our own faculties to introduce the kinds of materials that we could use for the education of our students.

We have core courses for our residents as well. Our cost is important, so surgery, medicine, pediatrics, neurology, psychiatry residents area all—all have a core curriculum, and we would hope that this legislation could help introduce courses as well that would allow us to incorporate them into our core curriculum for our residents. Continuing medical education, at least in our state, has not emphasized as yet courses related to bioterrorism and chemical warfare for our practicing physicians, and I think this is a huge need. I think our physicians in practice need to have access to data in a timely fashion, and, also, updated information because these are the pieces, events, medical contingents that we have not experienced often many of us in our practice life times.

And we need to have concise, well developed materials to access for our practitioners, for our residents, and for our students. One of the things that I think that we really need to do is provide the ground work with the basic forces, but then have access to information so that people can immediately have that. They cannot remember everything. If you have to have things that you can access if you need to if you're in the emergency room, and on the wards——

Mr. MORAN. Let me follow up with that, because I think that what you just said is true and important that we have a quick response in position, or a nurse practitioner who knows what to do when someone presents in the office lobby, or in the waiting room at the hospital complaining that they've come in contact with anthrax, or smallpox.

And my guess is that we're not yet at the point of—in most instances, of knowing what that response is supposed to be. Nor is there—is there someone at the University of Kansas School of Medicine to call and say someone claims to have some biological agent contact, what do we do?

Dr. POWELL. I think we learned—at least speaking from my—we aren't at that point yet. And I think there are two problems. First of all, we have a number of specialists. You can call someone in radiation biology, you can call someone in infectious diseases, but we haven't gotten coordinated effort.

And then, secondly, I think unless there is a mass emergency, if there are isolated attacks, people aren't going to come to an emergency room and say I have been exposed to anthrax, or I have been exposed to smallpox.

And that is part of our problem as we saw in the events following September 11, that the patients don't come in with labels with for us. And may very well give them the scenarios that many of them will not come to us that way.

And, therefore, we need to educate our students, our residents, and physicians across the State. And I think particularly paying attention to the emergency room and urgent treatment physicians as to how patients may present. And that, I don't think, we have done yet.

Mr. MORAN. Doctor, why the VA? And my explanation, at least to myself, is that you have a long, continuing, ongoing relationship with the Veterans Administration and its hospitals.

Is that why this makes sense to you?

Dr. POWELL. I think this makes sense to me for two reasons. The VA and the Department of Defense ought to be the entities, the agencies, that have the most direct experience with biological warfare, or chemical warfare because it's more practical for the people, the patient populations that they treat, for the kinds of physicians in the case of the Uniformed Services University that they are preparing.

We are preparing general physicians to enter residency programs in all different specialties. But particularly the Uniformed Services University is preparing physicians, military physicians. And the VA physicians at least have a mission of treating military personnel. We don't have that concentrated mission.

Also, the VA has this longstanding educational partnership. So we know how to work with the VA. We have worked with the VA for over 50 years in training medical students. So we're comfortable with the VA as an established relationship.

So those are the two reasons why this makes sense to me.

Mr. MORAN. Thank you very much. Dr. Wintermeyer, I have a question for you, but maybe in the second round. Let me turn the opportunity over to Mr. Filner.

Mr. FILNER. Mr. Filner reserves his time.

Mr. MORAN. Mr. Boozman.

Mr. BOOZMAN. I'm just anxious to hear your second question.

Mr. MORAN. Mr. Buyer.

Mr. BUYER. I'd like to thank you for putting this panel together. Let me compliment you, Dr. Powell. You are very articulate, not that doctors aren't, but you are very articulate. Do you have a military background at all?

Dr. POWELL. No, I don't. My brother was killed in Vietnam. So I have a close affinity to the military.

Mr. BUYER. Yes.

Dr. POWELL. And, also, I trained also as a medical student in a VA hospital, and my husband was a practicing physician in VA hospitals for 20 years.

Mr. BUYER. I detected something. The Chairman asked a perfect question; why the VA. And obviously I was pleased with how you answered, but I can share with you why I came up with this. And maybe it's also on my background.

When we have to prepare doctors in the arena of military medical readiness, and if we are giving our military anthrax inoculations because the threat is real, then we must prepare—and you're on the staff of USUHS. So you're preparing these doctors to treat those casualties.

Well, the VA has got to get with it, too, because they're going to be shipped to the VA. What we have attempted to do is to prepare the VA to receive this, the nexus is already in place with the teaching—as a teaching hospital for the medical universities.

And I just saw a win-win. So when you talked about partnership in my mind I kept thinking about the nexus, but it's all win-win here. We prepare the military medical readiness, you've got the expertise. The country's asking us to prepare a response, and I just saw it all as a win-win.

Now, you did catch me by surprise in your testimony when you said I like it so much we've got to extend it to nursing, pharmacy, allied health, dentistry. I agree, but, you know, we can—I'll agree with Mr. Filner here, whoa, wait.

Whoa, I don't know how this is all going to happen, but at first when we put this together last fall, beginning last winter, it was about the first responder groups.

And that was my immediate concern, and I also notice CDC. As a health agency, Congress was working with you on the bioterrorism bill. I noticed some within HHS wanted to protect some of their turf.

You know, I don't care about that. What I care about is that if this is the right nexus, then let's do it. If we disagree, then say, Steve, this isn't the right way to do this. Then what's the best way to do it?

If someone says, oh, let's just let HHS and CDC do it, fine, but I guess we have to do this anyway. Right? We have to prepare the military because it's going to happen on the battle field, and we have to prepare the VA because they're going to be the recipient. They're going to receive these patients, and we've got to prepare the public because we never even found out who released this biological toxin called anthrax.

This nut case could release it anywhere, or at an arena, and shame on us if the country has given us time to prepare, and we sent the money to the President and for whatever reason we haven't done it.

So I just wanted to add my two cents. And, Mr. Chairman, you asked a really key question here. But the HHS, correct me if I'm wrong, there is no turf battle here is there? You want to work in coordination and in partnership as Dr. Powell has mentioned, and also Dr. Yeskey?

Dr. YESKEY. That's absolutely correct. We encourage cooperation, and we want to work in a cooperative way and in coordination with

other Federal, State, and local agencies in preparing for bioterrorism.

Mr. BUYER. Dr. Omenaca testified, and his testimony really got my attention. “A greater degree of coordination between doctors directly involved in the management of patients suffering from a bioterrorist attack, and official institutions is needed.”

Now this is an internal medicine and an infectious disease guy. And if he's struggling and trying to figure this stuff out—he mentioned someone else who is a family doctor, an intern, or an emergency room doctor. Who then calls—as the Chairman said, the University of Kansas, or calls one—their professors. You know, they've got relationships.

Then he said, “I detected potential deficiencies in communications between clinicians, health departments, and perhaps even the CDC.” So that's what we've got. I mean you've got one of these experts that everybody turns to and he then has to turn to somebody, and he's getting all this conflicting information.

And so hopefully what we're doing here on this “education piece,” we have practicing physicians. We have people that we have to prepare for first response, but in the process we also, as we bring more docs on line, we just want to be able to think outside the box. Do you agree?

Dr. POWELL. Absolutely, I do.

Mr. BUYER. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Filner. Mr. Boozman.

Mr. BOOZMAN. I'm anxious to hear your question.

Mr. MORAN. You certainly did, and the pressure is really on; in some ways I might change the topic here, although something occurred to me as Mr. Buyer was speaking.

Is there any role model elsewhere in the world, perhaps in medical education, regarding this topic? Are we truly creating a program from scratch?

Dr. WINTERMEYER. Is that me?

Mr. MORAN. That is not the question. I'll be happy to have you answer.

Dr. WINTERMEYER. Okay. I wasn't sure if that was the question you had been saving for me.

In my mind I would make reference to BCLS, Basic Cardiac Life Support System, and ACLS Advance Cardiac Life Support. These are advanced life support modules, which the various organizations have developed, such as the American Heart Association, and are generally taught in two, or three day periods of time. In my mind this is a topic that would fit into that sort of model.

When I was deployed over to Saudi Arabia during the Gulf War, the people at Fort Detrick came over to multiple facilities in the Gulf and gave their chemical casualty care course, in which they took a week long course and condensed it into about 2 days for those of us over there.

So that's sort of model I think would be a reasonable model, if we're trying to develop something like that at IU School of Medicine to provide to our students and faculty as well.

I think that this sort of model is useful, but it's only part of the picture. As we all acknowledge, this sort of thing fortunately doesn't happen very often. It catches everybody's attention, and

then people, physicians in particular, go back to their usual routine.

We need to expose the students, we need to expose the practicing physicians to these topics, but we also need to make sure that they have ready access to that information so that 3 or 4 months down the road if a patient comes into their waiting room and the patient has smallpox or anthrax, the student or physician knows how to deal with it.

So I would very much encourage web based resources to be out there, even modules for Palm Pilots and that sort of thing, so that people can have access to them.

They've seen the big picture a few months ago, and now they're getting details that they need at that moment. So it's a two pronged picture as I see it.

Mr. MORAN. I also serve on the Transportation Committee, and we have looked at Israel, for example, as a role model here on safety. And I was interested if there was another country such as Israel that has been down this path.

If this question is a prelude to the question that I really wanted to explore with you, although it's—it's very much related at this point. I was curious as to whether or not your answer would be the Department of Defense. Whether our military hospitals, and doctors, healthcare professionals, are they within the military healthcare system further along, well advanced, knowledgeable, and trained in regard to the kind of issues we're talking about that may face the general public?

And, Doctor, first of all, let me thank you for your service to our country, and tell you that because of the experiences that you encountered I am very much interested in any thoughts that you may have in regard to the circumstances that our deployed men and women today face in Afghanistan, or elsewhere, as a result of biological or chemical agents.

The kind of experiences this subcommittee has taken of course of looking at what occurred during the Persian Gulf War in hopes that we can learn something from that to prevent the same kind of circumstances being presented to the VA by the men and women who return from Enduring Freedom.

And either now, or subsequent to this meeting, I would be very interested in any thoughts that you might have based upon your experiences and understanding of application of military health.

What have we learned from your experience, the experience of many veterans like you, from our Persian Gulf days, events, such that we are going to more likely returning men and women to the United States in much more healthy condition than we did a decade ago?

Dr. WINTERMEYER. I think you have a multi-faceted question.

Mr. MORAN. It was built up by my colleagues that I was reluctant——

Dr. WINTERMEYER. You couldn't let them down. I think the first part of your question is why is the Department of Defense the most appropriate model, at least in this country. I think I would answer that by making a reference to the fact that I was a medical student at a private university in New England. I was a resident at an Army facility just in the northern part of the District, at Walter

Reed. And then I was a fellow at a public university in California, and now I'm a faculty member at a public university in the midwest.

So I have seen a lot of different medical centers. Clearly the best education I ever got on this topic was when I was on active duty in the Army. The people that trained me were all faculty members, an adjunct faculty members at USUHS, and—I can't think of a better facility to develop a model curriculum if we're going to develop a model curriculum and try to disseminate it.

Looking back at the medical school I was at, and the other facilities I have been at, there is no group or critical mass of people on faculty that have the expertise to develop that. And that's part of the issues and mission at USUHS and they have the personnel there. So I'm comfortable with that.

Mr. MORAN. Let me follow up with that point. If you put two physicians side by side, one who has served in the military, and one who is a civilian in practice, one trained military aspects of healthcare, and one not, would we find a difference in the education and training level between those two physicians to address the issues of preparedness for a biological or chemical agent—an act of terrorism?

Dr. WINTERMEYER. As a basic general rule, yes. I did my residency in the Army. I did not go to medical school at USUHS, but I did my residency in the Army, and part of our training as an intern was to spend 4 days at Fort Sam Houston in the Combat Casualty Care Course, outdoor activity primarily dealing with battlefield casualties. And I certainly had training in dealing with NBC type exposures that people might have.

I have never had anything like that in the civilian world. Shortly after the events happened last fall, our Department of Medicine decided there were a lot of people in our department who didn't know much about anthrax. We needed to have a Ground Rounds and teach the people about anthrax.

The chief resident coordinated it and spoke to our Chief of Infectious Disease, who is a very reasonable person to speak to. Eventually he contacted me because he knew that I had some military background and dealt with or had been trained in dealing with these biological agents. Fortunately, I did not have to deal with any directly myself when I was over there.

So my impression is, yes, that military physicians do have a better training and expertise on that topic.

Mr. MORAN. Thank you very much, Doctor. Mr. Filner. Mr. Boozman. Mr. Buyer.

Mr. BUYER. Thank you. I just have one follow-up question for Dean Powell and Dr. Wintermeyer. For the purpose of legislative history, I would like to establish that this bill is not intended for there to be a Federal mandate of specific curriculum on medical universities.

That testimony from Health and Human Services about coordination, the testimony from Dr. Wintermeyer referencing USUHS as the experts, and that he's comfortable with regard to their curriculum and how that can be coordinated with the medical universities, and in cooperation with the CDC, is what we envision.

Secondly, this legislation does not have a specific purpose to establish new community standards of medical practice. These chemical agents and biological toxins and radiological agents are still uncommon, and therefore should not be used by trial lawyers to establish grounds of community standards for the purpose of medical malpractice.

I invite comment from Dean Powell and Dr. Wintermeyer on these two points.

Dr. POWELL. Well, I'm grateful for your analysis and clarification because I think those are both very important points. Certainly across the medical schools it would be I think unfortunate if there were expected standards of curriculum that were imposed on the medical schools.

So I welcome that very much. I think we all—you know, that we need to address these important issues, and doing it in a spirit of partnership and cooperation without coercion is very important.

Also, I think your second point is absolutely essential to the practitioners of this country and graduates. And I appreciate your clarification.

Dr. WINTERMEYER. I would concur with the Dean specifically regarding your second issue, albeit the events of last fall have generated great publicity and physicians throughout the country know a lot more about anthrax now than they did back in September, or early October, last fall.

The reality is that those physicians had never seen anthrax. If they were asked to show a picture of anthrax, they probably couldn't find one and they would have to refer a book dated 1904, or something like that. Or search the CDC web site.

So to expect that the accurate diagnosis of anthrax should be a standard of care is unrealistic. It is important that anthrax usually presents initially as a very nonspecific illness. So it's not like—and someone made reference earlier, it's not like these people come in with a post card on their head saying that they have anthrax. It's not an easy diagnosis to make rapidly, and the fact is that most physicians haven't seen it. So to expect rapid diagnosis is not realistic.

Mr. BUYER. Thank you very much for your testimony, and I also want to take the opportunity to complement HHS for all the work the men and women have done and how they responded to September 11. Please accept my compliments.

Dr. LICHTVELD. Thank you.

Dr. WINTERMEYER. Thank you.

Mr. MORAN. Thank you, Mr. Buyer. Dr. Lichtveld, just to give you the opportunity so that you can say anything you would like, I would like to grant you the microphone if there is anything you would like to say.

Dr. LICHTVELD. Thank you, Mr. Chairman. We're here at the pleasure of the subcommittee, and we're pleased to coordinate with the VA.

Mr. MORAN. Thank you. Thank you for your attendance. Our subcommittee has been provided with the testimony by six veterans organizations that will be placed in the record if there is not objection. And, also, Chairman Smith has submitted his statement for the record, and will be ordered to be included.

[The prepared statement of Chairman Smith appears on p. 49.]

Mr. MORAN. I believe this just about concludes this hearing, and we anticipate that these bills will be considered by the subcommittee for mark up prior to the recess in May.

So based upon the statements here today we ought to see if there are some issues that need to be resolved because the intention of the full committee is to have these two items on the agenda.

Again, I appreciate both panels for being with us today, and for—particularly the experts taking time out of their schedules. I'm always reluctant to intrude upon doctors when you ought to be saving lives. Perhaps by what we do today that can occur.

So, again, I appreciate your attendance, and this subcommittee is adjourned.

[Whereupon, at 4:50 p.m., the subcommittee was adjourned.]

APPENDIX

I

107TH CONGRESS
1ST SESSION

H. R. 3253

To amend title 38, United States Code, to provide for the establishment of emergency medical preparedness centers in the Department of Veterans Affairs.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 8, 2001

Mr. SMITH of New Jersey (for himself, Mr. EVANS, Mr. BILIRAKIS, Mr. RODRIGUEZ, Mr. BUYER, and Mr. STEARNS) introduced the following bill; which was referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to provide for the establishment of emergency medical preparedness centers in the Department of Veterans Affairs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "National Medical
5 Emergency Preparedness Act of 2001".

1 **SEC. 2. ESTABLISHMENT OF EMERGENCY MEDICAL PRE-**
2 **PAREDNESS CENTERS.**

3 (a) IN GENERAL.—(1) Subchapter II of chapter 73
4 of title 38, United States Code, is amended by adding at
5 the end the following new section:

6 **"§ 7323. Medical emergency preparedness centers**

7 "(a) ESTABLISHMENT OF CENTERS.—(1) The Sec-
8 retary shall establish at least four medical emergency pre-
9 paredness centers in accordance with this section. Each
10 such center shall be established at a Department medical
11 center and shall be staffed by Department employees.

12 "(2) The official within the central office of the Vet-
13 erans Health Administration responsible for medical pre-
14 paredness shall be responsible for supervising the oper-
15 ation of the centers established pursuant to this section
16 and shall provide for ongoing evaluation of the centers and
17 their compliance with the requirements of this section.

18 "(b) MISSION.—The mission of the centers shall be—

19 "(1) to carry out research on and develop meth-
20 ods of detection, diagnosis, vaccination, protection,
21 and treatment for chemical, biological, and radio-
22 logical threats to the public health and safety;

23 "(2) to provide education, training, and advice
24 to health-care professionals, including health-care
25 professionals outside the Veterans Health Adminis-
26 tration; and

1 "(3) to provide contingent rapid response lab-
2 oratory assistance and other assistance to local
3 health care authorities in the event of a national
4 emergency.

