S. HRG. 108–797

TERROR ATTACKS: ARE WE PREPARED?

HEARING

BEFORE THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

ON

EXAMINING PREPARATIONS FOR POSSIBLE FUTURE TERRORIST ATTACKS, FOCUSING ON A CONCEPT OF OPERATIONS PLAN, TAILORED TO EACH NATIONAL SPECIAL SECURITY EVENT, WHICH ESTABLISHES A FRAMEWORK FOR MANAGING FEDERAL PUBLIC HEALTH AND MEDICAL ASSETS AND COORDINATING WITH STATE AND LOCAL GOVERNMENTS IN AN EMERGENCY

JULY 22, 2004

Printed for the use of the Committee on Health, Education, Labor and Pensions

U.S. GOVERNMENT PRINTING OFFICE

95–103 PDF WASHINGTON : 2005

For sale by the Superintendent of Documents, U.S. Government Printing Office
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TERROR ATTACKS: ARE WE PREPARED?

THURSDAY, JULY 22, 2004

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
Washington, DC.

The committee met, pursuant to notice, at 10:00 a.m. in Room 430, Dirksen Senate Office Building, Hon. Judd Gregg (chairman of the committee) presiding.

Present: Senators Gregg, Kennedy, Dodd, and Alexander.

OPENING STATEMENT OF SENATOR GREGG

The CHAIRMAN. If we can get everybody's attention, Secretary Thompson is on his way. He is in a car on his way. I thought in order to expedite the hearing since we have got some very interesting witnesses we want to hear from, and unfortunately we have a variety of votes coming up which may totally disorient the events here—here is Secretary Thompson. Great.

Nice to have you, Mr. Secretary, and it is nice you are joined by Dr. Gerberding and Dr. Fauci, obviously.

The purpose of this hearing is to review the status of our preparation and our capacity to deal with a significant biological event. One would presume it would be terrorist driven. There has obviously been a tremendous amount of attention to this issue by this committee, but more importantly by the government generally. Since 9–11, we have put over $14 billion in the issue of defending this country against a biological attack, and we would like to review where we stand with the members of those government agencies which have the priority responsibility in this area.

The issue, I believe, breaks down into a number of functions. The first is our ability to detect prior to an event biological agents coming into the country and potentially being dispersed and where we stand in our capacity for such detection. The second goes to the issue of our capacity to deal with a biological event, specifically what our status is relative to the production and development of antibodies and vaccines, a major issue, our stockpile capability and what we have in the pipeline to deal with things like anthrax, botulism, smallpox, plague, and the top six areas that we have identified.

The third area that this breaks down into is our capacity to contain an event and to handle the surge of need in the area of health care which would occur from an event. If it is, for example, a smallpox outbreak, the capacity to contain the actual outbreak, if it is an anthrax attack, the capacity to deal with the issue of health care and caring for people who have come in contact with the

agent, and specifically whether or not we have gone through and participated in enough preparation in those areas which would be most likely subject to such attack; and, finally, the coordination issue, which is a constant issue of concern between the State and Federal agencies which are responsible.

I think the 9–11 report which has just come out, which I have only had a chance to review, as I suspect most people have, in a superficial way, but one of the very apparent conclusions of that is that preparation is absolutely key in our capacity to deal with these types of events, and our job, I think, as a Congress is to review where we stand in that preparation process. That is what this hearing is about, and we look forward to hearing from our witnesses. We have got an exceptional group of folks here to talk to us, and I will yield to Senator Kennedy for his thoughts.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Well, thank you very much, Mr. Chairman, and thank you for having this hearing. I think it is enormously important and it is timely as well. If we look at just yesterday when we were at the White House and the President signed the Bio-Shield legislation which will bring together both the private sector and the public sector in order to try and develop the kinds of vaccines and treatments to protect against some of these pathogens that may be used in a terrorist attack, this is progress. That is certainly enormously important.

Senator Gregg has identified that obviously we want there to be an emphasis on preventing an attack so that we are going to have accurate intelligence so such an attack and assault on the United States will not take place. We wanted to have the development of these vaccines and other materials so that if we are going to be attacked, they are going to be available and accessible to the public. That is enormously important, and it is very important to take steps developing vaccines, and there is significant progress on it.

We also want to be able to detect, but also, as the Chairman pointed out, contain an attack. That is where our health delivery systems play such an important role, and I know we are going to hear about what has been happening up in, for example, my own home city of Boston where Partners Health Care spent $6 million on terrorism preparedness, but received only $233,000 from the HHS hospital grant program; Boston Medical Center, spent $2.7 million, but received only $39,000; Dana-Farber spent $439,000, received only $15,000; Caritas Carney is reimbursed only about 3 percent of what it spent.