5 "(c) CENTER DIRECTORS.—Each center shall have a
6 Director with (1) expertise in managing organizations that
7 deal with threats referred to in subsection (b), (2) exper-
8 tise in providing care to populations exposed to toxic sub-
9 stances, or (3) significant research experience in those
10 fields.

11 "(d) SELECTION OF CENTERS.—(1) The Secretary
12 shall select the sites for the centers on the basis of a com-
13 petitive selection process and a finding under paragraph
14 (2). The centers selected shall be located in different re-
15 gions of the Nation, and any such center may be a consor-
16 tium of efforts of more than one medical center. At least
17 one of the centers shall be established to concentrate on
18 chemical threats, at least one shall be established to con-
19 centrate on biological threats, and at least one shall be
20 established to concentrate on radiological threats.

21 "(2) The finding referred to in paragraph (1) with
22 respect to a proposal for designation of a site as a location
23 of a center under this section is a finding by the Secretary,
24 upon the recommendation of the Under Secretary for
25 Health, that the facility or facilities submitting the pro-

1 posal have developed (or may reasonably be anticipated
2 to develop) each of the following:
3 "(A) An arrangement with a qualifying medical
4 school and a qualifying school of public health (or a
5 consortium of such schools) under which physicians
6 and other persons in the health field receive edu-
7 cation and training through the participating De-
8 partment medical centers so as to provide those per-
9 sons with training in the diagnosis and treatment of
10 illnesses induced by exposures to toxins, including
11 chemical and biological substances and nuclear ion-
12 izing radiation.
13 "(B) An arrangement with an accredited grad-
14 uate program of epidemiology under which students
15 receive education and training in epidemiology
16 through the participating Department facilities so as
17 to provide such students with training in the epide-
18 miology of contagious and infectious diseases and
19 chemical and radiation poisoning in an exposed pop-
20 ulation.
21 "(C) An arrangement under which nursing, so-
22 cial work, counseling, or allied health personnel and
23 students receive training and education in recog-
24 nizing and caring for conditions associated with ex-

1 posures to toxins through the participating Depart-
2 ment facilities.

3 "(D) The ability to attract scientists who have
4 made significant contributions to the development of
5 innovative approaches to the detection, diagnosis,
6 vaccination, protection, or treatment of persons ex-
7 posed to chemical, biological, or radiological sub-
8 stances.

9 "(3) For purposes of paragraph (2)(A)—

10 "(A) a qualifying medical school is an accred-
11 ited medical school that provides education and
12 training in toxicology and environmental health haz-
13 ards and with which one or more of the participating
14 Department medical centers is affiliated; and

15 "(B) a qualifying school of public health is an
16 accredited school of public health that provides edu-
17 cation and training in toxicology and environmental
18 health hazards and with which one or more of the
19 participating Department medical centers is affili-
20 ated.

21 "(e) FUNDING.—(1) Amounts appropriated for the
22 activities of the centers shall be appropriated separately
23 from amounts appropriated for the Department for med-
24 ical care.

1 "(2) There are authorized to be appropriated for the
2 centers under this section $20,000,000 for each of fiscal
3 years 2002 through 2006.

4 "(3) In addition to funds appropriated for a fiscal
5 year pursuant to the authorization of appropriations in
6 paragraph (2), the Under Secretary for Health shall allo-
7 cate to such centers from other funds appropriated for
8 that fiscal year generally for the Department of Veterans
9 Affairs medical care account and the Department of Vet-
10 erans Affairs medical and prosthetics research account
11 such amounts as the Under Secretary for Health deter-
12 mines appropriate to carry out the purposes of this sec-
13 tion.

14 "(f) RESEARCH ACTIVITIES.—Each center shall con-
15 duct research on improved medical preparedness to protect
16 the Nation from threats in the area of that center's exper-
17 tise. Each center may seek research funds from public and
18 private sources for such purpose.

19 "(g) PEER REVIEW PANEL.—(1) In order to provide
20 advice to assist the Secretary and the Under Secretary for
21 Health to carry out their responsibilities under this sec-
22 tion, the Under Secretary shall establish a peer review
23 panel to assess the scientific and clinical merit of pro-
24 posals that are submitted to the Secretary for the designa-
25 tion of centers under this section.

1 "(2) The peer review panel shall include experts in
2 the fields of toxicological research, bio-hazards manage-
3 ment education and training, radiology, clinical care of pa-
4 tients exposed to such hazards, and other persons as de-
5 termined appropriate by the Secretary. Members of the
6 panel shall serve as consultants to the Department.
7 "(3) The panel shall review each proposal submitted
8 to the panel by the officials referred to in paragraph (1)
9 and shall submit to the Under Secretary for Health its
10 views on the relative scientific and clinical merit of each
11 such proposal. The panel shall specifically determine with
12 respect to each such proposal whether that proposal is
13 among those proposals which have met the highest com-
14 petitive standards of scientific and clinical merit.
15 "(4) The panel shall not be subject to the Federal
16 Advisory Committee Act (5 U.S.C. App.).
17 "(h) RESEARCH PRODUCTS.—(1) The Under Sec-
18 retary for Health shall ensure that information produced
19 by the research, education and training, and clinical activi-
20 ties of centers established under this section is made avail-
21 able, as appropriate, to health-care providers in the United
22 States. Dissemination of such information shall be made
23 through publications, through programs of continuing
24 medical and related education provided through regional
25 medical education centers under subchapter VI of chapter

1 74 of this title, and through other means. Such programs
2 of continuing medical education shall receive priority in
3 the award of funding.

4 "(2) The Secretary shall ensure that the work of the
5 centers is conducted in close coordination with the Office
6 of Homeland Security and the Department of Defense,
7 and research products or other information of the centers
8 shall be coordinated and shared with that Office and the
9 Department of Defense.

10 "(i) ASSISTANCE TO OTHER AGENCIES.—The Sec-
11 retary may provide assistance requested by appropriate
12 Federal, State, and local civil and criminal authorities in
13 investigations, inquiries, and data analyses as necessary
14 to protect the public safety and prevent or obviate biologi-
15 cal, chemical, or radiological threats.

16 "(j) DETAIL OF EMPLOYEES FROM OTHER AGEN-
17 CIES.—Upon approval by the Secretary, the Director of
18 a center may request the temporary assignment or detail
19 to the center, on a nonreimbursable basis, of employees
20 from other Departments and agencies of the United States
21 who have expertise that would further the mission of the
22 center. Any such employee may be so assigned or detailed
23 on a nonreimbursable basis pursuant to such a request.
24 The duration of any such assignment or detail shall be

1 subject to approval by the Office of Personnel Manage-
2 ment.".

3 (2) The table of sections at the beginning of such
4 chapter is amended by inserting after the item relating
5 to section 7322 the following new item:

"7323. Medical emergency preparedness centers.".

6 (b) INITIAL FUNDING.—Funds for fiscal year 2002
7 for the medical emergency preparedness centers estab-
8 lished under section 7323 of title 38, United States Code,
9 as added by subsection (a), shall be provided from funds
10 made available under Public Law 107–38.

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107TH CONGRESS
1ST SESSION

H. R. 3254

To amend title 38, United States Code, to provide for a partnership between the Department of Veterans Affairs and the Department of Defense to develop and disseminate education and training programs on the medical responses to the consequences of terrorist activities.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 8, 2001

Mr. BUYER (for himself, Mr. SMITH of New Jersey, Mr. BILIRAKIS, Mr. STEARNS, Mr. SNYDER, and Mr. MCHUGH) introduced the following bill; which was referred to the Committee on Veterans' Affairs, and in addition to the Committee on Armed Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title 38, United States Code, to provide for a partnership between the Department of Veterans Affairs and the Department of Defense to develop and disseminate education and training programs on the medical responses to the consequences of terrorist activities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE.**
4 This Act may be cited as the "Medical Education for
5 National Defense in the 21st Century Act".

1 **SEC. 2. ESTABLISHMENT OF EMERGENCY MEDICAL EDU-**
2 **CATION PROGRAM.**
3 (a) IN GENERAL.—(1) Subchapter II of chapter 73
4 of title 38, United States Code, is amended by adding at
5 the end the following new section:
6 **"§ 7323. Emergency medical education: joint program**
7 **with Department of Defense**
8 "(a) JOINT EDUCATION PROGRAM.—The Secretary
9 and the Secretary of Defense shall carry out a joint pro-
10 gram to develop and disseminate a series of model edu-
11 cation and training programs on the medical responses to
12 the consequences of terrorist activities. The Secretaries
13 shall enter into an agreement for a partnership to imple-
14 ment the joint program.
15 "(b) IMPLEMENTING ENTITIES.—Within the Depart-
16 ment of Veterans Affairs, the joint program shall be car-
17 ried out through the Under Secretary for Health. Within
18 the Department of Defense, the joint program shall be
19 carried out through the F. Edward Hebért School of Medi-
20 cine of the Uniformed Services University of the Health
21 Sciences.
22 "(c) CONTENT OF PROGRAMS.—The education and
23 training programs developed under the joint program shall
24 be based on programs established at the F. Edward
25 Hebért School of Medicine and shall include, at a min-

1 imum, training for health care professionals in the fol-
2 lowing:
3 "(1) Recognition of chemical, biological, and ra-
4 diological agents that may be used in terrorist activi-
5 ties.
6 "(2) Identification of the potential symptoms of
7 those agents.
8 "(3) Understanding of the potential long-term
9 health consequences, including psychological effects,
10 resulting from exposure to those agents.
11 "(4) Emergency treatment for exposure to
12 those agents.
13 "(5) An appropriate course of followup treat-
14 ment, supportive care, and referral.
15 "(6) Actions that can be taken while providing
16 care for exposure to those agents to protect against
17 contamination.
18 "(7) Information on how to seek to consultative
19 support and to report suspected or actual use of
20 those agents.
21 "(d) POTENTIAL TRAINEES.—In designing the edu-
22 cation and training programs under this section, the Sec-
23 retaries shall ensure that different programs are designed
24 for health-care professionals at various levels. The pro-
25 grams shall be designed to be disseminated to health pro-

1 fessions students, graduate medical education trainees,
2 and health practitioners in a variety of fields.

3 "(e) CONSULTATION.—In establishing the joint med-
4 ical education and training program under this section,
5 the two Secretaries shall consult with appropriate rep-
6 resentatives of accrediting, certifying, and coordinating or-
7 ganizations in the field of health professions education.".

8 (2) The table of sections at the beginning of such
9 chapter is amended by inserting after the item relating
10 to section 7322 the following new item:

"7323. Emergency medical education: joint program with Department of Defense.".

11 (b) INITIAL FUNDING.—Funds for fiscal year 2002
12 for the joint medical education and training program es-
13 tablished under section 7323 of title 38, United States
14 Code, as added by subsection (a), shall be provided from
15 funds made available under Public Law 107–38.

16 (c) EFFECTIVE DATE.—The Secretary of Veterans
17 Affairs and the Secretary of Defense shall implement sec-
18 tion 7323 of title 38, United States Code, as added by
19 subsection (a), not later than the end of the 90-day period
20 beginning on the date of the enactment of this Act.

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PREPARED STATEMENT OF HON. CIRO D. RODRIGUEZ

TALKING POINTS

Opening Remarks for HVAC Health Subcommittee Hearing on H.R. 3253, Emergency Preparedness Act

H.R. 3254, Medical Education for National Defense in the 21st Century Act

- I am happy that we have the opportunity to have a hearing on these two pieces of legislation.
- The events of September 11th and the anthrax attacks have forced us to re-evaluate our ability to respond to chemical, biological, and radiological contingencies.
- We had a hearing a few months ago on the status of the VA's preparedness as a third line responder.
- The news was not very good.
- VA is the nation's largest health care system, it engages in some of the most promising research, and it provides first-rate medical training and education.
- Considering all the VA does, I see no reason why the VA cannot be positioned as a first responder in the event of a biological or chemical attack.
- Many VA medical centers, including the Audie Murphy Hospital in my district, already have shared teaching and research arrangements with medical schools and the ability to attract high-level scientists in fields relevant to bio-chemical and radiological threats.

  (Audie Murphy has relationships with the University of Texas Health Science Center in San Antonio, University Hospital, the University of Houston School of Public Health, Southwest Research Foundation, Southwest Foundation for Biomedical Research as well as military medical institutions).
- I am excited about the prospect of National Emergency Preparedness Centers which would not only engage in research to develop methods of detection, inoculation, and treatment but also coordinate research with universities and federal agencies and disseminate the latest information to healthcare workers at public and private hospitals.
- I believe the VA, through the creation of these National Emergency Preparedness Centers, can become a key partner in our nation's homeland defense efforts.
- I look forward to this development.
- Thank you, Mr. Chairman.

PREPARED STATEMENT OF HON. CLIFF STEARNS

VA'S ROLE IN COMBATING BIOTERRORISM

I want to thank Chairman Moran for holding this hearing. I welcome our witnesses, especially Dr. Roswell, who recently departed as the Medical Director for my VISN 8, in Florida: Congratulations on your confirmation.

As an original cosponsor of both of these pieces of legislation, I do believe that VA can play an invaluable role in combating bioterrorism. For HR 3254, We know that we have a tremendous resource here, with our over 1,000 facilities, affiliation with 100 medical and other health profession schools, and tens of thousands of dedicated employed health care professionals.

Equally, the Department of Defense offers an unparalleled training regimen at its Uniformed Services University of the Health Sciences. As we learned at the hearing October 15, at no other medical school in the United States is one taught to recognize exposure to as broad a panel of biological weapons as are the DOD medical students. Similarly, USUHS students are foremost in learning efficiencies in contamination and minimizing exposure to chemical and radiological materials.

For HR 3253, again, VA has the capabilities and framework to support research, education and assistance in the bioterrorism field. I do understand from Dr. Mackay's testimony that VA must implement any responsibilities of these new four preparation centers within the framework of the Office of Homeland Security's upcoming overall plan, due this July. Also, I want to reiterate a concern I have expressed that any new responsibilities we ask of the VA must not compromise the

VA's first, second and third missions. Most importantly, the VA must continue its priority of caring for our nation's veterans who have done so much for so many.

PREPARED STATEMENT OF HON. LANE EVANS

Good afternoon. I applaud the Chairman and Ranking Member for convening this legislative hearing on the two bio-terrorism bills before us today.

The events of September 11th served as a wake-up call for us. It sent a very clear message about the threat of terrorism and the danger associated with not taking that threat seriously.

The VA is neither a law enforcement agency nor an intelligence agency. As such, we do not look directly to the VA to stop a terrorist attack. We do however, look to the VA to lessen the consequences of a full array of catastrophic events that threaten the lives of our citizens—including terrorist attacks such as the one experience on September 11th.

The two bills before us today—H.R. 3253 and H.R. 3254 are aimed at expanding VA's capabilities to respond to bio-terrorism. Bio-terrorism poses a very serious threat and I think it is appropriate that we address this issue.

I welcome the witnesses this afternoon and I look forward to your testimony. Your views on these legislative proposals will help us in our attempts to ensure that the VA is poised to appropriately respond to bio-terrorism attacks.

Again, I thank the Chairman and Ranking Member.

PREPARED STATEMENT OF HON. JEFF MILLER

HEARING TO EXAMINE VA ROLE IN EMERGENCY PREPAREDNESS

Thank you Mr. Chairman.

I am pleased to be with you today. I would like to thank the distinguished members of the panels present today. Your input is invaluable to us as we work toward what is right and best for our veterans and our nation. I also want to join my colleagues in specifically recognizing Dr. Rob Roswell, the recently confirmed Under Secretary for Health. I look forward to working with you sir.

With over 200,000 employees, the VA operates the largest integrated healthcare system in the United States, and is therefore one of our greatest resources in responding to potential chemical and biological attacks. This is something that we should be very proud of and a resource that we should be eager and willing to use in order to address the challenges that our nation currently faces. That being said, it is vital that we find a viable funding stream that will provide the foundation for this extension of the VA mission. This Committee has worked tirelessly to gain additional funding devoted to health care, the primary mission of the VA, and we should take no actions that would be detrimental to this effort, whether it be in funding or in focus. I want to commend Chairman Smith and Chairman Buyer for introducing this legislation and the VA for their desire to do their part at this difficult time in our nation's history.

Again, I thank you for your testimony today and for your assistance as we do our duty for our nation's finest.

PREPARED STATEMENT OF HON. STEPHEN F. LYNCH

Good afternoon and thank you Mr. Chairman for your courtesy.

Firstly, Mr. Chairman, I would like to commend you and all the good work that you do for our nation's veterans that we are here today to discuss. All of us, I think, can agree that the VA does a great job with sometimes little and inadequate resources. Our VA takes care of our veterans' health care needs, education and training, and our VA also is a place where extensive medical research is happening.

September 11th has impacted all of our lives in very profound ways. As a nation, our priorities have necessarily changed. We have all awoken from a sweet dream of complacency and innocence that has ended.

In the days since the terrorist attacks, anthrax, smallpox and bioterrorism have become part of every household's vocabulary. As a nation, we must now take a closer look at our emergency preparedness.

In much the same way, the VA must also take a closer look at its mission. As we are all aware, stated within its fourth mission, the VA must serve as a backup to the DOD health system in a time war or other emergencies, to support our communities following domestic terrorist incidents and other major disasters.

What is the best use of the VA and all of its resources to accomplish this mission? The two bills before us today, are, good starting points.

The history of medical research undertaken by our VA places it in a unique position to address questions that have arisen around bioterrorism. This expertise can be used for measures outlined in Mr. Smith's bill. Medical emergency preparedness centers will allow the VA to brings its expertise to these areas.

By addressing terrorist threats to public health and safety with research, training, treatment disciplines and standards to prevent or deal with biological, chemical, and radiological attacks, these new centers will become an important national resource.

Additionally, Mr. Buyer's bill to establish national education and training programs for health care professionals responding to terrorist activities is a natural fit for the VA. The VA does a good job training America's healthcare professionals with more than 85,000 being trained annually at our VA healthcare facilities.

Though in principle I fully support the concepts of both pieces of legislation, I do have one serious concern.

Mr. Chairman, I am concerned about the possible funding streams available to implement this mission. In establishing these national medical preparedness centers, as well as the proposed medical education programs, the VA must receive specific earmarked appropriations that are separate from the VA's standard healthcare funding. We must not jeopardize the health of our veterans by targeting already strapped health care resources.

Additionally, I would like to hear more generally about the plans put in place by the VA in order to undertake its fourth mission. I appreciate the Deputy Secretary appearing before us today to explain to us the machinations of this system. For instance, I would like to know how many VA beds would be available today in the event of a national incident? What infrastructure does the VA already have established?

Once again, thank you Mr. Chairman for the opportunity to comment today. I look forward to hearing from our witnesses and in working with the committee on these issues.

Thank you.

PREPARED STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. Chairman, thank you for holding this Subcommittee Hearing today. In light of the dangerous world that we all face today, it is our responsibility to safeguard the American people from every potential biological, chemical, radiological or nuclear hazard that we may have to face in the future. I believe that the key is preparation, and this preparation includes training and educating medical and health professionals to identify these hazards and then to be able to respond and treat patients before it is too late. I hope that these two bills, H.R. 3253 and H.R. 3254, can bring us closer to that reality.

However, I think we should also move cautiously in this area. First, we must ensure that these new roles for the V A do not degrade the primary mission of the V A which is to provide first class health care services to our veterans who have given so much to this nation. I am also concerned about the funding for these bills. We may be able to fund these measures through emergency appropriations for homeland defense efforts this year, but where will the money come from in the future? With the current strains on our budget as a result of the war on terrorism and veterans health care increases, and hopefully concurrent receipt, we must exercise fiscal restraint wherever possible. Lastly, we must be weary of duplication of effort here. Both the Departments of Defense and Health and Human Services along with State and local agencies have dedicated resources to this effort since September 11. We need to take a close look at what these bills will accomplish and coordinate our efforts.

In Charleston within my district, the Ralph H. Johnson V A Medical Center is a busy facility which offers all levels of inpatient and outpatient care to veterans. It enjoys a successful affiliation with the Medical University of South Carolina. As a result of this partnership, it has one of the leading open-heart surgery programs in the Southeastern United States and conducts major research in diabetes, heart disease, kidney disease, fetal alcohol syndrome, rheumatology and other areas. Hopefully, these experiences can be transferred to success in new partnerships between the VA and the academic community in areas of bioterrorism.

Mr. Chairman, thanks again for holding this hearing today and thank you to all of the witnesses for educating us on this important subject.

PREPARED STATEMENT OF HON. CHRISTOPHER H. SMITH

EXPANDING THE VA'S ROLE IN HOMELAND SECURITY (H.R. 3253)

Mr. Chairman, I commend you for holding today's hearing to consider legislation that would expand the VA's role in fighting biological and chemical terrorism.

While it will not be a surprise to most of the people in this room, I suspect that the vast majority of Americans do not realize that the Department of Veterans Affairs has the world's largest integrated health care network, with over 200,000 health care professionals, 163 medical centers, more than 800 outpatient clinics, 115 medical research programs, affiliations with over 100 schools of medicine and a $25 billion annual budget.

Dedicated to providing health care to the America's military veterans, the VA is now the federal government's leading provider of direct medical services, with over 4.5 million patients treated last year. From providing top quality medical care to veterans, to performing comprehensive, cutting edge research, such as for prosthetics and Alzheimer's, the VA health care system has become a unique national resource.

That's why we fought so hard to increase their health care budget for next year, which I am pleased to say has been increased by $2.8 billion in the budget resolution approved by the House last month.

As you know, Mr. Chairman, the VA already has some defined roles in both the National Disaster Medical System (NDMS) and the Federal Response Plan (FRP) in the event of national emergencies. Among its specialized duties are conducting and evaluating disaster and terrorist attack simulation exercises; managing the nation's stockpile of pharmaceuticals for biological and chemical toxins; maintaining a rapid response team for radiological releases; and training public and private NDMS medical center personnel around the country in properly responding to biological, chemical, or radiological disasters.

Yet despite the VA's capacity, experience and expertise in public health matters, it is almost routinely overlooked when it comes to discussions of homeland security, even those concerning bio-terrorism. In the Administration's budget submission, almost $6 billion was requested to prevent bio-terrorism, including $2.4 billion for additional research, yet not one dollar was earmarked for the VA. In fact, if you look at the Administration's latest strategy document on Homeland Security, which can be found on their webpage, the VA is not even mentioned once. The VA can and must be asked to do more.

Last October, I proposed legislation (H.R. 3253) to create four National Medical Preparedness Centers to be operated by the Department of Veterans Affairs, two for dealing with chemical and biological threats, and two for dealing with radiological threats. In coordination with the Department of Defense, HHS, FEMA, CDC, NIH, and other agencies or organizations with appropriate expertise, these Centers would research and develop new methods to detect, diagnose, vaccinate and treat potential victims of chemical, biological, and radiological terrorism. The Centers would serve both as direct research centers and as coordinating centers for ongoing and promising new research at other government agencies and research universities.

Furthermore, these Centers would serve as training resources for the thousands of community hospitals that would be first responders to future bio-terror attacks. Finally, the Centers would be charged with establishing state-of-the-art laboratories to help local health care authorities quickly determine the presence of dangerous biological and chemical toxins, such as anthrax.

Mr. Chairman, I also need to emphasize that my legislation provides that the cost of these new centers would be taken from additional funds provided to combat terrorism, and not taken from the already hard-pressed VA health care system.

There is ample precedent and experience within the VA for undertaking this expanded mission. Through their extensive medical research programs, the VA has documented expertise in diagnosing and treating viral diseases with devastating health consequences, such as their groundbreaking work on HIV and hepatitis C. And just last month, Dr. Karl Hostetler and his VA colleagues in San Diego developed a new oral treatment for smallpox, one of the most deadly bio-terror threats confronting the world today.

In addition, the VA already operates two War-Related Illness Centers tasked with developing specialized treatments for illnesses and injuries related to combat. In essence, these new National Medical Preparedness Centers would similarly study illnesses and injuries most likely to come from a terrorist attack, and develop new treatments and protocols to mitigate their dangers.

Mr. Chairman, I believe it is appropriate for the VA to playa larger role in homeland security and the legislation I have proposed is one way to take advantage of

its expertise while continuing to meet their primary mission of taking care of our veterans.

Statement of

The Honorable Leo S. MacKay, Jr. PhD

Deputy Secretary

Department Of Veterans Affairs

Before the

Subcommittee On Health

House Committee On Veterans' Affairs on

H.R. 3253, the National Medical Emergency Preparedness Act of 2001; and H.R. 3254, the Medical Education for National Defense in the 21st Century

April 10, 2002

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to comment on two bills, H.R. 3254, the "Medical Education for National Defense in the 21st Century Act" and H.R. 3253, the "National Medical Emergency Preparedness Act of 2001."

VA has the infrastructure and expertise to be a vital and integral link in our nation's Homeland Security efforts. We are the largest integrated national health care system with personnel and facilities in virtually every community across the U.S. VA has a robust research program and is already actively engaged in numerous projects in the areas of bio-terrorism and medical emergency preparedness. We have made tremendous strides in improving our capacity to maintain operations in the event of a medical emergency by increasing our ability to protect our staff and by providing education and training. VA currently sponsors the largest medical education and health professions training program in the United States. Last year, approximately 85,000 health professionals trained in our medical facilities. VA facilities are affiliated with almost 1,400 medical and other allied health care schools. It is imperative that not only VA but also non-VA health care providers receive the education and training needed to become highly adept at recognizing and responding to both the immediate and potential long-term medical needs of individuals exposed to chemical, biological, radiological, and other unconventional warfare agents.

As you are aware, under the Federal Response Plan, the Department of Health and Human Services (HHS) has been designated as lead Federal agency for assessing and providing health and medical services during medical

emergencies. VA may be, and has in fact been, called upon to furnish needed medical assistance and related services.

The Executive Office of the President, through the Office of Homeland Security (OHS), is currently crafting a comprehensive coordinated federal policy on Homeland Security. VA is actively participating in this OHS effort. It is expected that OHS will deliver this policy to the President this July. The precise role and responsibilities VA will be assigned in the area of Homeland Security will be reflected in that policy. We expect that we will have much to contribute in this area based on our depth of expertise and infrastructure, as alluded to above.

Because the President's Homeland Security policy is forthcoming, we would like to work with the Committee to ensure that the provisions of H.R. 3253 and H.R. 3254 are consistent with the comprehensive federal plan.

Finally, I am very concerned that carrying out the proposed activities without dedicated funding could unacceptably diminish VA's ability to fulfill its primary mission—providing health care and services to veterans and their families. These new activities cannot be accommodated within our already stretched medical care accounts. Dedicated funding appropriated separately for this effort must be consistent with the discretionary spending limits of the President's budget.

Having said this, I would like to address the bills and provide a brief explanation of H.R. 3253 and H.R. 3254 and our views on their major provisions.

H.R. 3254

Mr. Chairman, the first bill, H.R. 3254, would require that the Secretaries of Veterans Affairs and Defense jointly develop and distribute a series of model education and training programs to prepare health professionals to respond to consequences of terrorist activities. The programs' content would emphasize education and training in the recognition of chemical, biological, and radiological agents that may be used in terrorist activities and identification of the potential symptoms related to use of those agents. They would also focus on management of clinical consequences of terrorist acts. The education and training programs would also be required to address short-term and long-term health consequences, including psychological effects that may result from exposure to such agents and the appropriate treatment of those health consequences. In addition, the programs must identify measures to be taken by health care professionals to prevent them from suffering secondary contamination or infection while treating victims of a national medical emergency. H.R. 3254 would also require that the proposed joint education and training programs be designed for health professions students, graduate medical education trainees, and health practitioners in a variety of fields.

Initial funding for these programs would be authorized from funds made available under the Emergency Supplemental Appropriations Act (Public Law 107-38).

VA strongly supports the goals of H.R. 3254. The proposed training and education activities on national medical emergencies would complement and strengthen the current training and education efforts being carried out by HHS through the Health Resources Administration and the Centers for Disease Control and Prevention.

As drafted, the bill provides that DoD would carry out the joint program through the F. Edward Hebert School of Medicine of the Uniformed Services University of the Health Sciences. We recommend that the Committee consider placing DoD responsibility for the joint program in the Assistant Secretary of Defense (Health Affairs), which is the appropriate policy-level counterpart to the Under Secretary for Health.

If enacted, the Department projects the first-year costs associated with H.R. 3254 to be $5,641,500, with ten-year costs estimated to be $55,065,000.

H.R. 3253

Mr. Chairman, I next turn to H.R. 3253. This bill would require the Secretary to establish four or more Emergency Medical Preparedness Centers within the Veterans Health Administration (VHA). Under the proposal, VA employees would staff the proposed Centers, and the VHA Headquarters official responsible for medical preparedness would be responsible for supervising and evaluating the Centers' operations. The Centers would have three specific missions. First, they would carry out research and develop methods in detection diagnosis, vaccination, protection, and treatment for CBR threats to the public health and safety. Second, they would provide education, training, and advice to VA and non-VA healthcare professionals. Third, the Centers would provide contingent rapid response laboratory assistance and other assistance to local health care authorities in the event of a national emergency.

H.R. 3253 would require that at least one of the proposed Centers focus on chemical threats, another concentrate on biological threats, and a third on radiological threats. Each Center would be required to conduct research on improved medical preparedness in that Center's particular area of expertise. To carry out this particular mandate, each Center would be authorized to seek funding from both public and private sources.

Finally, the bill would authorize initial funding from the Emergency Supplemental Appropriations Act (Public Law 107-38). It would also authorize additional appropriations and require the Under Secretary for Health to allocate from funds appropriated for the Medical Care Account and the Medical and

Prosthetics Research Accounts such amounts as the Under Secretary for Health determines appropriate to carry out the activities of the Centers.

We strongly support the goals of H.R. 3253 and believe that VA's expertise and infrastructure is needed to help the nation respond to the health consequences of terrorists' use, and potential use, of CBR agents and other similar unconventional weapons. However, H.R. 3253 would also authorize the Secretary to assist Federal, State, and local civil and law enforcement authorities with investigations to protect the public safety and to prevent or obviate CBR-related threats. Although we have the expertise to support such activities, I believe we should limit our role to support these needs on an expedited referral basis.

We also note that the training mission of the Centers is somewhat similar to the goals of H.R. 3254 addressed earlier. We recommend that the Subcommittee work to integrate the similar training provisions of the two bills.

I would like to point out that VA has already initiated several research activities that, in our view, are consistent with the proposed activities of the Centers. For instance, VA's Office of Research and Development (ORD) recently issued two solicitations for research relating to bio-terrorism. VA Medical Research Service will fund and establish Research Enhancement Award Programs for scientifically meritorious program projects relating to the diagnosis, prevention, and treatment of potentially fatal airborne pathogens or toxins. The Health Services Research and Development Service will support research focused on improving the capacity of the VA system to prepare for and respond to terrorist attacks. In addition, ORD is providing grants to VA facilities to enhance the physical security of research laboratories and animal facilities. Overall, in FY 2003 VA will commit up to $2 million from research funds for these and similar initiatives. VA is proud of the success of its research programs, including our research efforts into war-related illnesses. We embrace our national role in addressing these concerns. As Secretary Principi pointed out in a recent interview, VA was involved in biological and chemical warfare research prior to Sept. 11, 2001. Our research includes possible treatments for various biochemical threats, including a promising antiviral agent against smallpox. Our aim is to continue these dynamic and vital research efforts as part of the overall national effort.

I would underscore that any new role or responsibilities must be consistent with the overall comprehensive federal strategy on Homeland Security.

Moreover, a separate appropriation consistent with the overall discretionary spending limits of the President's budget must be provided. We welcome the opportunity to work with the Committee to that end.

We are currently working on a cost estimate for this bill, which we will share with the committee when completed.

This concludes my statement. I will be happy to answer any questions you may have.

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

Bioterrorism: CDC's Public Health Response

Statement of

Kevin Yeskey, M.D.

Director,
Bioterrorism Preparedness and Response Program,
National Center for Infectious Diseases,
Centers for Disease Control and Prevention,
U.S. Department of Health and Human Services

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Good morning, Mr. Chairman and Members of the Subcommittee. I am Dr. Kevin Yeskey, Director, Bioterrorism Preparedness and Response Program, National Center for Infectious Diseases, Centers for Disease Control and Prevention (CDC). Thank you for the opportunity to discuss CDC's public health response to the threat of bioterrorism. I will update you on CDC's status of implementing the overall goals of our bioterrorism preparedness program.

As has been highlighted recently, increased vigilance and preparedness for unexplained illnesses and injuries are an essential part of the public health effort to protect the American people against bioterrorism. Prior to the September 11 attack on the United States, CDC was making substantial progress toward defining, developing, and implementing a nationwide public health response network to increase the capacity of public health officials at all levels–federal, state, and local–to prepare for and respond to deliberate attacks on the health of our citizens. The events of September 11 were a defining moment for all of us, and since then we have dramatically increased our levels of preparedness and are implementing plans to increase it even further.

Public Health Leadership

The Department of Health and Human Services' (DHHS) anti-bioterrorism efforts are focused on improving the nation's public health surveillance network to quickly detect and identify the biological agent that has been released; strengthening the capacities for medical response, especially at the local level; expanding the stockpile of pharmaceuticals for use if needed; expanding research on disease agents that might be released, rapid methods for

identifying biological agents, and improved treatments and vaccines; and preventing bioterrorism by regulation of the shipment of hazardous biological agents or toxins.

As the nation's disease prevention and control agency, it is CDC's responsibility on behalf of DHHS to provide national leadership in the public health and medical communities in a concerted effort to detect, diagnose, respond to, and prevent illnesses, including those that occur as a result of a deliberate release of biological agents. This task is an integral part of CDC's overall mission to monitor and protect the health of the U.S. population.

In 1998, CDC issued *Preventing Emerging Infectious Diseases: A Strategy for the 21st Century*, which describes CDC's plan for combating today's emerging diseases and preventing those of tomorrow. It focuses on four goals, each of which has direct relevance to preparedness for bioterrorism: disease surveillance and outbreak response; applied research to identify risk factors for disease and to develop diagnostic tests, drugs, vaccines, and surveillance tools; infrastructure and training; and disease prevention and control. This plan was developed with input from state and local health departments, disease experts, and partner organizations such as the American Society for Microbiology, the Association of Public Health Laboratories, the Council of State and Territorial Epidemiologists, and the Infectious Disease Society of America. It emphasizes the need to be prepared for the unexpected – whether it is a naturally occurring influenza pandemic or the deliberate release of anthrax by a terrorist. It is within the context of these overall goals that CDC is addressing preparing our nation's public health infrastructure to respond to acts of biological terrorism. In addition, CDC presented in March 2001 a report to the Senate entitled *Public Health's Infrastructure: A Status Report*. Recommendations in this report complement the strategies outlined for emerging infectious diseases and preparedness and

response to bioterrorism. These recommendations include training of the public health workforce, strengthening of data and communications systems, and improving the public health systems at the state and local level.

CDC's Strategic Plan for Bioterrorism

CDC outlined necessary steps for strengthening public health and healthcare capacity to protect the nation against bioterrorist threats in its April 21, 2001, *MMWR* release of *Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response - Recommendations of the CDC Strategic Planning Workgroup*. This report reinforces the work CDC has been contributing to this effort since 1998 and lays a framework from which to enhance public health infrastructure. In keeping with the message of this report, five key focus areas have been identified which provide the foundation for local, state, and federal planning efforts: Preparedness and Prevention, Detection and Surveillance, Diagnosis and Characterization of Biological and Chemical Agents, Response, and Communication. These areas capture the goals of CDC's Bioterrorism Preparedness and Response Program for general bioterrorism preparedness.