Now, money is not all of the answer to this, but what we are finding out with these hospitals, and this is pretty characteristic around the country, that these are funds that are being taken away from patient care, and we have not got the unlimited kinds of resources. The major hospitals even in smaller towns have not got those kinds of resources. Prior to 9–11, Senator Frist and I had strongly supported having additional kinds of help and assistance for the hospitals that will have a major role in containment of an attack. Smaller community hospitals, or other kinds of health delivery systems also have an important role.

We will hear later on, Mr. Chairman, some of the challenges that are out there in our community, and we want to make sure that we are giving the kind of support to the Administration in terms of the funding levels so that they can do their job. If they are not going to get the funding levels that are going to be necessary to do the job, we can not expect that they are going to give the kind of support to the communities and health facilities to be able to do the job in areas of the bioterrorism threat.

This hearing is very important. I think you have got an outstanding group of witnesses. We look forward to the testimony. I know the Secretary yesterday spoke at a conference, enormously well attended, about the importance of information technology and how we can deal with a lot of different issues not only in bioterrorism, but just on health care generally. This is an area that I know you are interested in. I know he is very interested. We are all interested, and we will have a chance to deal with that at another time, but I hope we can look forward to the comments and the testimony of our distinguished panels.

Thank you.

The CHAIRMAN. Thank you, Senator. You made a point which I want to emphasize, because just to preamble this, I hope our witnesses will address these issues. We are concerned about the flow of dollars out, the fact that no 2004 dollars have gone out, the fact that 62 percent of the 2003 dollars have not gone out, and that we still have even 2002 money that has not gone out. We are also concerned about the fact that the hospitals, it appears to be a formula which is essentially spreading money thinly across a lot of hospitals rather than focusing the money on the hospitals which would be the most likely targets for having to handle surge capacity.

I am also concerned about the fact that even the most minimal standards, which are essentially reporting standards which HRSA has set up—of those minimal standards, which are three, few States have met all three. Issues like that, issues such as the fact that we are hearing rumor that the smallpox vaccine which we are purchasing may not be able to get through FDA approval and that the anthrax vaccines have complications.

Those are some of the specifics. Obviously, Mr. Secretary, you are going to talk about the general issues, but we hope you will get down to specifics also. It is a pleasure to have you here, Mr. Secretary. You have got an extraordinary group of people helping you and you have made great strides. There is a long way to go; I am sure you will admit to that, but I want to congratulate especially CDC and NIH, who are represented, of course, by Dr. Gerberding and Dr. Fauci for really the exceptional leadership they have given us in the health care field generally and your leadership as head of HHS, which I think has been extraordinary.

Mr. Secretary.

STATEMENT OF HON. TOMMY THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY JULIE L. GERBERDING, M.D., DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION; AND ANTHONY S. FAUCI, M.D., DIRECTOR, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, BETHESDA, MD

Secretary THOMPSON. Good morning, Mr. Chairman, and thank you for your compliments, and thank you, Senator Kennedy and Senator Gregg, for your leadership in so many areas on public health, and I appreciate that and congratulate you and thank you very much.

Thank you for inviting me to discuss an issue of the highest importance, protecting our country from the threats of bioterrorism. As you all know, our highest priority is to safeguard the American people. This is a responsibility that President Bush takes seriously and I know that it is a responsibility that each of you take very seriously as well.

I am very proud to talk about my department's important role in defending America, because we have accomplished a great deal over the past few years. The contrast between what we were doing a few years ago and what we are doing today is absolutely striking. The Department will spend 12 times as much this year on bioterrorism preparedness as we did 3 years ago. Thanks to your support, funding has gone from $305 million in 2001 to $3.9 billion in 2004, and we have requested $4.1 billion for next year.

On bioterrorism-related research alone, we have gone from spending $53 million in 2001 to $1.6 billion in 2004. That is more than 30 times as much for bioterrorism research. The Department has almost 10 times as many staff members working on bioterrorism readiness as we did in 2001. We have gone from 212 to 1,700 this year. We have dramatically improved our capacity to respond to the threat of smallpox. In 2001, when I came in as Secretary, we had less than 15 million doses of smallpox vaccine available and no dilulence. The vaccine was undiluted, and we had no capacity to distribute it. Today, we have more than enough doses to vaccinate every man, woman, and child in America if necessary.

Research is also underway towards a new improved smallpox vaccine, and Dr. Fauci is here to testify about that if you so desire. Research is also underway towards an improved anthrax vaccine, and we expect it to be available beginning in the middle of 2005. We right now in our stockpiles, Mr. Chairman and Senator Kennedy, we have enough doses to last 60 days for 13 million people, and we are estimating within the next 12 months to have that up to 20 to 22 million people.

Senator KENNEDY. Can I say just on this point, Mr. Chairman—I want to, since you are talking about availability of resources, just give the assurance to the people of Boston, and New York as well, as they are concerned about the security issues, about the anticipation of what has been done to protect those communities. I did not want to interrupt your testimony, but at some time maybe at the end, there would be great interest in both of those communities if you might just give a comment about what steps you have taken also in terms of the preventive aspects.