- ***Preparedness and Prevention***

CDC has been working to ensure that all levels of the public health community – federal, state, and local – are prepared to work in coordination with the medical and emergency response communities to address the public health consequences of biological and chemical terrorism.

CDC has created diagnostic and epidemiological guidelines for state and local health

departments and will continue to help states conduct drills and exercises to assess local readiness for bioterrorism. For example, in November 2001 the Centers for Disease Control and Prevention (CDC) released "Interim Smallpox Response Plan and Guidelines," which identifies many of the federal, state, and local public health activities that would need to be undertaken in a smallpox emergency, including response plan implementation, notification procedures for suspected cases, CDC and state and local responsibilities and activities, and CDC vaccine and personnel mobilization.

In addition, CDC, the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), the Department of Defense (DoD), and other agencies are facilitating the availability of medical countermeasures, and supporting and encouraging research to address scientific issues related to bioterrorism. In some cases, new vaccines, antitoxins, or innovative drug treatments need to be developed, manufactured, and/or stocked. Moreover, we need to learn more about the pathogenesis and epidemiology of the infectious diseases which do not affect the U.S. population currently. We have only limited knowledge about how artificial methods of dispersion may affect the infection rate, range of illness, and public health impact of these biological agents.

- ***Detection and Surveillance***

As was evidenced in the anthrax attacks in Florida, New York, and Washington, DC, the initial detection of a biological terrorist attack occurs at the local level. Therefore, it is essential to educate and train members of the medical community – both public and private – who may be the first to examine and treat the victims. It is also necessary to upgrade the surveillance systems

of state and local health departments, as well as within healthcare facilities such as hospitals, which will be relied upon to spot unusual patterns of disease occurrence and to identify any additional cases of illness. CDC is providing terrorism-related training to epidemiologists and laboratorians, infection control personnel, emergency responders, emergency department personnel and other front-line health-care providers, and health and safety personnel. CDC is providing educational materials regarding potential bioterrorism agents to the medical and public health communities on its website for Public Health Emergency Preparedness and Response at www.bt.cdc.gov. CDC is working with partners such as the Johns Hopkins Center for Civilian Biodefense Studies (www.hopkins-biodefense.org) and the Infectious Diseases Society of America to develop training and educational materials for incorporation into medical and public health graduate and post-graduate curricula. With public health partners, CDC is spearheading the development of the National Electronic Disease Surveillance System, which will facilitate automated, timely electronic capture of data from the healthcare system.

- ***Diagnosis and Characterization of Biological and Chemical Agents***

To ensure that prevention and treatment measures can be implemented quickly in the event of a biological or chemical terrorist attack, rapid diagnosis is critical. CDC has developed guidelines and quality assurance standards for the safe and secure collection, storage, transport, and processing of biologic and environmental samples. In collaboration with other federal and non-federal partners, CDC is co-sponsoring a series of training exercises for state public health laboratory personnel on requirements for the safe use, containment, and transport of dangerous biological agents and toxins. CDC is also enhancing its efforts to foster the safe design and

operation of Biosafety Level 3 laboratories, which are required for handling many highly dangerous pathogens. Furthermore, CDC is developing a Rapid Toxic Screen to detect people's exposure to 150 chemical agents using blood or urine samples.

- ***Response***

A decisive and timely response to a biological terrorist event involves a fully documented and well rehearsed plan of detection, epidemiologic investigation, and medical treatment for affected persons, and the initiation of disease prevention measures to minimize illness, injury and death. CDC is addressing this by (1) assisting state and local health agencies in developing their plans for investigating and responding to unusual events and unexplained illnesses, and (2) bolstering CDC's capacities within the overall federal bioterrorism response effort. CDC has formalized draft plans for the notification and mobilization of personnel and laboratory resources in response to a bioterrorism emergency, as well as overall strategies for vaccination, and development and implementation of other potential outbreak control strategies such as isolation and quarantine measures. In addition, CDC is developing national standards to ensure that respirators used by first responders and by other health care providers responding to terrorist acts provide adequate protection against weapons of terrorism.

- ***Communication Systems***

Rapid and secure communications are crucial to ensure a prompt and coordinated response to an intentional release of a biological agent. Thus, strengthening communication among clinicians, emergency rooms, infection control practitioners, hospitals, pharmaceutical companies,

and public health personnel is of paramount importance. To this end, CDC is making a significant investment in building the nation's public health communications infrastructure through the Health Alert Network (HAN). HAN is a nationwide program to establish the communications, information, distance-learning, and organizational infrastructure for a new level of defense against health threats, including bioterrorism. CDC has also established the Epidemic Information Exchange (*Epi-X*), a secure, web-based communications system that provides information sharing capabilities to state and local health officials.

Ongoing communication of accurate and up-to-date information helps calm public fears and limit collateral effects of the attack. CDC communicates with the public directly through its website on emergency preparedness and through a public inquiry telephone and email system, which, during the anthrax epidemiological investigation, responded to hundreds of questions daily. In addition, CDC communicates to the public by releasing daily updates to the news media, answering inquiries from the press and providing medical experts for interviews.

The National Pharmaceutical Stockpile

Another integral component of public health preparedness at CDC has been the development of a National Pharmaceutical Stockpile (NPS), which is mobilized in response to an episode caused by a biological or chemical agent. The role of the CDC's NPS program is to maintain a national repository of life-saving pharmaceuticals and medical materiel that can be delivered to the site or sites of a biological or chemical terrorism event in order to reduce morbidity and mortality in a civilian population. The NPS is a backup and means of support to state and local first responders, healthcare providers, and public health officials. The NPS

program consists of a two-tier response: (1) 12-hour push packages, which are pre-assembled arrays of pharmaceuticals and medical supplies that can be delivered to the scene of a terrorism event within 12 hours of the federal decision to deploy the assets and that will make possible the treatment or prophylaxis of disease caused by a variety of threat agents; and (2) a Vendor-Managed Inventory (VMI) that can be tailored to a specific threat agent.

For the first time ever, CDC deployed the National Pharmaceutical Stockpile (NPS) in September, sending push packages of medical materiel to New York City and Washington, DC. In response to the cases of anthrax exposure, this program was also used to deliver antibiotics for post-exposure prophylaxis to employees in affected buildings, postal workers, mail handlers, and postal patrons. In order to facilitate the procurement of the pharmaceuticals, medical supplies, and antidotes that comprise the NPS, CDC established an interagency agreement with the National Acquisition Center of the Department of Veterans Affairs (VA) in November of 1999. This partnership has allowed CDC to take advantage of the $4 billion annual pharmaceutical buying power of the VA to analyze the various markets and then develop unique and very favorable contractual arrangements for the stockpile program. These contracts provide for the acquisition of pharmaceuticals and other materiel, inventory rotation and maintenance, and emergency transport. CDC's partnership with the VA has also permitted the stockpile program to access the VA's prime vendors for pharmaceuticals and medical/surgical supplies under very favorable terms.

Core Capacities for State and Local Health Bioterrorism Preparedness and Response

Prior to September 11, CDC was working with partners at all levels to develop core

capacities needed to respond to pubic health threats and emergencies. CDC has developed specific guidelines to assist public health agencies in their efforts to build comprehensive bioterrorism preparedness and response programs. This collaborative effort engaged federal, state, and local partners in determining their needs in order to improve their preparedness and response to bioterrorism. The process enabled health departments to more effectively target specific improvements to protect the public's health in the event of a biological or chemical terrorist event, and provides the framework for ongoing program efforts. The core capacities effort is dual purpose; while these capacities focus on bioterrorism events, they are also relevant to naturally occurring infectious disease outbreaks and natural disasters.

The events of last fall demonstrate that we must move much more rapidly to expand our capacity to respond to all public health emergencies. In late January, HHS announced that a total of $1.1 billion in funding would be provided to states to assist them in their efforts to prepare for bioterrorism, other infectious disease outbreaks, and other public health threats and emergencies. On January 31st, Secretary Thompson sent a letter to the governor in each state detailing how much of the $1.1 billion his or her state would receive to allow them to initiate and expand planning and building of the public health systems necessary to respond. State proposals outlining these plans are due to HHS by April 15th. The funds will be made available through cooperative agreements with State health departments--and several large metropolitan area health departments--to be awarded by CDC and the Health Resources and Services Administration, and through contracts awarded by the Office of Emergency Preparedness with cities for the Metropolitan Medical Response System Initiative.

The funds are to be used for the development of comprehensive public health emergency

preparedness and response capabilities; upgrading infectious disease surveillance and investigation; enhancing the readiness of hospital systems to deal with large numbers of casualties; expanding public health laboratory and communications capacities; education and training for public health personnel, including clinicians, hospital workers, and other critical public health responders; and improving connectivity between hospitals and local, city, and state health departments to enhance disease detection.

CDC's Education and Training Efforts for Bioterrorism

CDC's goal in education and training is for the entire public health system to maintain a public health workforce fully capable of delivering the Essential Public Health Services during routine and emergency operations. As one of the nation's largest providers of healthcare, the Department of Veterans' Affairs (VA) is a partner in CDC's efforts. CDC and the VA collaborate through a number of different training and education mechanisms, including: the Public Health Training Network (PHTN), laboratory training activities, and the Association of American Medical College's (AAMC) bioterrorism initiative "First Contact, First Response."

Since October 2000, seventy-nine VA Medical Centers have participated as satellite downlink sites for PHTN presentations. In 2001, more than 66,000 health professionals earned continuing education credits through PHTN programs. The National Laboratory Training Network (NLTN) provides clinical, environmental, and public health laboratory training courses, with six regional offices available to identify training needs, deliver courses, and evaluate NLTN training programs. In the last year alone, NLTN delivered more than 226 courses to an audience of more than 6,200 students. Since 1997, NLTN has trained 359 students from the VA. In

2000, CDC established a national system of Centers for Public Health Preparedness (CPHP) to strengthen state and local workforce capacity to respond to bioterrorism and to support CDC's prevention programs in general. The Centers have developed over 180 bioterrorism-related training programs, short courses, seminars, public meetings, media interviews, and national satellite broadcasts to address local and regional concerns preparedness concerns. The AAMC's educational plan has been designed with CDC to address the preparedness of the workforce, in both the near and distant futures, by including specific educational experiences for medical students, resident physicians and practicing physicians. Specifically, regional medicine-public health education centers will be established to facilitate preparedness education activities and foster collaboration between medical schools and state/local public health agencies.

CDC is committed to collaborate with the VA, DoD, FEMA, FDA and other federal partners, State and local governmental agencies as well as medical societies, national professional organizations in implementing the Centers for Preparedness and other education and training programs targeting clinicians and other public health and healthcare professionals.

Challenges

As we continue to strengthen our homeland security and, among other things, our ability to deal with bioterrorism, it is our hope that we will not face bioterrorist attacks that impose mass casualties on our cities. We must nevertheless plan for it, so that, if the unthinkable should occur, we are prepared to deal with it. Thus, for example, the Administration is seeking legislation that would amend the Public Health Service Act to allow the President, when he determines that the public health so requires, to authorize the U.S. armed forces to provide support to the Secretary of Health and Human Services in the exercise of the Secretary's statutory quarantine-related powers.

CDC has been addressing issues of detection, epidemiologic investigation, diagnostics, and enhanced infrastructure and communications as part of its overall bioterrorism preparedness strategies. CDC will continue to work with partners to address challenges such as improving coordination among other federal agencies during a response and understanding the necessary relationship needed between conducting a criminal investigation versus an epidemiologic case investigation. These issues, as well as overall preparedness planning at federal, state, and local levels, require additional action to ensure that the nation is fully prepared to respond to acts of biological and chemical terrorism.

Disease experts at CDC are working with partners at other federal agencies and in state and local health departments to develop strategies to prevent the spread of disease during and after bioterrorist attacks. Specific components include (1) creating protocols for review by the FDA for immunizing at-risk populations subject to the availability of suitable vaccines; (2) isolating large numbers of exposed individuals when there is risk that the disease can be spread from person to person; (3) reducing occupational exposures; (4) assessing methods of safeguarding food and water from deliberate contamination; and (5) exploring ways to improve linkages between animal and human disease surveillance networks since threat agents that affect both humans and animals may first be detected in animals.

Conclusion

In conclusion, CDC is committed to working with other federal agencies and partners, as well as state and local public health departments to ensure the health and medical care of our citizens. We have made substantial progress to date in enhancing the nation's capability to prepare for and respond to a bioterrorist event. The best public health strategy to protect the

health of civilians against a biological attack is the development, organization, and enhancement of public health prevention systems and tools. Priorities include strengthened public health laboratory capacity, increased surveillance and outbreak investigation capacity, and health communications, education, and training at the federal, state, and local levels. Not only will this approach ensure that we are prepared for deliberate bioterrorist threats, but it will also ensure that we will be able to recognize and control naturally occurring new or re-emerging infectious diseases. A strong and flexible public health infrastructure is the best defense against any disease outbreak.

Thank you very much for your attention. I will be happy to answer any questions you may have.

Dr. Deborah Powell, Dean of the School of Medicine
University of Kansas

House Veterans' Affairs Subcommittee on Health

Expanding the Department of Veterans Affair's Role in Bioterrorism Prevention and Response

Wednesday, April 10, 2002

To the House Committee on Veterans Affairs, Subcommittee on Health

Good afternoon and thank you, Mr. Chairman, for the opportunity to testify before you concerning two pieces of proposed legislation, HR3243 the National Medical Emergency Preparedness Act of 2001, and HR3254 the Medical Education for National Defense in the 21st Century Act. I am Dr. Deborah Powell, Executive Dean and Vice Chancellor for Clinical Affairs of the University of Kansas School of Medicine. The University of Kansas School of Medicine will be 100 years old in 2005. Our medical school has been a partner medical school with the Kansas City Veterans Affairs Medical Center since the founding of that medical center 50 years ago next year. Ours is one of the oldest medical school/VA affiliations in the country. Our school is also unusual in that we are the affiliated medical school for 4 VA Medical Centers in our VISN; Kansas City, Wichita, Topeka, and Leavenworth. We are also extremely unusual in that our medical school, located in Kansas City, Kansas has its primary VA affiliation with the VA Medical Center located approximately 15 minutes away in Kansas City, Missouri. Ours is truly a bi-state partnership. As was the case for my own medical education in Boston, Massachusetts, more years ago than I care to state to the committee, the Veterans Affairs Medical Centers are a crucial part of our educational efforts for our 700 medical students and more than 390 resident physicians in training. The University of Kansas School of Medicine could not provide the education for our medical students without our VA partnership. Every year approximately 125 third year medical students receive a month of their first experience in Internal Medicine at the VA in Kansas City. Medical students also rotate at the VA Medical Center in surgery, psychiatry, neurology, as well as the surgical subspecialties. The VA has been a very important partner to us in the education of our students and supportive partner in the training of our resident physicians. The Veterans Affair Medical Centers in Kansas City, Leavenworth and Topeka currently provide 97

residency positions in primary care and specialty fields to the University of Kansas School of Medicine.

The events following the September 11th tragedies have made all of us involved in medical education, acutely aware of the possibilities and in some instances the actual fact of acts of terrorism producing disease and medical conditions not usually seen by practitioners or students. It has raised our awareness of the necessity of preparing our students for situations that they may encounter in their practice and has revealed to us, in many instances, the inadequacies of our systems currently in place. It is entirely appropriate that the Department of Veterans Affairs and the Department of Defense take a leadership role in partnering with us to address these critical educational needs. The 125 medical schools of this country are represented by the Association of American Medical Colleges and my first point to the committee, is that I believe that this VA and Department of Defense initiative must be done in partnership with the AAMC which serves as a direct conduit to all 125 US Medical Schools. This partnership cannot be confined to medical schools alone. All health professionals must be educated to recognize and treat the results of bio-terrorism, chemical terrorism, and radiological terrorism. The partnership therefore, must be extended to schools of nursing, pharmacy, allied health sciences, dentistry and public health through their appropriate institutions. One umbrella organization for all of these entities is the Association of Academic Health Centers. The AAHC has a long history of representing the Academic Health Centers across this country, many of which contain one or more of these various health care educational schools. Finally, young resident physicians in training and our graduate medical education programs, are important part of any educational offering. Thus the partnership must include the Accreditation Council for Graduate Medical Education. Finally to assure that our practicing physicians received appropriate access to information, other organizations such as the American Board of Medical Specialties responsible for credentialing and re- certifying all board certified medical specialists in this country should be consulted. This list is not meant to be exhaustive, but it is certainly important to recognize the role that these other constituent agencies need to play in any such program. In fact, I believe the legislation addresses the role of appropriate consultation and should be commended for that and also should be commended for recognizing how different the educational needs of health professionals are at different stages of their training and directing that educational programs be developed which are suitable for this type of health professional and for their level of training.

The second point that I would like to make is that in some instances the response to bioterrorism is primarily state directed utilizing federal resources. Federal programs that are state administered must be managed in a way to respond to regional needs and must not be solely state directed. For us in Kansas City, where we are a part of a bi-state metropolitan area and for other borders areas such as Illinois and Iowa, state and federal governments must be cognizant of this important issue. If Kansas and Missouri look only to their home states we in the Kansas City metropolitan area may be neglecting a large part of the patient populations we serve who cross state lines daily and the training venues where our students are educated. I am sure that this can happen but we must not be myopic in our approach. Appropriate response to bioterrorism will call for many important partnerships including bi-state partnerships.

The third point is that all of us in medical education, are struggling with how to educate our students about accessing rather than memorizing information. Medical education is truly a process of continuous learning. It is impossible in four years of medical school, even combined with an additional three to seven years of residency training to educate a practitioner about what they will experience in their forty plus years of practice lifetime. Therefore, it is important to introduce medical students to basic concepts and to educate them in how to continuously access appropriate information quickly and efficiently and build the means of doing this throughout their career. Educating physicians in the appropriate usage of information technology, is critically important for all of us in medical education. All educational materials that may be developed and presented under this proposed legislation, therefore, should be designed with the idea of being accessible information that can be readily accessed by practitioners of different levels.

And this leads me to a difficulty that must be addressed with the Veterans Affairs information systems. I have been very impressed by the investment that the Veterans Administration Medical Centers and the Department of Veterans Affairs have made in the development of medical center information systems. I have viewed the information systems in our Kansas City VA Medical Center and have also gone to presentations at national meetings where representatives of the Department of Veterans Affairs have presented progress in linking different Veterans Affairs Medical Centers for accessing patient information and on systems for discovering and most importantly preventing medical errors and instituting important quality procedures within the VA Medical Center system. However, the language of the VA information systems is MUMPS, which is an archaic computer language that has caused considerable difficulties for those of us outside the VA system. I am not a computer expert and I cannot talk with you any way

knowledgeably about the problems of the interfaces between the VA system and facilities outside the VA. I am aware that emerging technologies are allowing some access to potential databases written in MUMPS language. The problem however, is the fact that the system, while in the public domain, cannot be widely utilized by others outside the VA. This problem needs to be addressed as new opportunities such as the current legislation present themselves. We certainly need to find formats for transfer of information, which is compatible to a wide audience, and these are clearly available. I would hate for the rich resources which the VA has put together and which they will put together in the future not to be accessible because of technical difficulties.

Continuing on the theme of information technology, I would like to stress the need for rapid information sharing in times of national crisis. It is critical for us in the health care profession to be able to share data about unusual presentation of medical conditions, symptoms, and possible treatments both for consultation and to alert each other about the scale of some of these potential national emergencies. To do that we must build linkages among our medical centers, hospitals, health clinics, health departments, etc. A place to start is clearly our emergency rooms and urgent treatment centers, since these are still the usual presentation site for large segments of our population. There are many considerations which must be taken into account when building these linkages. Certainly the issue of crossing state boundaries is one that we are particularly aware of in Kansas City. We must be aware of the restrictions on data sharing under the Health Insurance Portability and Accountability Act (HIPAA). Nevertheless, I firmly believe that these linkages must be built and must be accessible by different health professionals. Again the Association of Academic Health Centers should take a leadership role in this effort but this is truly a private/public partnership with the American Hospital Association, the American Medical Association, and the American Public Health Association.

The University of Kansas Medical Center would be excited to be considered as a partner for the establishment of one of the emergency preparedness centers as described in HR 3253. I believe that we bring many assets to such a partnership. First, we are an educational institution which already has partnerships with four VA medical centers within our VISN crossing state lines between Kansas and Missouri. We have had a history of partnering with other institutions as exemplified by our AAMC funded Pipelines Initiative with the University of Missouri Kansas City which has brought together schools of Dentistry, Pharmacy, Nursing, Allied Health and Medicine. Kansas is one of only six states nationally which operates a combined Department of Health and Environment and we have

active collaborations with our land grant institutions, Kansas State University as well as the University of Kansas. Certainly issues of bioterrorism in its multiple forms also must involve the agricultural community and those relationships with our other educational partners and with our state are already in place. Faculty members at the University of Kansas School of Medicine have outlined a plan for a comprehensive weapons of mass destruction response structure utilizing our capabilities in forensic sciences and proposing liaisons with the national pharmaceutical stockpile and local agencies across state lines. We have in place an excellent network for education for all health providers across the state of Kansas with our medical education network sites and area health education centers and we also are actively engaged in providing continuing medical education in a variety of formats, including web-based formats for practitioners in our state and region. We have both in the School of Medicine and in our School of Nursing traditions of educational innovation and would be excited about the opportunities to blend these resources with those of the Veteran's Administration in creating a Center of Emergency Preparedness for the heartland.

Finally, let me say that I am extremely supportive of any efforts that can be found to strengthen the partnerships between the Veterans Affairs Medical Centers and our health professional schools, particularly our schools of medicine. These are historical partnerships which can be re-strengthened and re-energized in this time of national crisis. This is truly a time of enormous opportunity and we at the University of Kansas will be happy to play whatever role we can in assuring the success of these initiatives.

PREPARED STATEMENT OF DR. STEPHEN WINTERMEYER

TESTIMONY OF STEPHEN F. WINTERMEYER, M.D., M.P.H., INDIANA UNIVERSITY SCHOOL OF MEDICINE

Chairman Moran, members of the committee, good afternoon. I am Dr. Stephen Wintermeyer, Associate Professor of Clinical Medicine in the Division of Pulmonary, Allergy, Critical Care and Occupational Medicine at the Indiana University School of Medicine. Dean D. Craig Brater of the IU School of Medicine has asked me to represent the school at this hearing today.

Let me speak briefly about myself and the IU School of Medicine. I know the VA system well. I have been a medical student in a VA hospital. I have served as a resident and fellow in a VA hospital. I am presently a member of the medical staff at the Richard L. Roudebush Veterans Affairs Medical Center in Indianapolis. Equally important, I have been a patient in a VA and have been a family member of a patient in a VA. I have tremendous respect for the VA health system. I also know something about biological, chemical and nuclear weapons. As a physician on active duty in the U.S. Army for six years, I was deployed to the Middle East for six months to serve in Operations Desert Shield and Desert Storm. As Chief of Medicine and Ambulatory Care for the 46th Combat Support Hospital during these operations, among other things, I made the decision, along with my hospital commander, to start our troops on pyridostigmine, a nerve agent prophylactic medication. At the present time, in addition to giving talks on Bioterrorism, I am the Associate Chair of the IU School of Medicine Task Force on Bioterrorism.

The Indiana University School of Medicine is the second largest medical school in the country. At IU, we enjoy a mutually beneficial and appreciated affiliation with the Richard L. Roudebush Veterans Affairs Medical Center. Our school's primary effort regarding Bioterrorism is our Task Force on Bioterrorism, created by Dean D. Craig Brater right after the 9/11 tragedy. This Task Force is chaired by Dr. Rose Fife, our Associate Dean for Research and includes members from our Schools of Medicine, Nursing and Dentistry, the Veterans Affairs Medical Center (including several faculty members who are veterans themselves), our county and state departments of health, the Indiana Poison Control Center, the university environmental health and safety department services, and our other primary teaching hospitals.

I should like to emphasize that the VA is a very important participant on this Task Force. We have been dealing with issues of training, personnel mobilization, emergency transport, general education, and so on. As an example of one area of immediate interest for the Task Force, we enclose with this testimony a draft course outline for a "crash course" that we are developing on emergency preparedness for medical students, nursing students, residents, and other trainees and faculty. The group developing the course includes members of our county department of health, the Indiana Poison Control Center and full-time IUSM faculty members from the Departments of Emergency Medicine, Medicine and Obstetrics/Gynecology.

Additionally, Dr. Fife and other members of the School's Task Force, including our VA representative, serve on a Task Force organized by the Mayor of Indianapolis to deal with disaster preparedness. This group has been working on innovative measures including emergency credentialing of physicians at hospitals other than their home hospital in the event of disasters to ensure that medical personnel will be distributed throughout the city, and, indeed, region, as needed. They also have been dealing with issues such as networking among hospitals such as building a common electronic medical record, emergency transportation, quarantine facilities, access to drugs, and care of mass casualties, to list a few. The activities of the Task Force are examples of what can and should be done cooperatively among hospitals and institutions to improve our ability to withstand any future attacks or other disasters. The VA's participation as a major member of this Task Force ensures that programs developed by the VA in this arena can be readily deployed throughout the community.

I am here today to speak in support of both H.R. 3253, the National Medical Emergency Preparedness Act of 2001 and H.R. 3254, the Medical Education for National Defense in the 21st Century Act. H.R. 3253 establishes Emergency Preparedness Centers with the VA. Such centers would involve strong collaboration with qualifying medical schools, public health schools and other research and educational entities. With the VA's national network and affiliations with medical schools, such as ours, and its recent integral role in educating both the medical and lay communities about bioterrorism, VA hospitals are in an excellent position to work with these medical schools to expand research in medical emergency preparedness and to further enhance the training of health care professionals in this area. H.R. 3254

creates a joint program between the Department of Veterans Affairs and the Department of Defense in which a series of model education and training programs on the medical response to the consequences of terrorist activities are developed and disseminated. Again, the long history of collaboration between VA hospitals and medical schools put the VA in an excellent position to get this valuable job done. H.R. 3253 and H.R. 3254 are valuable initiatives that work in synergy to address critically important educational and research needs in the area of emergency preparedness. This synergy is leveraged even more through partnering with USUHS and VA-affiliated medical schools.

In closing, let me reinforce our support for these laudatory initiatives but also emphasize that they will require new resources for the VA system. Existing resources should not be reassigned for this proposal; rather additional resources should be added for this specific program. To do otherwise would jeopardize other valuable VA programs. Indeed, the programs that would be created by these two pieces of legislation require a stable foundation on which to build. The stable foundation is a solid and vibrant Veterans Affairs Health System.

I thank you for this opportunity to present to you today.

Draft Outline
Course on Disaster Preparedness
Indiana University School of Medicine
April 2002

I. Overview
Half-day course on the NBC (Nuclear, Biological, Chemical) disaster preparedness

II. Target groups
- A. Medical, nursing students
- B. Residents/fellows
- C. Faculty (in future)

III. Curriculum
- A. Overview of issues
- B. Role of students, trainees in triage, etc.
- C. Lecture on nuclear (radioactive) agents
- D. Lecture on biological agents
- E. Lecture on chemical agents
- F. Lecture on mass trauma
- G. Summary, including resources specific to various hospitals

IV. Major Needs
- A. Development of practical exercises
- B. Follow-up/re-emphasis
- C. Development of evaluation tools
- D. Determination of placement within curriculum

INDIANA UNIVERSITY SCHOOL OF MEDICINE
FEDERAL GRANT AND CONTRACT AWARDS

AGENCY	7/1/98 - 6/30/99	7/1/99 - 6/30/00	7/1/00 - 6/30/01
AHRQ			686,729
CDC	820,156	1,659,788	1,616,903
DHHS		22,809	
DoD		401,558	1,453,228
DoEducation	126,110	126,875	
FDA		459,992	500,000
HRSA	1,348,869	1,378,610	1,619,585
NASA	149,600	190,000	187,300
NIH	65,564,367	71,826,287	76,405,995
NSF	274,750	266,088	87,359
PHS	636,591	570,276	178,197
Traffic Safety Adm	60,000		
VA	7,097,198	6,943,234	8,556,261
TOTALS	76,077,641	83,845,517	91,291,557

STATEMENT OF
JAMES R. FISCHL, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON HEALTH
ON THE
NATIONAL MEDICAL EMERGENCY PREPAREDNESS ACT OF 2001, AND MEDICAL EDUCATION FOR NATIONAL DEFENSE IN THE 21ST CENTURY ACT

APRIL 10, 2002

Mr. Chairman and Members of the Subcommittee:

Thank you for the invitation to contribute The American Legion's views regarding these very important issues of enhancing the Department of Veterans Affairs' role in preparations for a national medical emergency. The events of September 11th shocked not only a sense of outrage and safety in this nation, but also forced the nation to take a serious look at its ability to respond in the event of a national emergency.

H.R. 3253 – National Medical Emergency Preparedness Act of 2001

This act would provide the Secretary the authority to establish at least four medical emergency preparedness centers at Department medical centers and staffed by Department employees. The mission of the centers includes carrying out research and developing methods of detection, diagnosis, vaccination, protection, and treatment for chemical, biological, and radiological threats to the public health and safety. The centers would also provide education, training, and advice to health-care professionals, including health care professionals outside the Veterans Health Administration (VHA); and provide contingent rapid response laboratory assistance and other assistance to local health care authorities in the event of a national emergency.

The Department of Veterans Affairs (VA) unilaterally responded to the tragic events of September 11th very quickly. The Veterans Benefits Administration (VBA), Veterans Health Administration and the National Cemetery Administration were mobilized to assist in answering questions, provide mental health services, filing for benefits, and assisting with burial arrangements. VA also worked with Federal Emergency Management Agency (FEMA), the Office of Crime Victims (OCV), American Airlines and the American Red Cross. VA's National Center for Post-Traumatic Stress Disorder (PTSD) sent six team members from the Palo Alto Education Division to the Pentagon Family Assistance Center within days of the attack. For more than two weeks, this team provided psychological support and education to the recovery workers and family members at two separate locations.

Even though the response was quick and more than adequate, much work remains to be done on the ability of this Nation to respond immediately in the event of a national emergency. The establishment of these emergency preparedness centers is a step in the right direction. However, there already exists a Center within VA that performs many of the functions proposed in this Act. A team from The American Legion conducted an on-site visit and was very impressed with the operation. We would like to see close involvement of this entity in the establishment of the proposed additional emergency preparedness centers.

The Emergency Management Strategic Healthcare Group (EMSHG) Emergency Operations Center was activated in response to VA's concerns over Y2K, and has remained the alternate site for VA Central Office in the event of a national emergency. It has been revised to oversee VA's response to combat and civilian casualties resulting from weapons of mass destruction (WMD); nuclear, biological, or chemical (NBC) attacks or natural or accidental disasters. The mission of EMSHG is to provide

comprehensive emergency management services to VA, coordinate backup to DoD and assist the public via the National Disaster Medical System (NDMS) and the Federal Response Plan (FRP).

The EMSHG has National, District, and Area Emergency Managers (AEM) in each of the 21 Veterans Integrated Service Networks (VISNs). The EMSHG works to ensure that the Continuity of Operations Plan (COOP) will be able to be activated in the event of a wide scale emergency, so that mission essential functions will continue, risks mitigated, assets protected, security enforced, and recovery achieved. The COOP was activated after the September 11th attacks, for the first time in VA history.

In 1982, Public Law 97-174 created VA's fourth mission, which is to act as a contingent for the DoD healthcare system in times of war or other national emergencies. In 1984, VA signed an interagency Memorandum of Understanding (MOU) agreement with the Department of Health and Human Services (HHS), FEMA, and civilian hospitals to provide support as part of NDMS as part of the FRP. There are 27 FRP agencies. HHS is always the lead agency under the FRP, while VA acts as a support agency. Under this MOU, VA may be tasked to provide engineering services, mass care and sheltering, resource support and health and medical services. Under Executive Order 12657, VA is also tasked to provide support under the Federal Radiological Emergency Response Plan (FRERP) in the event of an accident at a nuclear power plant or attacks resulting in radiological injuries. Finally, Presidential Directive 62 charges VA with the responsibility of maintaining pharmaceutical caches (antidotes, vaccines and ventilators) and training for NDMS hospitals. The emergency cache is deployed to high threat events, i.e. the Olympics, Presidential Inauguration, etc. VA does not activate under the National Transportation Safety Board (NTSB) plan and was not part of the Pentagon response effort until DoD arranged for VA to be on site.

Much of the emergency management mission in the community falls to the AEM. When they are not actually in the midst of responding to a disaster, they are the organizers and trainers in the networks. They arrange and maintain VA's partnerships with state and county governments, other hospitals that could take patients in an emergency, the Red Cross and the professional associations (i.e. International Critical Incident Stress Foundation.) They arrange joint training exercises between VA and DoD and the other NDMS facilities.

The EMSHG has divided the VA medical centers into three levels. There are 66 hospitals designated as Primary Receiving Centers (PRC) for DoD casualties and injured Prisoners of War (POW). There are 65 hospitals that are Secondary Support Centers and 58 Installation Support Centers. Since DoD has downsized so many of its inpatient beds, it is primarily interested in the PRCs and bed availability. Both VA and DoD have reduced their bed space by approximately 60 percent since 1993. In 1994, VA had 75 PRCs in its VA/DoD contingency planning. The greatest need for these beds would be in orthopedics, spinal cord injury, burn units and neurology. EMSHG has a liaison at the Global Patient Movement Requirements Center at Scott Air Force Base in Illinois who facilitates the transfer of patients.

Currently, VA inpatient capacity operates at approximately 85 percent utilization. In the event of military casualties, VA is able to estimate bed availability by considering occupancy, elective surgery cancellations, staff leave cancellations and reliance on its MOUs with private sector hospitals.

VA Bed Availability for DoD casualties:

24 hours	72 hours	30 days
3,272 beds	5,500 beds	7,574 beds

However, it is significant to note that bed availability could be opened up if additional staff were made available to cover those beds. Currently, VA does have excess bed space, but not the staff to activate those beds. In an emergent situation, The American Legion believes that Reservists and Guardsmen could be brought in to activate those beds, as long as that space is not lost in the CARES process. However, the converse also needs to be taken into consideration when there are VA employees who are Reservists

and National Guard members who would be deployed during a national emergency. If the local AEM could communicate more with the military installations in their networks, then they might be better able to evaluate what the bed space and other needs of the military might be and how to best respond to them in a crisis situation. It seems that the challenge for VA is that DoD is not a homogenous entity and command, structure, regulations, missions vary between Army, Navy, Marine Corps and Air Force bases. In addition, the types of commands (i.e. infantry, armored, air wing) will also be extremely varied. Assessing needs is difficult in such a diverse environment, especially since VA is an outside entity to DoD commanders.

Another source of aid to help in a personnel shortage is the retiree community. Veterans Service Organizations could help in identifying retired health care professionals willing to respond to national emergencies. Other essential professionals could also be identified such as law enforcement and administrative personnel. These professionals could be placed on a National Registry and accessed in the event of a national emergency to augment existing staff.