Excuse me.

Secretary THOMPSON. Thank you very much, Senator.

In building on these successes yesterday morning, the President signed in your presence, Senators, Project BioShield into law, a proposal that was drafted by our Department and was lobbied by our Department, and it is a new initiative that creates a more secure source of funding to purchase the new vaccines and treatments. $5.6 billion has already been appropriated for BioShield over the next 10 years, and in particular, I like to take this opportunity to thank Senator Gregg and Senator Kennedy for their tremendous efforts to pass this vital initiative. It would not have happened without your leadership in our country, and my department is in your debt for that.

In order to protect the safety and security of America's food supply, and you all know that this is a big concern of mine, we have increased the food import examination more than six-fold from 12,000 in 2001 to over 78,000 in 2003, and our goal is to hit 96,000 this year. We went from only a few States in having coordinated public health and hospital plans in 2001 to having every single State complete joint planning this year.

Our public health infrastructure is better than ever. From county health departments to CDC in Atlanta to the 24-hour command centers next to my office in the Department of Health and Human Services as well as the command center at CDC, and thanks to the improved infrastructure, we are better able to identify and track outbreaks quickly and are better equipped to connect our resources to State laboratories and health offices. We now are connected. When I started, we were only connected to 77 laboratories. We now have 121 laboratories connected to CDC and to the information room in the Department as well as we have expanded a number of communities. We have 90 percent of all health departments now connected to the health alert network throughout the country.

Still, we know that hospitals, State health departments, and other front-line agencies cannot possibly be fully prepared for any disaster. We have established strategic national stockpiles of pharmaceuticals and medical supplies as part of a nationwide preparedness training and education program for State and local health care providers, first responders, and governments. These push packages and stockpiles include large quantities of antibiotics, chemical antidotes, life support medications, and other medical and surgical items. We call these push packages, and they are stationed in strategically located warehouses ready for immediate deployment.

We went down, some of my staff went down, and investigated how fast they could load, how fast they could be prepared to respond, and it was amazing how quickly they were able to do it. These supplies can be delivered to anywhere in the United States or in the United States territories within 12 hours. I believe we could do it much faster, but our goal, of course, is always 12 hours.

Because of all of these dramatic steps, I am happy to report that we are better prepared to prevent and to respond to any public health emergency. That does not mean that we can prevent everything, but we can respond very quickly. We have identified several specific areas where we can do even more to protect America.

First, we are anticipating future threats. We know that terrorists want to do everything they can to harm America, and they can be creative in their use of new or different biological agents. We are working to stay a step ahead of those who would harm us, using biotechnology, medical research, and other methods to evaluate new toxins and agents that can require new detection methods, preventive measures, and treatments.

Second, we are working to develop safe, effective medical countermeasures against biological weapons agents, and we are taking into consideration the possibility of new or genetically-engineered agencies.

Third, we will continue to lead the effort to prepare for mass casualty care. Our public health system has to be prepared to deal with widespread illness and casualties in the event of a biological attack or a naturally occurring outbreak of disease. We are working to create a national surge capacity so that hospitals and Federal, State, local, and private agencies will able to provide rapidly expandable mass casualty care. The Department is also taking a number of specific steps to prepare for upcoming profile events, which Senator Kennedy just mentioned, including the Democratic and the Republican National conventions.

For each of these events, the Department has developed a detailed plan, Senator Kennedy, that establishes a framework for managing Federal public health and medical assets that may be required in an emergency. We have made every effort to plan and be prepared for a broad range of contingencies. We have invested staff, resources, and energy to coordinate with our Federal, State, and local partners, and with the event planners to ensure to the extent feasible a rapid and effective response to any public health emergency that may occur. We also are making available push packages for each one of the conventions in the immediate area. All of us hope that these two political conventions will be safe, but even if they are not, we are very prepared to respond.

As during any high profile event, including the recent State funeral for President Reagan, we took charge of making sure that medical doctors and medical personnel were available for any kind of attack if it were to happen, as well as the G–8 Summit on Sea Island. The Department's command center, which operates on a 24–7 basis serves as the primary vehicle for communicating and coordinating with not only HHS personnel in the field, but also relevant staff from the Department of Homeland Security, other Federal agencies, and key State and local event officials.

I know some of you have seen the command center. I was going to show it to you, but I know both Senator Kennedy and you, Senator Gregg, were over there. We have invited your staffs to come over. Several of the staff have been over, and we are extending an invitation to the rest of the staff to come over. It is, we think, an epicenter of what a command center should be like, and we have had the Department of Defense, Department of Homeland Security, NSC, and the Vice President come down and view it. All of them were quite impressed of our capabilities to observe, to watch, and to respond. I invite all of you to come tour it as well. I know you will be impressed with those capabilities.

So, let me reiterate, the stakes here cannot be any higher. We are committed. We are resolved. We will continue to do our part in helping to prepare and protect the country. I have with me Dr. Gerberding from CDC and Dr. Fauci from NIH and Stuart Simonson, who is the Assistant Secretary of bio preparedness in the Department to help answer any questions, specific questions, that you may want to refer to those individuals.

Thank you for giving me this opportunity. Thank you very much for having the hearing, and I will be more than happy to answer any questions you might have.

[The prepared statement of Secretary Thompson follows:]

PREPARED STATEMENT OF SECRETARY TOMMY G. THOMPSON

Good morning, Mr. Chairman and Members of the Committee. I am Tommy Thompson, Secretary of Health and Human Services. I welcome this opportunity to share with you information on some of the preparations that our Department has made for high profile events such as the upcoming Democratic and Republican National Conventions. As you undoubtedly know from the extensive media coverage over the last several weeks, the security that will be in place for these two National Special Security Events will be without precedent. The number of Federal, State and local agencies as well as the sheer number of personnel involved in the planning and implementation of security measures for each of these events is unparalleled. While the Department of Homeland Security, acting through the Secret Service, is the lead agency for overseeing and coordinating all efforts related to the security of those who will be attending or working at the conventions, there are myriad other agencies that are tasked with specific areas of responsibility.

I am here today to share with you some of the plans that our Department has made and will be implementing prior to and during the course of these two high visibility events. For security reasons, I am not in a position to provide any specific details about these plans. However, I am able to speak about them in general terms to give you an idea of the extent and magnitude of our efforts.

For each National Special Security Event or NSSE, HHS develops a detailed concept of operations (CONOPS) plan, tailored to the event and the venue, which establishes a framework for managing Federal public health and medical assets and coordinating with State and local governments in an emergency. This CONOPS plan, developed through extensive collaboration with Federal, State and local public health, medical and emergency management officials in the host city, describes the array of actions that HHS is either taking or prepared to take to support the Secret Service. It outlines not only the visible activities, but also the behind-the-scenes efforts that are critical to preparing for and responding to a public health emergency that takes place in the midst of a national high-profile event. The Special Events CONOPS plan is in turn supported by the HHS CONOPS Plan that spells out the responsibilities not only of my immediate office, but also those of every relevant agency within HHS.

One of the key agencies in our planning for NSSEs is the Centers for Disease Control and Prevention. CDC's principal responsibility is to work with State and local public health officials to prepare for and respond to a potential bioterrorist attack. Over the past several months, CDC staff has been working with health officials in both Boston and New York City to expand or otherwise enhance the local syndromic surveillance systems to ensure close monitoring of uncommon symptoms as well as unusual patterns of common symptoms reported by hospital emergency departments and other outpatient clinics. Should a suspect case be detected, clinical samples will be collected and promptly transferred to a laboratory within the Laboratory Response Network (LRN) for identification and characterization. In the case of Boston and New York City, both local public health labs are members of the LRN, thus reducing the time consumed in transporting the samples to an appropriate lab. In fact, these two laboratories are fully equipped and staffed to diagnose the presence of organisms most likely to be used as a biological weapon.

To ensure that the requisite expertise is readily available, CDC's Bioterrorism Rapid Response and Advanced Technology (BRRAT) lab will provide onsite technical laboratory support and consultation. Additional laboratory equipment from CDC as well as LRN biothreat agent assays will be deployed along with the BRRAT Laboratory Director and other CDC staff who will assist in the onsite management of laboratory testing, data analysis, and any ensuing investigations. A CDC on-call re-

sponse team will be on a "bags-packed" status, ready to mobilize if the need arises. Furthermore, a broad range of subject matter experts are on full, stand-by alert prior to and during the entire duration of the high profile event.

In Massachusetts, the State health department has collaborated with both the CDC and the Boston Emergency Medical Service in creating the Enhanced Surveillance Report form to capture information on patient visits to first-aid stations at the Democratic National Convention. In addition to manual collection methods, the State and city are currently researching information technology solutions to automate the daily collection of these completed forms. The State is also working closely with appropriate representatives of the Boston EMS and the Boston Public Health Commission Office of Environmental Health on a variety of emergency preparedness activities. Recently they have completed an updated provider registry identifying clinicians with radiological expertise and are now proceeding to identify clinicians knowledgeable about chemical agents.

In New York City, the public health department is implementing electronic clinical laboratory reporting at city hospital laboratories. For disease reports that appear to require urgent notification, this system has a feature to alert relevant health department staff on a 24/7 basis. Another system has been established to actively track outbreak response and ensure timely and complete investigations of all suspect outbreaks, whether detected by traditional or syndromic surveillance. The goal of this system is to implement investigations of urgent case and outbreak reports within 24 hours of receipt of such reports. As part of its effort to develop surge capacity for mass casualties, New York City has recruited approximately 2,500 volunteers for its Medical Reserve Corps and a protocol has been developed for rapid credentialing of these volunteers if the need should arise.