The American Legion was very impressed with the team and its operations at the EMSHG and is very supportive of its efforts to facilitate coordination in the event of a National disaster. Many things remain to be done that The American Legion would like to see incorporated into the medical emergency preparedness centers based on some of the observations we made during the EMSHG site visit. These include the following:

1. Assess how VA will continue to act as a back up for DoD and the NDMS under the CARES process. The EMSHG should be incorporated into any further VISN evaluations and as the options are implemented in VISN 12;
2. Increase coordination with the National Center for PTSD and the Readjustment Counseling Services as part of the strategic planning process;
3. Garner DoD input in developing a better understanding of their needs through national and local efforts, especially in evaluating their bed space needs;
4. Consider VA's role with the NTSB when military assets and personnel are involved.
5. VA needs to identify unutilized space available for use.
6. Create a National Registry of personnel to contact in the event of a national emergency.

The American Legion reiterates its support for the establishment of the emergency preparedness centers. Duplication of effort is a waste of time. There is already a role model out there that can be used to structure these new centers. While some adjustments will need to be made, the EMSHG should be used as a vital resource to integrate these emergency preparedness centers into the overall mission smoothly and quickly and make them a viable strategic piece of VA and national security.

H.R. 3254 – Medical Education for National Defense in the 21st Century Act

This act would provide the Secretary of Veterans Affairs and the Secretary of Defense the authority to carry out a joint program to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. Specifically the programs would include:

- recognition of chemical, biological, and radiological agents that may be used in terrorist activities;
- identification of the potential symptoms of those agent;
- understanding of the potential long term health consequences, including psychological effects, resulting from exposure to those agents;
- emergency treatment for exposure to those agents;
- appropriate course of follow-up treatment, supportive care, and referral;
- actions that can be taken while providing care for exposure to those agents to protect against contamination;
- information on how to seek consultative support and to report suspected or actual use of those agents.

Again, the Department of Veterans Affairs (VA) already has entities established that conduct education, research and training in some of those areas if not all of them. The National Center for Post-Traumatic Stress Disorder (PTSD) and the Readjustment Counseling Service were both key responders to the September 11th attacks. The reputation and consultation services of the National Center for PTSD are recognized throughout the world. The National Center provides Disaster Mental Health along with many other types of care.

Also, the Education and Research division of EMSHG (located in Indianapolis) is a significant mission that supports and executes the training, education, and research needs and requirements consistent with the established mission and goals of the VA. It works with internal and external partners to produce products and services for emergency preparedness. Within this section, there is the Emergency Management Academy that combines web-based training, videos, conferences, and emergency management team exercises. Training and education have been areas where VA and DoD, along with the private sector, have worked well together. They have recently conducted a large-scale mass casualty training exercise at Consequence Island (PR) in cooperation with a decontamination team from Pfizer Pharmaceuticals, Inc.

The American Legion believes that there is a direct focus on the translation of research into practice in this area. Within VHA, there is already a model for improving research translation into practice via the Quality Enhancement Research Initiative (QUERI), which has been very helpful in providing the field with evidence-based best practices.

The American Legion believes that the National Center for PTSD, the EMSHG, and the Readjustment Counseling Service should be involved in any emergency management strategic planning to include education and research since they are the ones who actually respond to an incident. The mental health component of VA's mission plays a major role in the aftermath of a traumatic incident and has long-term implications for resource demands and community involvement.

The American Legion supports the establishment of these emergency medical education programs. We feel it would be most beneficial to incorporate those entities discussed into the planning and implementation phases of the education programs. There seems to be plenty of information and experience already out there and it would be a shame not to take advantage of it by integrating already existing entities and their missions into the educational programs proposed by this Act. The knowledge gained would almost certainly serve to enhance the quality of the education programs.

Mr. Chairman, that concludes this statement.

TESTIMONY

of

RICHARD JONES
AMVETS NATIONAL LEGISLATIVE DIRECTOR

before the

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to present the views of AMVETS regarding H.R. 3253, the National Medical Emergency Preparedness Act of 2001 and H.R. 3254, the Medical Education for the National Defense in the 21st Century Act.

H.R. 3253, the National Medical Emergency Preparedness Act of 2001:

AMVETS supports H.R.3253, the National Medical Emergency Preparedness Act of 2001. This is timely and important legislation, which will better allow our nation to address the many faceted threats we face as we move forward in a dangerous and uncertain age.

Mr. Chairman, as we all are painfully aware, this nation suffered a national scare last fall in the wake of the anthrax attack. As that event showed, without medical awareness, medical care workers and first responders will not have the single most important tool to use in an attack—the expertise to treat exposure effectively and help us avoid public panic and the loss of commonplace and essential services. H.R. 3253 is a reasonable first step in implementing the lessons learned from last fall.

If and when the next terrorist act threatens our homeland, it could be just as easily in the form of chemical or radiological hazard as the biological threat seen with anthrax. AMVETS believes the establishment of medical emergency preparedness centers within the Department of Veterans Affairs (VA) represents a commonsense approach toward protecting public health and safety in the future.

The VA is known worldwide for its research, quality of patient care, and ability to train healthcare workers. It has already shown a capacity to apply expertise and leading edge research in the fields of geriatrics, mental health, and prosthetics.

With these good works as a model, AMVETS believes the VA will provide superior research into the detection and treatment of biological, chemical, or radiological attacks or events that may threaten us in the future.

The important consideration in establishing these national medical preparedness centers, however, is funding. It is critical that these operations receive specific earmarked appropriations, separate from the VA's standard healthcare funding.

H.R. 3254, the Medical Education for the National Defense in the 21st Century Act:

AMVETS supports H.R. 3254, the Medical Education for the National Defense in the 21st Century Act. We believe this proposal goes "hand-in-glove" with the goals outlined by H.R. 3253.

As we witnessed during the anthrax event, several of the cases of anthrax went misdiagnosed, or worse, undiagnosed. This inability by healthcare workers to recognize the incidence of anthrax in its initial stages led to the unfortunate deaths of several people. These tragic failures should serve as a wake up call for us all. Our healthcare system must be equipped and trained to handle any threat, especially one involving biological, chemical or radiological agents.

The Smith bill, H.R. 3253, and the Buyer measure, H.R. 3254, are complimentary. The tactics and procedures that flow from the provisions of H.R. 3253 would be useless unless disseminated to healthcare professionals and our entire nation for effective treatment and response. At the present time, the Department of Defense Uniform Services University of Health Services, located on Jones Bridge Road in Bethesda, Maryland, is the only medical school in the nation that stresses diagnoses and treatment of persons exposed to biological, chemical or radiological agents as a fundamental part of its curriculum.

Mr. Chairman, AMVETS believes that the proposed medical education programs would be a good investment for the country and help enable our healthcare professionals to play a more significant role in the future health and security needs of our nation.

The inescapable fact is that we cannot simply rely on chance to counter those who would do us harm. We must be prepared to treat the victims of such an attack if it were ever to occur. The proposal outlined in this legislation provides essential assistance that can help protect us all in the event of a future attack.

AMVETS thanks you for the opportunity to present our views on these proposals.

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STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
APRIL 10, 2002

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to present the views of the Disabled American Veterans (DAV) on H.R. 3253, the National Medical Emergency Preparedness Act of 2001, and H.R. 3254, the Medical Education for National Defense in the 21st Century Act. As an organization of more than one million service-connected disabled veterans, DAV is especially concerned about maintaining a Department of Veterans Affairs (VA) health care system that can meet its primary mission of providing medical care to our nation's veterans and effectively carry out all its other missions.

The National Medical Emergency Preparedness Act of 2001, H.R. 3253, seeks to establish at least four medical emergency preparedness centers in VA to carry out research on and develop methods of detection, diagnosis, vaccination, protection, and treatment for chemical, biological, and radiological threats to the public health and safety. It also seeks to provide education, training, and advice to health-care professionals throughout the United States, and to provide contingent rapid response laboratory assistance to local health care authorities in the event of a national emergency.

The Medical Education for National Defense in the 21st Century Act, H.R. 3254, seeks to establish a joint program between VA and the Department of Defense (DoD) to develop and disseminate a series of model education and training programs on the medical responses to the consequences of terrorist activities. The programs developed would focus on the recognition of chemical, biological, and radiological agents that may be used in terrorist activities and training for health care professionals to identify potential symptoms of those agents, long term health consequences, emergency and follow-up treatment, and protection against contamination from such agents. Under this measure the education and training programs would be disseminated to health professions students, graduate medical education trainees, and health practitioners in a variety of fields.

DAV does not have a resolution from our membership on either of these measures; however, their purposes appear beneficial. DAV does not oppose favorable consideration of H.R. 3253 and H.R. 3254 by the Subcommittee. These bills would allow VA to enhance its support role in Federal security and homeland emergency efforts. VA's extensive health care system, graduate medical education and research program, and unique specialized services make VA an essential asset in responding to potential chemical, biological and radiological attacks. Clearly, VA's foremost responsibility is its primary mission of providing medical care to our

Nation's veterans; however, VA is a unique national resource, and all Americans benefit from its exceptional health-related training and research programs.

The VA's Veterans Health Administration (VHA) is the Nation's largest direct provider of health care services, with over 1,300 care facilities, including hospitals, ambulatory care and community based outpatient clinics, counseling centers, nursing homes and domiciliary facilities. VA's primary mission is to provide health care to our Nation's veterans. Its second mission is to provide education and training for health care personnel. VA trains approximately 85,000 health care professionals annually and is affiliated with nearly 1,400 medical and other schools. Its third mission is to conduct medical research. VA's fourth mission, defined in Public Law 97-174, the Veterans Administration and Department of Defense Health Resources Sharing Act, enacted in 1982, provides that VA is the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]"

Currently, multiple federal agencies, including VA, are involved in emergency response for potential terrorist acts and other domestic disaster or emergency situations. State and local agencies have the primary responsibility for managing medical response during catastrophic events. VA's role is to augment the efforts of state and local authorities should such events occur. As part of its emergency preparedness responsibilities, VA is charged with planning for emergency health care service for VA beneficiaries, active duty personnel, and, as resources permit, to civilians in communities affected by national security emergencies. In the past, VA has been there in times of crisis, providing emergency relief following earthquakes, hurricanes, and flood disasters. Following the terrorist attacks of September 11, VA stood ready to respond. Although casualties were minimal, VA cared for patients, deployed staff, supplies, and made its inventory readily available. In New York, VA assisted emergency workers and the National Guard to help them carry out their duties in the immediate aftermath of the terrorist attacks. Staff from VA's National Center for Posttraumatic Stress Disorder (PTSD) began to assist DoD in its relief efforts at the Pentagon. In the months following the attacks, VA also broadcast the DoD sponsored series on "Medical Management of Biological and Chemical Casualties" and "Medical Response to Chemical and Biological Agent Exposure" throughout its satellite Network.

VA plays a key supporting role as part of the Federal Response Plan and the National Disaster Medical System. VA's Medical Emergency Radiological Response Team is trained to respond to radiological emergencies. VHA also supports the Public Health Service and Health and Human Service's office of Emergency Preparedness to ensure that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide in case of a catastrophic event such as the use of weapons of mass destruction. Additionally, VA, well known as a leading authority in treating PTSD, makes available its highly trained mental health staff to assist victims traumatized by large-scale disasters.

The terrorist attacks in New York, Washington, D.C., and Pennsylvania made us feel vulnerable and keenly aware that attacks could occur anywhere in the United States at any time. The immediate establishment of the Office of Homeland Defense by the President was reflective of the urgency and serious threat of terrorism here at home and our resolve to be prepared to

handle the consequences of potential future attacks. The tragic deaths from anthrax fueled fears of other toxic agents being let loose on unsuspecting citizens. As a nation, we resolved to face these fears and to address new potential threats with concrete solutions. The introduction of these two measures is reflective of that goal. Clearly, VA has a multitude of resources and expertise that could be utilized should we experience a chemical, biological, or radiological attack. In past conflicts, veterans have experienced exposure to a variety of toxic substances during military service, prompting VA to develop a core of specialized medical programs and treatments. VA has expertise in areas such as radiation exposure, exposure to toxic chemical, biological, and environmental agents, and recently developed two new centers for the Study of War-Related Illnesses. VA also has unique expertise in diagnosing and treating stress-related disorders such as PTSD. Clearly, VA could contribute greatly to the advancement of knowledge and treatment of patients with exposure to chemical, biological, and radiological agents.

However, if we expect VA to address these new threats—and address them promptly and effectively—VA must be provided with sufficient funding to correct its deficiencies and carry out all its missions. VA is currently struggling to carry out its primary mission of providing timely, quality health care to our Nation's veterans. As this Subcommittee is aware, increasing numbers of veterans are seeking care from VA; however, medical care funding has not kept pace with inflation and increasing enrollment, which has placed significant financial stress on the VA system and caused longer waiting times for patient care. Continued budget shortfalls and open enrollment have stretched VA to its limits, making it extremely difficult for VA to provide the timely, quality health care services veterans deserve.

VA and the General Accounting Office (GAO) provided testimony before the House Veterans Affairs Committee on October 15, 2001, and discussed VA's ability to respond to DoD contingencies and national emergencies. Clearly, VA will play a vital role in helping our nation meets its new challenges, and a high degree of readiness is essential in the event of additional terrorist acts on our homeland. Some of the deficiencies and opportunities VA identified to improve its ability to carry out all its missions included substantial upgrades to personal protection gear, equipment, and training to properly respond to a chemical attack. Secondly, VA reported it would be very difficult to treat veterans, military personnel, and civilians at the same time, should a mass-casualty event occur. Thirdly, VA noted that significant staffing shortages could result if there was a call-up of Reserve or National Guard units. Finally, VA reported that long-term needs for PTSD counseling following a catastrophic event might impact on its ability to treat veterans. Despite these challenges, VA confirmed its intent to meet its critical emergency response missions.

GAO confirmed in its testimony that VA's role as part of the Government's response for disasters has grown with the reduction of medical capacity in the Public Health Service and military medical facilities. The testimony addressed VA's strengths and limitations in its emergency response capabilities and relative to planning for homeland security and noted that VA hospitals do not have the capability to process and treat mass casualties resulting from weapons of mass destruction. It also noted that VA hospitals are better prepared for treating injuries resulting from chemical exposure than those resulting from biological agents or radiological material. Notably, it pointed out that VA hospitals, like private sector community hospitals, lack decontamination equipment and supplies for treating mass casualties. Finally,

GAO stated that, "[c]urrently, VA's budget authority does not include funds to address these shortcomings."

In closing, DAV agrees with GAO's concluding observations that VA, in its supporting role, makes a significant contribution to the emergency preparedness response activities carried out by the lead Federal agencies. We also concur that enhancing VA's role may be beneficial; however, the potential impact on VA being able to carry out all its health care missions if suggested enhancements are made, is unclear, as is the impact on the VA medical care budget.

VA is clearly in a unique position to support other lead agencies in and managing large-scale disasters. H.R. 3253 and H.R. 3254 would certainly enhance VA's capabilities and contributions in this regard, but without sufficient funding to meet its primary mission, it is questionable if additional obligations should be put upon VA to carry out these added responsibilities.

In closing, we thank the Subcommittee for holding this hearing today and providing DAV the opportunity to express our views on these two important measures.

STATEMENT OF THE

PARALYZED VETERANS OF AMERICA

FOR THE RECORD OF THE

SUBCOMMITTEE ON HEALTH OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

H.R. 3253 AND H.R. 3254

APRIL 10, 2002

The Paralyzed Veterans of America (PVA) appreciates the opportunity to express our views on H.R. 3253, the "National Medical Emergency Preparedness Act of 2001," and H.R. 3254, the "Medical Education for the National Defense in the 21st Century Act." PVA supports both of these measures.

Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," currently part of 38 U.S.C. § 8111A, established the Department of Veterans Affairs (VA) as the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" 38 U.S.C. § 8111A. On September 18, 2001, in response to the terrorist attacks on September 11, 2001, the President signed into law an "Authorization for Use of Military Force" which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This

resolution, P.L. 107-40, satisfies the statutory requirement that triggers the VA's responsibilities to serve as a backup to the Department of Defense (DOD).

An important part of the VA's critical 4th mission is to also assist states and localities. In fact, the Government Accounting Office (GAO), in its January 2001 report entitled "Major Management Challenges and Program Risks" (GAO-01-255) characterizes the VA's role as the "primary backup to other federal agencies during national emergencies." The VA must be prepared, and provided with the resources it needs, as well as explicit statutory guidelines, to accomplish this comprehensive and vital mission.

The GAO has characterized the VA's role as serving as a "backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidences and other major disasters[.]" As the GAO further stated, the "VA's role as part of the federal government's response for disasters has grown with the reduction of medical capacity in the Public Health Service and military medical facilities." The VA is the only health care system that is capable of providing a comprehensive and national response to the threats we face from terrorist activities and national disasters and emergencies.

Unfortunately, amongst the growing recognition of the VA's critical role in assisting our states and localities, the Administration has failed to step forward and provide the funding necessary to accomplish this important mission, nor the leadership necessary to move forward. It is estimated that the VA will require $250 million in fiscal year 2003 to begin to satisfy its 4th mission requirements. As for leadership, we are pleased that these two measures take important steps in highlighting the VA's critical role, and providing explicit guidance on how the VA is to best meet its role.

H.R. 3253, the "National Medical Emergency Preparedness Act of 2001," would establish at least four medical emergency preparedness centers at VA facilities staffed by VA employees. H.R. 3254, the "Medical Education for National Defense in the 21st Century Act," would establish a joint medical education program with the Department of

Defense addressing the consequences of terrorist activities. PVA supports these two measures, and we applaud this Subcommittee in addressing issues of importance to the VA's 4th mission.

We look forward to working with this Subcommittee, and with the full Committee, to further address the VA's critical role in assisting our states and localities and in the lives of our veterans, and all of our citizens.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000 (estimated).

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

Fiscal Year 2000

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act , 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Federal Aviation Administration – Accessibility consultation -- $12,500.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $200,000.

STATEMENT OF

PAUL A. HAYDEN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 3253, *NATIONAL MEDICAL EMERGENCY PREPAREDNESS ACT OF 2001* AND
H.R. 3254, *MEDICAL EDUCATION FOR NATIONAL DEFENSE IN THE 21ST CENTURY ACT*

WASHINGTON, DC APRIL 10, 2002

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary, I would like to thank you for the opportunity to comment on the legislation before you today. In President Bush's State of the Union message, he stated that preventing a bioterrorist, as well as a chemical or nuclear attack, is of paramount importance to the security of the country. At the same time, if an attack were to occur, we must be prepared to handle it successfully. Preparedness is ultimately at the heart of what the following legislation is about.

H.R. 3253
National Medical Emergency Preparedness Act of 2001

The VFW strongly supports this legislation that would establish at least four regional medical emergency preparedness centers that would carry out research, provide education and rapid response laboratory assistance into the detection, diagnosis, vaccination, protection, and treatment of chemical, biological and radiological threats to the public health and safety.

We testified on October 15, 2001, that the Department of Veterans Affairs (VA) has an obligation to backup the Department of Defense (DOD) in times of war or national emergency, commonly referred to as their "fourth mission." Further, the VA is a federal-level partner with the Federal Emergency Management Agency (FEMA) and the National Disaster Medical System. We believe that expanding the Department of Veterans Affairs' ability to respond to national disasters is only logical following the tragedy of September 11, 2001.

We also agree with the Secretary of Health and Human Services, Tommy G. Thompson, that "our nation's hospitals stand in the first line of defense against potential incidents that could involve large scale casualties, including bioterrorism and chemical terrorism" and " they must be ready to respond effectively, and they need the nation's assistance to become prepared." This bill moves our nation's largest health care system, the Veterans Health Administration, a step closer towards total preparedness.

H.R. 3254
Medical Education for National Defense in the 21st Century Act

The VFW also supports this preparedness legislation that would allow DOD and VA "to develop and disseminate education and training programs on the medical responses to the consequences of terrorist activities."

To quote Secretary Thompson again, "Our first goal is to ensure that hospitals [and frontline providers] have the capacity to identify the signs of… attack and be prepared to respond." Recognizing that VA and DOD have unique capabilities in this area, this legislation would strengthen their role in training our nation's health care professionals.

In summary, we are fully aware that in order for VA to respond to DOD contingencies and national emergencies, they must be properly prepared. This forms the basis for our support. We, however, wish to remind members of this subcommittee that VA is currently struggling to provide care to its primary constituent, the veteran, which leads us to caution that VA should not be over burdened with fourth mission requirements unless Congress is prepared to fully fund them. The VFW recommends an additional $250 million for VA to properly carry out its fourth mission preparedness.

This concludes my testimony, and I would be happy to answer any questions you or the members of this subcommittee may have.

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

Statement for the Record of

VIETNAM VETERANS OF AMERICA

Submitted by

Thomas H. Corey
National President

Before the

Subcommittee on Health

House Committee on Veterans Affairs

Regarding

H.R. 3253 and H.R. 3254

April 10, 2002

Vietnam Veterans of America

Statement for the record
before HVAC Subcommittee on Health
H.R. 3253 and H.R. 3254
April 10, 2002

Chairman Moran, Ranking Member Filner, and other distinguished members of the subcommittee, Vietnam Veterans of America (VVA) is pleased to have this opportunity to provide a statement for the record on H.R. 3253, the National Medical Emergency Preparedness Act of 2001, and H.R. 3254, the Medical Education for National Defense in the 21st Century Act. VVA will address each bill in turn.

H.R. 3253 National Medical Emergency Preparedness Act of 2001

Since the war on terrorism began last year, VVA has testified repeatedly on the need for the VA to be properly prepared to meet the obligations of the VA's "Fourth Mission," and be prepared to handle mass casualty contingencies, particularly those involving weapons of mass destruction (WMD). Accordingly, in the broadest terms, we share this committee's view that VA must do more to address this critical "fourth mission" problem area. However, H.R. 3253 as currently drafted is not the vehicle for achieving our common goal.

Given the abundant evidence that VVA and our fellow Veteran Service Organizations have presented to this committee about the funding shortfalls in veterans health care, VVA was surprised to find the following language in H.R. 3253:

> `(e) FUNDING- (1) Amounts appropriated for the activities of the centers shall be appropriated separately from amounts appropriated for the Department for medical care.
>
> `(2) There are authorized to be appropriated for the centers under this section $20,000,000 for each of fiscal years 2002 through 2006.
>
> `(3) In addition to funds appropriated for a fiscal year pursuant to the authorization of appropriations in paragraph (2), ***the Under Secretary for Health shall allocate to such centers from other funds appropriated for that fiscal year generally for the Department of Veterans Affairs medical care account and the Department of Veterans Affairs medical and prosthetics research account such amounts as the Under Secretary for Health determines appropriate to carry out the purposes of this section.*** (emphasis added)

VVA believes that while this proposal needs significant refinement, the most important point is that this effort should be funded from the $24 billion that the Congress appropriated for P.L. 107-38 the Homeland Defense in the Fall of 2001. Thus far VA has only asked for $77 million from this fund and received far, less than this amount. Given the overall downsizing of the VA medical system, and the fact that every VA hospital in the country is reducing staff and services by at least 5 to 7% this fiscal year (not even counting the $500 million to $700 million shortfall), there is not even enough organizational capacity to take care of the veterans whom the VA currently serves, much less possible military casualties returning from overseas or civilian casualties at home. VVA respectfully urges the Committee to work with other appropriate committees in the Congress as well as the Executive branch to ensure that adequate funds are transferred from the Homeland Security (P.L. 107-38) accounts to properly fund this effort and to restore vitally needed organizational capacity in the VA health care system now and in the future. VVA estimates this requires a minimum of $500 million over the next two years.

Additionally, VVA finds the following language in the bill equally problematic:

> `(g) PEER REVIEW PANEL- (1) In order to provide advice to assist the Secretary and the Under Secretary for Health to carry out their responsibilities under this section, the Under Secretary shall establish a peer review panel to assess the scientific and clinical merit of proposals that are submitted to the Secretary for the designation of centers under this section.
>
> `(2) The peer review panel shall include experts in the fields of toxicological research, bio-hazards management education and training, radiology, clinical care of patients exposed to such hazards, and other persons as determined appropriate by the Secretary. Members of the panel shall serve as consultants to the Department.
>
> `(3) The panel shall review each proposal submitted to the panel by the officials referred to in paragraph (1) and shall submit to the Under Secretary for Health its views on the relative scientific and clinical merit of each such proposal. The panel shall specifically determine with respect to each such proposal whether that proposal is among those proposals which have met the highest competitive standards of scientific and clinical merit.
>
> `(4) The panel shall not be subject to the Federal Advisory Committee Act (5 U.S.C. App.).

This language makes no provision for the inclusion of veteran advocates on the proposed peer review panel, an omission VVA finds extremely curious. VVA recommends that if this proposal advances, that VSO representation is key to its success.

VVA also notes that there is no language defining outcome measures included in the bill. The principles in both the letter and the spirit of the Government Performance & Results Act (GPRA) should be the guidelines followed in all programs. If the VA subsequently asserts that it has trained a certain number of medical professionals at each center to deal with WMD casualties, how will the committee know this is in fact the case? What types of individual standardized proficiency tests will these personnel be required to take on a regular basis? How will unit performance be measured? How frequently will WMD exercises be held, and how will such exercises be graded? What mechanisms will be established to ensure that individual and unit proficiency and training shortfalls are successfully addressed? In short, how will the Congress measure VA's WMD defense efforts in the absence of clearly defined outcome measures that are directly tied to managerial performance? VVA respectfully urges the Committee to correct this omission in the proposal.

VVA feels that efforts to confront WMD contingencies must be part of a larger overall effort, spearheaded by the Department of Health and Human Services, to establish national training and education standards and procedures for dealing with WMD events. VA does not exist in a public health vacuum; its approach to WMD defense must be directly connected to the larger overall public effort to address this issue. VVA urges the committee to work with other committees in the House that deal with civilian public health issues to develop a unified approach to this problem.

Vietnam Veterans of America

Statement for the record
before HVAC Subcommittee on Health
H.R. 3253 and H.R. 3254
April 10, 2002

H.R. 3254 Medical Education for National Defense in the 21st Century

Last fall's anthrax letter attacks forcefully demonstrated how disruptive (and deadly) such unconventional attacks could be on a vulnerable public health system. VVA agrees with this committee that public health professionals generally should become far more acquainted with WMD-related health threats than is currently the case. In fact, VVA strongly believes that VA should also be engaged in a major effort to educate the private sector medical providers in the importance of discovering if their patients are veterans and, if so, taking a complete military history for use in diagnosis and treatment. Perhaps what is needed is a comprehensive approach to the problem, one that must include the Department of Health and Human Services (HHS) as the lead agency and executive agent for any such program, but of course include VA and the Department of Defense as cooperating and participating agencies.

HHS, university medical centers, and private medical centers must play the lead role in formulating America's public health response to WMD contingencies. VA and DoD can and should be partners in this effort, but in a supporting role. Thus, HHS and the larger public health policy community should come together to develop the kinds of WMD-related curricula, training, and exercise programs necessary for properly equipping the United States to deal with domestic WMD contingencies. VVA would suggest that the President direct the creation of a national WMD medical preparedness center within HHS. VA, DoD, and the relevant state agencies would all be full partners in this new center, which would focus on all aspects of domestic WMD medical preparedness and response: education, individual and unit training, and exercises.

Further, research into the effects of WMD agents should be led by the National Institutes of Health, and should include an emphasis on the health effects of sublethal exposures to WMD agents. VVA believes that this area of research remains significantly under-funded and inadequately explored. We hope this committee will work with its sister committees in the House with jurisdiction over HHS to develop the kind of comprehensive approach we have outlined here today.

Mr. Chairman, this concludes our statement. Please accept our thanks for the opportunity to share our views with you and the committee on this very important topic.

Chairman Moran to Department of Veterans Affairs

House Veterans Affairs Committee
Subcommittee on Health
Hearing on H.R. 3253 and H.R. 3254
April 10, 2002

Follow-up Questions for
The Honorable Leo S. Mackay, Jr., Ph.D.
Deputy Secretary of Veterans Affairs

Question 1: Your testimony indicates you are concerned that, without dedicated funding, the new programs our two bills would establish could diminish VA's ability to fulfill its primary mission. Are these truly VA's concerns, or OMB's concerns, or those of the Office of Homeland Security? Since both these bills include provisions *that require outside funding,* in effect forbidding the Secretary from proceeding unless outside funding is available, what is the purpose of your raising concerns about funding?

Response: The concerns about receiving dedicated funding represent the Department of Veterans Affairs' (VA) position. Although H.R. 3253 and H.R. 3254 did authorize funding to meet the objectives of the legislation, it is not clear that the necessary funds under Public Law 107-38 will, in fact, be available for these purposes. Without additional funding specifically dedicated to those activities, VA is concerned about carrying out the proposed activities of H.R. 3253 and H.R. 3254.

Question 2: Beyond the funding question, considering the events of the past year and the new world we have entered with regard to terrorism here on our very shores, should Congress charge the Department with new public health functions beyond its primary mission of providing heath care and services to veterans? Please explain the rationale for your response.

Response: Because of the new reality of the threat to the American homeland, VA cannot help but operate differently. We must make prudent preparation to safeguard the life and health of our employees and veterans under our care. As well, VA as an integrated and pre-deployed health care asset can play a role beyond the purely self-defensive in public health preparedness and response if funded to do so. The issue, really, is one of opportunity cost. Can the Congress and OHS afford *not* to take advantage of this tremendous resource if the American people are to be adequately protected?

Under the Federal Response Plan, VA today functions as a reservoir of services, expertise and trained health-care workers when requested to provide excess capacity in a given location to support local capabilities. VA may be reimbursed for these services. This is the same ethic that we seek with regard to emergency planning/homeland defense: make available to the public defense the

tremendous resource of VA's endowment of people, expertise, and geographic expanse, but recompense it for the services it provides in defense of the public.

Question 3: You estimated the first-year costs associated with H.R. 3254 to be $5.6 million, and ten-year costs to be $55 million. What is VA's basis for this estimate? Since VA is now spending billions of dollars annually on its academic affairs with schools of health professions nationwide, does your estimate indicate this bill would represent insignificant incremental costs, or is there some other implication the Subcommittee should note?

Response: A breakdown of the costs is attached. These are the additional costs to VA associated with the development and production by VHA's Employee Education System of appropriate training and education programs to meet its obligations under H.R. 3254. They have no relation to funds that VA spends in regard to its academic affiliations program. We will coordinate with the Department of Health and Human Services in designing and implementing bioterrorism-related training for health professionals.

Question 4: In your participation with the Office of Homeland Security to craft a comprehensive and coordinated federal policy on bio-terrorism, what is your estimate of the cost of the expertise, infrastructure and time that the Department is committing to the effort? Would it be fair to conclude that this work extends beyond your primary mission of caring for veterans? Please explain the rationale for your response.

Response: The President's formation of the Office of Homeland Security, with its Homeland Security Councils (HSC) and Policy Coordinating Committees (PCC) and working groups, created a new set of inter-agency activities and responsibilities for VA. VA's newly established Office of Operations, Security and Preparedness (OSP) has the mission to coordinate all of VA's involvement in HSCs and PCCs, and enhance liaison activities with other Federal agencies. In addition, OSP was formed with the specific intent of improving and increasing VA's ability to respond to any contingency (whether natural disaster or terrorist assault) with minimal disruption to ongoing services to veterans and their families. VA's focus is on all hazards that require comprehensive emergency management including bioterrorism. Therefore, we cannot separate out costs related exclusively to bioterrorism. The cost to establish OSP was approximately $7.9 million.

Caring for veterans is the Department's primary mission, and VA is also tasked with conducting research to improve medical care that we provide, and with educating health care practitioners through affiliations with colleges, universities, etc. VA's participation in developing a comprehensive federal policy on bio-terrorism goes directly to the Department's ability to meet the needs of veterans who may be victims of bio-terrorist attacks, either in the United States or on foreign battlefields. This work directly supports VA's fourth mission of

contingency support to DoD and natural disasters. VA is the largest integrated, pre-deployed Federal health care system in this nation that is strategically positioned to respond during an emergency. Disasters occur locally. VA's strategic local presence in most communities makes our role inevitable in times of natural disasters or terrorist attacks. We must be prepared to take care of our veterans as well as our employees. Additional resources and authorization would be required to extend our care to other affected citizens. When properly tasked and resourced, VA can supplement Homeland Security with minimal disruption to the Department's primary mission of caring for veterans and their families.

Question 5: The written testimony submitted by the Vietnam Veterans of America does not support H.R. 3253 due to the funding matter that was thoroughly reviewed during the hearing. Mindful of the views of VVA, and in your opinion, can your 4th mission – supporting military and national emergencies – be carried out without jeopardizing the current resources available to VHA?

Response: VA believes that the existing 4th mission can be performed, as it now exists, without jeopardizing the current resources available to VHA. VHA has worked closely with DOD to provide contingency back up for many years, and VA does not see this changing, although excess capacity in both systems may be lower today than it was 10 years ago. In national emergencies, VA has a secondary role to HHS and provides support in an emergency. HHS also has other partners in the National Disaster Medical System, including DOD and civilian facilities.

Attachment – Response to Question 3

Item	Year 1	Years 2 to 10 *
VAKN broadcasts (36 new broadcasts per year)* *based on avg. cost	$1,170,000	$1,170,000
rebroadcasting costs* *based on $1,450/hr for transponder time + $1,500 for uplink truck per day x 4 hr/day	$1,900,000	$1,900,000
videotape distribution* *based on cost per tape of from $3 to $6 x 150,000 tapes	$500,000	$500,000
web-based instructional modules	$150,000	$300,000
Staffing (direct)	$248,000	$248,000
Staffing (additional)	$128,500	$128,500
marketing (.001)	$300,000	$300,000
program evaluation	$600,000	$300,000
Educational Tools and Products	$645,000	$645,000
	$5,641,500	$5,491,500

* Per year costs given for years 2-10.
Total 10-year costs = $55,065,000.

Chairman Moran to Centers for Disease Control and Prevention

Centers for Disease Control and Prevention
Follow-Up Questions for the U.S. House of Representatives
Committee on Veterans' Affairs
May 23, 2002

Q1. The President's budget has proposed $5.9 billion to defend against biological terrorism; $20 million of these funds will go to the "Epidemiological Intelligence Service" at CDC to strengthen the surveillance and response for all types of epidemics. Assuming this appropriation is approved, what role, if any will VA play in an endeavor of this nature?

A1. Eight million dollars of bioterrorism funds in FY 2002 will go to the Epidemic Intelligence Service for strengthening surveillance and response. Assignment of EIS officers in every state will build infrastructure and enhance epidemiologic capacity in the states and strengthen emergency preparedness and response. The first phase will be the deployment of EIS Officers or EIS-trained epidemiologists in every state and every jurisdiction with populations of more than 500,000. Additional training will be required for the current EIS officers and specialists, as well as a cache of alumni who are assigned to CDC or state health departments. For these initial phases, a VA role is not planned.

The additional twelve million dollars will fund the development and maintenance of a comprehensive coordinated response infrastructure at CDC for Bioterrorism and other public health emergencies.

Q2. Your testimony indicates that CDC is committed to working with other federal agencies and partners to ensure the health and medical care of American citizens. Were they established, could the medical emergency preparedness centers that would be created by H.R. 3253 be places of interest to aid CDC in developing strategies to prevent the spread of disease during and after bioterrorist attacks?