Through funds provided by the Health Resources and Services Administration, hospitals in both Boston and New York City have been able to secure personal protective equipment for medical and ancillary staff and train them in the use of such equipment. Efforts have been made to increase the isolation capacity of hospitals in the event of an intentional release of a biological agent that results in a deadly communicable disease. Hospitals in both of these cities have also expanded their capacity to decontaminate large numbers of victims should there be either a chemical, biological or radiological attack. Adequate amounts of pharmaceuticals are now in place at various hospitals in Boston and NYC to treat hospital staff and their family members during the first 72 hours following an attack prior to the arrival of Federal stockpiles. Furthermore, equipment has been installed in hospital emergency departments to ensure rapid communications among hospitals, other first responder agencies and local Emergency Operations Centers.

Food safety and security will be the primary responsibility of the Food and Drug Administration during the upcoming political conventions. FDA has been working with State and local public health officials to prepare for and respond to a potential terrorist incident involving foods. In Boston, FDA will be providing coverage at the Fleet Center around the clock and will be monitoring retail food establishments, hotels and high-risk food producers/manufacturers. The FDA's Northeast Regional Laboratory (NRL), located in Jamaica, New York, is equipped to perform the full range of chemical and microbiological analyses on products regulated by FDA and will serve as a back up to the State and local public health labs. The NRL, certified as a Biosafety Level 3 laboratory, has the capability to rule out a broad range of biological agents, refer them to appropriate facilities, confirm the presence of a variety of select agents and toxins as well as screen for various poisons. FDA's Emergency Operations Center located in Rockville, Maryland will be operational during the entire course of both the Democratic and the Republican National Conventions.

In addition to these preparations, HHS will also be working closely with the Department of Homeland Security to monitor BioWatch air samplers in 31 cities, including Boston and New York City. The filters in these environmental samplers are collected daily and tested for air-borne pathogens by laboratories in the LRN that are supported by CDC.

One of the most important components of our preparations for NSSEs is the Strategic National Stockpile (SNS) Program. The SNS Program has pre-positioned Push Packs—large caches of pharmaceuticals, vaccines, medical equipment and supplies—in strategic locations across the country. From these locations, an SNS Push Pack can be transported to any affected area in less than 12 hours. If the incident requires additional pharmaceuticals and/or medical supplies, follow-on vendor managed inventory (VMI) supplies can be shipped to arrive within 24 to 36 hours. If the agent used in the attack has been identified, VMI contents can be tailored to provide the appropriate pharmaceuticals, supplies and other products. The Stockpile contains sufficient quantities of antibiotics at this time to provide a 60-day prophylaxis course to over 12 million individuals exposed to anthrax. By the end of this

fiscal year we will have acquired enough antibiotics to treat over 20 million people. These antibiotics also constitute appropriate prophylaxis or treatment for plague and tularemia. We have now acquired a sufficient volume of smallpox vaccine to immunize every man, woman and child in the United States. We also have adequate amounts of vaccinia immunoglobulin (VIG) to treat certain adverse reactions to the smallpox vaccine as well as quantities of antitoxins for treatment of botulism. Members of the SNS Program staff will, of course, be deployed to all NSSEs to coordinate issues in the field related to Stockpile assets.

For high-visibility events such as the political conventions, the SNS will also provide Special Events Packages that are configured with nerve agent antidotes and cyanide kits that will be forward deployed to appropriate locations in Boston and New York City. While a bioterrorist attack may not claim victims for days or even weeks, a chemical attack, particularly one involving nerve agents, can cause immediate nervous system failure. Consequently, response time is critical. Thus, in addition to the Special Events Packages, CHEMPACKs will also be available. The CHEMPACK Project, a voluntary program launched in September 2002, has been designed to provide State and local governments with pre-positioned repositories of nerve agent antidotes that would greatly enhance the ability of first responders to react quickly to treat victims of a large-scale nerve agent attack. By January of 2006, we hope to have forward deployed 2,300 of these CHEMPACKs across the country.

To ensure that the contents of the Stockpile match the medical needs of the Nation in the event of a terrorist incident involving mass casualties, HHS has underway an ambitious program to develop medical countermeasures—the diagnostics, drugs, vaccines, antitoxins and other pharmaceuticals—that are essential to our preparedness. For instance, we have embarked on a project to develop a safer smallpox vaccine that can be used with immunocompromised individuals. While we are working to acquire quantities of the currently licensed anthrax vaccine for delivery to the Stockpile under an agreement between the Department of Defense and the Department of Homeland Security, HHS will also be acquiring, under the Project BioShield program, a significant amount of the next-generation anthrax vaccine.