A2. CDC's education and training activities for health care professionals are designed to support long term strategic goals as outlined in the Bioterrorism Preparedness and Response state grant program (CDC-Supplement 99051), a National Collaborative Training Plan for Preparedness and a national strategic plan for Public Health Workforce Development. These activities include Regional Medicine-Public Health Education Centers being developed by the Association of American Medical Colleges through a cooperative agreement with CDC. These Centers will provide structured educational opportunities for medical students and residents in community settings and continuing education for practicing physicians. The goal is to establish 10 centers nationally. In addition to core activities, all centers will focus on specific emerging public health priorities including bioterrorism, other infectious disease outbreaks and public health emergencies. These CDC-AAMC Regional Medicine-Public Health Centers will represent a consortium of medical schools, health departments, and other important community health resources such as hospitals, clinics, volunteer groups. The VA Medical Centers, as members of the AAMC, can become an important partner in this initiative.

In addition, CDC funds a national system of 22 Centers for Public Health Preparedness, including 15 comprehensive academic centers, 4 specialty and 3 advanced practice sites. These centers provide support to a total of 38 states in preparing front-line staff. While all Centers for Public Health Preparedness have core activities, the academic centers located in schools of public health, work with state and local partners to develop and deliver education and training for public health and health care professionals in bioterrorism and public health emergency preparedness.

The establishment of medical emergency preparedness centers would present another opportunity for CDC to participate in activities to better prepare our Nation for public health threats. Careful coordination of the medical center activities with CDC's on-going education and training activities would be critical in order to avoid any duplication of effort and to assure that preparedness of health care professionals reflects an integrated national plan.

To ensure that prevention and treatment measures can be implemented quickly in the event of a biological or chemical terrorist attack, rapid diagnosis is critical. CDC is formalizing current draft plans for the notification and mobilization of personnel and laboratory resources in response to a bioterrorism emergency, as well as overall strategies for vaccination, and development and implementation of other potential outbreak control strategies such as quarantine measures. CDC is the reference laboratory for the Laboratory Response Network and stands ready to assist state and local public health laboratories in their efforts to rapidly identify a suspected bioterrorist agent.

Q3. Dr. Yeskey, are you aware of VA's current projects: the establishment of Research Enhancement Award Programs for scientifically meritorious program projects relating to the diagnosis, prevention, and treatment of potentially fatal airborne pathogens or toxins; two centers for the study of war-related illnesses; development of a possible antiviral agent against smallpox, and other VA research relating to bioterrorism? Has CDC had any roles in VA's work in these areas? If so, please describe this activity for the Committee.

A3. CDC has done limited work with the antiviral drug for smallpox in animals. CDC's National Center for Environmental Health has cooperated with the VA in some Gulf War programs and done some studies on Persian Gulf War Syndrome in a PA Guard Unit and with the University of Iowa and Drue Barrett, NCEH sits on a joint PGWS science board. We are unaware of any past collaborations with VA on the diagnosis, prevention, and treatment of potentially fatal airborne pathogens or toxins.

Q4. CDC's statement conveys a sense that CDC alone is handling the responsibilities confronting us. The Committee sensed that CDC doesn't really welcome VA to this activity. Is that an appropriate conclusion on my part?

A4. Mounting a response to bioterrorism is a tremendous undertaking and requires the effort of many entities at all levels: federal, state, and local. **CDC is committed to working with other federal agencies and partners, as well as state and local public health departments to ensure the health and medical care of our citizens.**

CHAIRMAN MORAN TO DR. DEBORAH POWELL

Veterans' Affairs Health Subcommittee
Dr. Powell's Response to Questions

1. **In your testimony you discussed the important of students "accessing rather than memorizing information." I concur that it is vital for a student to retain what is learned in the classroom as well as to continue a working knowledge through their experience with patients. You mentioned that any "educational materials' created out of the proposed legislation should be made readily accessible to practitioners at different levels. Would you please expand your views?** The amount of information that a physician requires to practice preventive, diagnostic and therapeutic medicine is immense. In medical school we try to stress that medicine is a career of continuous education and that a physician must continually update and increase their knowledge for all the years of their practice. We also try to build on knowledge introduced in the first two medical school years by presenting the information in different contexts in the last two years of medical school. We are currently also almost finished with our core curriculum for all residents in all specialties of our programs which will continue to stress topics related to the core competencies of the ACGME which cross all the disciplines of medical specialties. I believe that products of an educational collaboration among DOD, the VA and partner medical schools should be used by the medical schools at different points of the physician education continuum – in medical school during the formal curriculum, in residency training during our core curriculum and through continuing medical education courses for practicing physicians throughout the state. The latter could be done in a number of formats and might be targeted first to primary care physicians (including emergency room physicians). The University of Kansas has approximately 1500 physician preceptors, voluntary faculty across the state of Kansas, who can be a prime audience for these types of educational programs. The programs can be offered to them through our six regional Medical Education Network sites. Therefore in Kansas we are well situated to implement this potential partnership. I would imagine that other states which partner VA Medical Centers may have other similar structures in place to accomplish these goals.

2. **In your written testimony, you indicated that medical students in your school rotate through VA's internal medicine, surgery, psychiatry, neurology and surgical subspecialty departments. How does H.R. 3254 fit into the scheme of discipline exposures for your students; how will it affect instructors, and the other resources necessary? Will you change the curriculum and rotations to include a "bio-terrorism" rotation, or will this new exposure be handled in a different manner?** At the present time, at the University of Kansas School of Medicine, our intention would be to fit educational experiences on the medical implications of terrorism into our existing curriculum rather than to develop new courses. However, we would like to include this subject material at multiple points in the curriculum for maximal educational benefit. That might mean that students are exposed to training at the VA hospital at times different

from an in addition to the rotations we currently have (i.e. as early as first year) and for shorter periods (i.e. one a day symposium). There are existing areas of our curriculum where VA faculty are not currently involved (for example our fourth year Health of the Public required course or our fourth year required Critical Care selective). This subject matter would be particularly applicable to these courses.

If we are to use the VA Medical Center for additional training experiences, more instructors from the VA would be needed, both for direct teaching and for course planning discussions with faculty based at our school. Classroom time can be minimized by the utilization of WEB based or other electronic course materials, but this will need to be developed. This will require time commitments both from the VA and from our faculty.

3. **Your statement endorses any efforts that can strengthen the partnerships between VA Medical Centers and health professional schools; and that VA and DOD should take a leadership role in partnering with health-professional schools to address such critical educational needs. One of the veterans' service organizations submitted written testimony to the Subcommittee that VA and DOD should play only supporting roles in formulating the public heath response to weapons of mass destruction contingencies, due primarily to significant VA and DOD under-funding. It was suggested that HHS, with university medical centers and private medical centers, play the leading role. What would your school of medicine do differently if HHS, not VA, were the lead partner in such a training program?** If HHS rather than the VA and DoD were to take the lead role in this educational partnership, the interaction with the universitities would be an entirely different nature.

The fundamental difference in my estimation is that the medical schools have a long standing relationship (in our case about 50 years) with the VAMCs for education of medical students and residents. Many of us have our clinical faculty and scientists working at VAMCs, for both clinical practice, teaching and research. Education is one of the core missions of the VAMCs. The primary interaction of the medical schools and HHS is the research sphere and to a lesser extent in the clinical arena. Both of these are mainly interactions with NIH. The medical schools do not have a vibrant educational interaction with NIH.

IF HHS were to take the lead role in the educational portion of these two pieces of legislation (and in particular HR3254), they might do this in the form of grants to individual schools or clusters of schools or to other agencies to develop educational materials for the schools. It would be impossible to duplicate the educational facilities or partnerships that already exist with the VA and recreate these in any way with HHS.

4. **You also mentioned some difficulties that the university faces with VA information systems. Compatibility of VA systems with those of partner institutions is an old problem. Do you have any suggestions based on KU's experience that might remedy this IT problem?** This incompatibility of systems is a critical issue for the VA and partner medical schools. As an example of why this could be a problem in the initiatives proposed by the legislation is as follows: In the April 23 edition of the Kansas City Star, the front page picture article announced Cerner Corporation's (a Kansas City based company) new Health Sentry system, an early warning computer system developed with the Kansas City Health Department. This network will connect health departments to health providers and to the CDC by providing hospital and lab data to the health department. It is an exciting concept and the VA information systems should be part of it. The aim is "to make the KC area the most well protected community in the country" according to the KC Star article. I am not aware of the VA being included in planning for this project or if this inclusion is possible at this time given the system for lab data collection used by the VA.

   In some instances the VA systems do not pose a significant problem. We have recently developed a Diagnostic Radiology residency program with the VA. As a part of this program, a VA telradiology unit was loaned to our Radiology faculty to facilitate resident training and supervision. After the initial set up, there have not been technical problems with this equipment.

5. **As a general issue, do you see any reason that VA should not be given a broader mission in the Nation's struggle against terrorism?** I see no reason for the VA not to be given a broader mission in the struggle against terrorism since the VA already has a mission of patient care, research and education, all of which are important elements in this endeavor. However as was mentioned repeatedly at the hearings, the VA should not be asked to do this without supplemental resources.

6. **The statement of the Centers of Disease Control and Prevention (CDC) indicates that CDC is appropriately the nation's watchdog and guarantor of public health. I believe that, at the local level, in rural settings like Kansas, the so-called "first responders" – fire and emergency personnel, local and state police, and national guard units – must first know what to do, how to do it, and why, n the event of bio-terror. Do you agree with my assessment and why?** I also agree that first responders must know the what, how and why in dealing with biological, chemical or radiological terrorism. In rural areas, like much of Kansas, first responders may also include local physicians (often family physicians who function as emergency room physicians in many of our rural hospitals), nurses and pharmacists. It is for this reason that I mentioned in my testimony the need for educational materials to be developed as continuing medical education programs for physicians and for other health professionals. In rural Kansas it is not inconceivable that isolated victims of random attacks might first consult their local pharmacist, for example.

   The cost of these educational programs could be minimized by WEB-based educational programs, prepared for specific provider groups.

Congressman Filner to Dr. Deborah Powell

Response from Dr. Deborah E. Powell, Dean, The University of Kansas
Subcommittee on Health hearing on April 10. 2002

1. Your testimony encourages a renewal of the historic relationships between VA and health professional schools. Can you recommend or suggest specific opportunities to revitalize these relationships? In what respects are these relationships in need of revitalization and what has prompted your testimony on this subject?

The VA has been an essential educational partner for the nation's medical schools in both undergraduate and graduate medical education for more than a half century. Most practicing US physicians spent a portion of their medical training at a VA hospital. However, in the last 5 years of my academic career I have for the first time experienced some problems with this partnership. I have no idea if these problems are system-wide. I can only speak from the experience of myself as one medical school Dean in one network (VISN 15). The University of Kansas School of Medicine is affiliated with 4 VA hospitals in our VISN. The Kansas City VAMC in Kansas City, Missouri is our closest VA facility and a primary teaching hospital for our school, but we also utilize the Leavenworth, Topeka and Wichita VAMCs for education of medical students and residents. When I arrived in Kansas City from Lexington, Kentucky in 1997, I was accustomed to a VA affiliation with an active Dean's committee, vibrant education and research programs and faculty who taught and saw patients both at the University Hospital and at the VA. Of course it helped that our VA and University Hospitals were adjacent and connected by a tunnel. In Kansas City the closest VA is 20 minutes away and faculty practice and teach at our University hospital or the VAMC but only rarely in both places. During the ensuing years it became apparent that research activity at the VA was decreasing and that education was not highly valued. There was no regular Dean's committee meeting and it has only been in the past year that we have been able to hold regular formal Dean's Committee meetings at Kansas City VA and at Leavenworth. (Although I did make visits to both VAs and held informal meetings several times a year at both VAs during this time period.) There continued to be throughout the 5 years a regular Dean's Committee meeting in Wichita. The change from VA Chiefs of each major teaching service (ie Surgery, Medicine, Neurology, Psychiatry, etc) to VA Heads of Primary Care and of Specialty Services caused a disconnect between our academic departments and the corresponding faculty at the VA. At some VAs the Chiefs of the clinical services such as Medicine and Surgery hold Vice-Chair positions in the medical school academic departments and oversee the education and research programs at the VA as well as the patient care activities. Since my husband had served for over 20 years as the Chief of the Pathology Service at eh Lexington, Kentucky VAMC, I was very familiar with the role of the VA service Chief and the relationship with the medical school. I was so concerned about the poor relationship and the lack of educational and research emphasis that I discussed this with the VA Central Office on several occasions during the 1997 through 2000 time period. I do not want to imply that the VA was solely at fault for the problems during this time because the University of Kansas had not done all it could to optimize its relationship with the faculty at its partner VAMCs.

However I think that the VA must reaffirm its historic educational mission and I consider that both HR3253 and HR3254 offer an opportunity for educational partnerships (and research partnerships) for the VA and medical schools in new areas where the VA should have considerable expertise. With these new programs, the VA could the developer and initiator of curriculum, planning with the medical schools in rather than simply providing a training site for clinical rotations. There are other VA initiatives in patient safety and health care quality which provide new educational opportunities as well. Finally the new ACGME core competencies address the need for residents to work in and understand different healthcare systems. VA hospitals and their partner medical schools and University hospitals could work together to develop ways of teaching and evaluating this competency.

We, the US medical schools and VAMCs, need to review and renew our historic educational partnerships and hold each other accountable for their success. While the primary role of the VAMCs is always to provide the highest quality health care to our veterans, this role can be enhanced by the educational partnership. Training young physicians in VA hospitals serves as a mechanism for attracting these same physicians to see practice opportunities in the VA. It is very important to assure that the Directors of VA hospitals and of the Networks understand and appreciate the value of the partnership with their affiliated medical schools. These are the VA leaders who can make it work on a local level.

CHAIRMAN MORAN TO DR. STEPHEN F. WINTERMEYER

INDIANA UNIVERSITY,
Indianapolis, IN, April 25, 2002

Hon. JERRY MORAN
Chairman, Subcommittee on Health,
Committee on Veterans' Affairs,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: I hereby present responses to your questions in your letter to me dated April 12, 2002.

1. *Dr. Wintermeyer, you testified you served in the U.S. Army during Operations Desert Shield and Desert Storm and that you personally made a major medical decision concerning the troops deployed under your care. Was your decision, to administer pyridostigmine bromide, known as PB, to your troops in the field, based on the information you received before deployment, or information you received during your deployment—or did other factors justify it? In other words, was the decision to use the PB based on your military training prior to deployment or information available to you in the combat area?*

   My decision to instruct the members of my unit, the 46th Combat Support Hospital, to start taking pyridostigmine bromide (PB) by mouth was made in conjunction with my commander, Colonel Theodore Raia, Commander, 46th Combat Support Hospital. The decision was made based on both information learned prior to our deployment and to information received in the combat theatre.

   I had some general knowledge of chemical weapons (diagnosis, decontamination, treatment) and biological weapons (diagnosis, decontamination, treatment) prior to deployment. This information was obtained primarily through reading manuals that were provided to me in the weeks preceding deployment. Most of the knowledge I received regarding chemical and biological weapons was obtained by attending a 3 day Chemical Casualty Care Course. This course was put on by U.S. Army personnel at a number of sites in Saudi Arabia during Operation Desert Shield. I attended the course along with a number of my colleagues from the 46th CSH. The final information on which Colonel Raia and I based our decision was the knowledge that Operation Desert Storm had just started. Colonel Raia and I did not know at that time whether or not our unit might be exposed to chemical weapons. Thus, we chose to start our troops on pyridostigmine as a preventive measure.

2. *I assume that you are familiar with the biohazards training program at the F. Edward Hebért School of Medicine in Bethesda. In your judgment, is this a good model that can be made portable to other health professionals training venues?*

   At the present time, I cannot say I am very familiar with the biohazards training program at the F. Edward Hebért School of Medicine at the Uniform Services University of the Health Sciences in Bethesda, Maryland. I did my internal Medicine residency at Walter Reed Army Medical Center from 1985 to 1988. From 1986 to 1988, I was a teaching fellow at USUHS. However, I have not been associated with USUHS since that time.

   However, based on my knowledge of USUHS and the fact that it includes education of chemical and biological weapons more so than other medical schools, I suspect their program is significantly better than that offered at other medical schools.

   I would be being very happy to evaluate the USUHS program if I were provided a copy of it or another opportunity to do so.

3. *Dr. Wintermeyer, you submitted a mock course description that would implement the essence of the Buyer bill, H.R. 3254, and I appreciate your effort to do so. How do you envision a training program based on this bill to be disseminated to health professions schools like Indiana University and University of Kansas?*

   H.R. 3254 provides for a model program to be disseminated to medical schools via the VA.

For medical students to get this training, the following would need to be accomplished:

1. Basic curriculum development
2. Curriculum revision to reflect local conditions/resources
3. Provision of time in the curriculum for such training
4. Provision of resources
   a. Faculty
   b. Teaching site
   c. Equipment

H.R. 3254 would allow for the formation of the basic curriculum. I envision the American Association of Medical Colleges (AAMC) requiring that member medical schools provide such curriculum training in their curriculum. I believe that this would be necessary for such training to be performed. There are so many demands on the medical school curriculum that without a formal requirement from AAMC, such training would likely not make it into the curriculum.

One should also consider graduate medical training (residents/fellows). Such training should be required by the American Council for Graduate Medical Education (ACGME). If ACGME did not require such training in residencies, it also would likely not be provided. I feel that the following residency programs should have significant training in biological and chemical weapons:

1. Internal medicine
2. Emergency medicine
3. Public health
4. Preventive medicine

Residency programs in other fields should at least contain information regarding the appropriate decontamination of patients to insure the safety of other patients and health care providers.

Since H.R. 3254 provides for the dissemination of the model curriculum through VA's in association with medical schools, there would need to be a point person at each VA Hospital that would take the curriculum from USUHS. That person would be a faculty member at the affiliated medical school. That person should be in charge or work closely with someone in charge of implementing this material into the curriculum. The medical school would need to come up with the faculty time, training site and equipment necessary to implement this training.

I hope my answers are informative to you and other members of your Subcommittee.

Sincerely,

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