In addition to all these preparedness efforts, I will also be sending the Secretary's Emergency Response Team (SERT) to Boston and New York City. The SERT Team was created soon after the events of September 11, 2001 so that HHS can rapidly deploy a group of specially trained professionals to any locale in the country to assess the consequences of a disaster, whether naturally occurring or terrorist-triggered, and coordinate public health and medical services between the local or State incident management authorities and our department. Representatives of various agencies within HHS serve on the SERT Team, depending on the types and array of technical expertise required. For example, the Food and Drug Administration (FDA) is able to provide food safety inspectors, and CDC can provide epidemiologists to investigate an infectious disease outbreak caused by the intentional release of a deadly pathogen.

During any high profile event, including the recent State funeral for President Reagan and the G–8 Summit on Sea Island, the HHS Secretary's Command Center, which operates on a 24/7 basis, serves as the primary vehicle for communicating and coordinating with not only HHS personnel in the field but also relevant staff from the Department of Homeland Security, other Federal agencies, and key State, local and event officials. HHS CONOPS plans for the political conventions identify specific coordination responsibilities with personnel from FEMA, the State's emergency management agency, the city's emergency management agency, the city health department, the State public health laboratory, the FBI, EPA and DOD, just to mention a few. During an NSSE, the Command Center's staff is augmented by additional personnel as well as incident management staff. Furthermore, ten members of the Public Health Service Commissioned Corps Readiness Force will also be on stand-by.

The activities that I have described represent some, but certainly not all, of the efforts that HHS has made to prepare for the high profile events that will take place in Boston and New York City in the next several weeks. We have made every effort to plan and be prepared for a broad range of contingencies. We have invested staff, resources and energy to coordinate with our Federal, State and local partners and with the event planners to ensure, to the extent feasible, a rapid and effective response to any public health emergency that may occur. We will also take into consideration the needs of unique groups in our emergency planning efforts, including the needs of people with disabilities, people who are elderly, and children. All of us hope fervently that these two political conventions will be uneventful but, if they are not, we are prepared to respond.

The CHAIRMAN. Thank you, Mr. Secretary, and I appreciate that quick summary of the progress which has been made, which is dramatic. There is no question about that, and do not take my questions to be criticism. They are just to try to get at issues which I do not know that we have yet resolved. Ever since 9–11, we have been playing catch-up, and we know we have got a long way to go.

Secretary THOMPSON. That is true.

The CHAIRMAN. I think we just have to be up front about the fact that there are some areas we have not gone as far as we need to go in. What I want to talk about is some of those areas that I am concerned about primarily.

I guess I would start with this question, and I would like to ask it to all three of you in your different areas of responsibility. I would like you to list the three areas where you think we have not gone far enough yet, where we do not really have our house in order yet, where we really need to do more, and what should we do. I will start with you, Mr. Secretary, and then go to Dr. Gerberding and Dr. Fauci.

Secretary THOMPSON. Number one that immediately comes to mind is food inspections, food technology. That has been a concern of mine ever since I started. We were investing very little resources in it when I came in as Secretary. We are doing a lot better job, but we still have got a long ways to go.

The second one we are working on, but it is one that I am still very concerned about, is surge capacity for hospitals. This is one in which we have serious problems yet. I would not classify them as problems. We have got a long ways to go to make sure that we have surge capacity in any particular area. We have plans in place. We are working on them, but I am not satisfied.

The third one, of course, is making sure that we have countermeasures available for things like the hemorrhagic fever viruses and tularemia, the plague, and botulinum toxins that are necessary, and we are working on them. Dr. Fauci is doing a great job, but research takes a long time, and these are three areas that I think immediately come to mind that we have a lot of work to do on.

The CHAIRMAN. Dr. Gerberding, you do not have to limit it to three if there is more.

Dr. GERBERDING. Thank you. The first thing I would say is we are still very concerned about countermeasures and the adequacy of the ability to mitigate the adverse consequences of exposure should one occur. We have made great strides in the development of countermeasures for the stockpile, but a long way to go before we have adequate protection against all of the agents that we would be concerned about.

A second major issue is connectivity, and by that, I am really speaking of the whole network of communication and information that would allow us to rapidly detect an emerging health threat, not just domestically, but increasingly we have concerns about the global connectivity. You know we are working on that with the support of the committee and the Congress, but we have a long way to go to assure that we can handle a threat such as an infectious disease agent that emerges somewhere else in the world and has been imported, and part of that connectivity includes concerns

about our quarantine stations. We currently have only eight quarantine stations at major points of entry in the United States. We have a plan to scale up to 25. The President's 2005 budget request includes support for that, but we have a great deal to do to assure that we can recognize and contain threats at our borders when they come in.

The last concern that is probably the biggest one that I face overall is the concern about complacency and the lack of attention and focus that more and more people are experiencing in this regard. We need to maintain vigilance. We need to take these threats seriously, and we need to continue to focus on a comprehensive preparedness plan, and as time goes by without experiencing a threat, there is a tendency for people to lose interest or focus their attentions elsewhere. Complacency is the overarching issue that we are trying to address through all of these efforts at CDC.

The CHAIRMAN. Dr. Fauci.

Dr. FAUCI. Thank you, Mr. Chairman.

In the arena of research and development of countermeasures, as you mentioned, I believe we have come a long way, but without a doubt in this particular area, we still have a long way to go. My concern is something that I believe BioShield is going to help us with, is the inherent slowness of the process of research and getting that research to translate into definable countermeasures, and the provisions in BioShield, I believe, are going to help us particularly with the expediting of the research itself, with the rapid hiring of individuals that can be involved in issues that we are not generally involved in, like product development. That has not moved as quickly as I would like, but I believe it is going to start catching up.

The second is the delicate balance between trying to do the very best science at the same time as we provide and clearly pay attention to issues like safety issues in clinical trials, because if you try and rush research, there is always a danger that we are going to get into a situation where there may be human safety issues. If you do not push it, on the other hand, it will go at a pace that I think is not the pace that I think we need for the emergency nature of the situation.

The other is human capital. We are doing a good job in getting individuals interested, the best scientists. We still need to keep the pressure up without depleting scientists who are involved in other important arenas of public health, and this, again, is what we call the delicate balance.

Finally, an issue that we discussed before this committee, but it is still an issue, and that is that spectrum from basic research and concept development to the actual advanced development and production of a product that is, indeed, a usable countermeasure and trying to push the process with research at the same time as we provide the incentives for industry to get involved with us in making the product, and there is a range in that which has been unaccounted for in previous situations where the research endeavor has to get pushed to the point where the industry feels comfortable enough to take over and make the product. Again, this is something that BioShield hopefully is addressing by providing the ap-

propriate incentives, but this is still an issue that we are not doing as well as I believe we can, but hopefully it will improve.

The CHAIRMAN. Thank you, Doctor.

I think we will take 10 minutes. You can take as much time as you want, obviously. Since there are only the two of us here, I think we can just take as much time as we want.

Okay. Following up on that concern, let us start with the surge issue. We are hearing from our hospitals two concerns—and I have the same concerns that Senator Kennedy, I suspect, has because our health care systems are very much integrated in New England. The first is that the dollars are going out in such a formula way that it is essentially sprinkling the money across hospitals at such a low level that hospitals which are most likely to need the surge, some of Senator Kennedy's hospitals being the primary ones, get so little dollars that they cannot cover the costs—he just cited some—and that the average amount that has been going out or the most amount, maybe, is approximately $80,000 per hospital, something like that, some ridiculously small amount of money. It is being spread pretty thin rather than going out on threat-based formula where you essentially give the hospitals which are clearly going to be the ones that pick up the biggest amount of the surge the most amount of money so that they can handle it.

Second, we are hearing that the way that the surge dollars are being proposed provides no credit for beds which are already there which would immediately be cleared out by taking patients out who were elective or who were in a position where you could move them out quickly, but instead, we are basically creating new beds, trying to create new beds, warehoused with backup facilities which will inevitably create huge overhead costs which may not ever be executed or used, and as a result, misallocation of resources within the hospitals for surge.

And third—and there are three things—third, the lack of integration between States and regions where you have regions that are community hospitals—right here in the Washington area, for example, there appears to be, and the GAO says, there is no integration between the hospital structures in Virginia and Maryland and the District. I know in New Hampshire, the New Hampshire hospitals are concerned, what happens if there is an evacuation in Boston. They cannot get into the Boston plans. The Boston plans cannot get into the New Hampshire plans. The fact is that we have a territorial problem here, which is basically jurisdictional by States and the District of Columbia.

I would like you to address those three concerns relative to surge and whatever other concerns you have relative to surge.

Secretary THOMPSON. Thank you, Mr. Chairman. Let me start out by telling you that all of the things that you have indicated are things that we are working on and trying to reach some type of agreement. First of all, let me tell you that all the hospitals would just like to have the money sent to them. There is no question about that, and we are trying to develop a plan that is more regionally centered.

The CHAIRMAN. Is your plan based on some hospitals having a higher likelihood to carry the threat than others?

Secretary THOMPSON. We are trying to work with the local hospitals to find out which ones have the capabilities as well as the expertise to do that, and we have an overall plan to do that, but we are also trying to work with—we do not have the power to dictate, and so we are trying to coordinate it. The money, as you probably know, a good portion of the money, two-thirds of the money goes to CDC for States and one-third of the money, $525 million approximately for fiscal years 2003 and 2004 for all the hospitals across America, and that has been appropriated to HRSA.

The second thing is we have decided to reallocate this year $55 million which is going to go into what we call city readiness initiative, and this is for fiscal year 2004, and we are working on that right now. The Appropriations Committee has given us authority to do so. The first $27 million of that is going to be going into cities in order to be able to do a better job of deploying the medicines and the drugs that will be coming in as well as deploying the personnel. $12 million would be going to the Postal Department for backups. In fact, if we have a huge catastrophe in a particular community, we have reached agreement with the postal authorities that they will deliver the medicines to every particular house. If there was a catastrophe in Boston, so to speak, and there was such a huge number of casualties that could not get into the hospital, such as anthrax and the spores were out there, we would want to be able to get an antibiotic into the particular homes. We would use the Postal Department. We set that up and we are taking $12 million to do that.

Then we put $12 million in CDC for a new program called BioSense. We have bio detectors. We are now starting BioSense which is going to give CDC a better opportunity to see what medicines are being purchased, what kind of people and what kind of diseases are going to the emergency hospital, and this is BioSense, and this is also going to be helpful. We have reallocated $55 million of that.

All of these type of things are towards trying to create an opportunity for surge capacity. We have also got an interdepartmental program set up which is headed up by a new general that we have just hired that is working with the Department of Defense, Department of Veterans Affairs, and so on to make a complete inventory of all the bed spaces that are available in the Department of Defense so that we can move and be able to use. We have also got a program set up to take a look at convention centers as well as National Guard armories to move in if we have to have immediate surge capacity that could not be placed into a hospital.

The CHAIRMAN. The first part of your answer is where I want to focus, and that is do we have—does each State have a State plan.

Secretary THOMPSON. Right.

The CHAIRMAN. That State plan theoretically identifies the hospitals which will be having to carry the burden. Do we have the capacity as the Federal Government to come and review those State plans——

Secretary THOMPSON. Yes

The CHAIRMAN [continuing]. And say, "We are sorry, you are spending too much money on the hospital in Laconia, NH and not enough on the hospital in Nashua, NH", which is where it is more

likely to have the issues and so that you can override and reorient depending on what you determine, what CDC determines, is the threat, No. 1? No. 2, do you have the capacity to direct the different States to function together as a region, specifically here in the Washington, DC area and New York City area where you have multi-jurisdiction events going on?

Secretary THOMPSON. We do if there was an emergency.

The CHAIRMAN. But you do not have it in the planning stages?

Secretary THOMPSON. We have it in the planning stages. We are working with the States and local officials, and we are doing it on a national basis as well. We are trying to develop it, but do we have the authority to tell the States after we give them the money that the money should have gone to Hospital A instead of Hospital B? We can suggest it, but we do not have the authority to tell them.

The CHAIRMAN. Shouldn't you have that authority? Shouldn't you have the authority to be able to review in a threat-based way based on the public health issues, the State plans and the regional plans to determine whether or not they reflect what is the best case scenario?

Secretary THOMPSON. I think we should, Senator Gregg, but what we are trying to do is, we are trying to work locally with the State health departments, the municipality health departments, the first responders, and the hospital associations to be able to do that. We are trying to look at what the expertise in the hospitals are and be able to cover as many contingencies as possible, but I do think we should have the authority to be able to direct exactly where that money should go.

The CHAIRMAN. I think you should. I think the buck should stop somewhere. It should stop at your office or Tom Ridge's office, and there should be a final decision made as to which hospital needs higher capacity capability than the next hospital, and if the States made a bad decision, you should do it.

Secretary THOMPSON. Lacking that, Senator, we have been working very closely with the hospitals and with the local health departments and the State health departments to develop a good State plan, and we are working with them with our input. We have experts out meeting with them. We have called them into the office. We are working with them, but the direct exact amount of money is a little problematic.

Senator KENNEDY. I think the point that has been made by the Chairman, a number of points, are enormously important. There are provisions in legislation, but they have never been funded, that permit the department to make direct grants to communities and hospitals and also to regional groups, but this part has never been funded. It has never been funded. I think that is something that is certainly worthy of giving some thought, particularly as the Chairman has pointed out, in light of what I think is really the most significant aspect of the GAO study, and that is the surge capacity. No State met the third benchmark of the plan. The first two benchmarks are relatively easy, but no State reported meeting the benchmark plan for the hospitals in the State to respond to an epidemic involving at least 500 patients.

That is a very serious challenge. I think, as the Secretary has pointed out, the States have, in many respects, been dilatory in terms of giving bioterrorism preparedness that sense of urgency and getting those resources out. We can at least try and see—and I think, in listening to the exchange, I would be glad to work with the chairman and see what can be done as he is a member of the Appropriations Committee, to see what can be done in the future on these community hospitals and giving greater focus and attention where there is the greatest need. We should also encourage regionalization, which I think is enormously important.

I do not know whether you want to make a brief comment on what you are doing to deal with the whole surge capacity, just generally. I mean, this is a challenge. It is a problem. We have not got States that are able to deal with 500 additional patients or whatever we are going to be facing. We obviously do not want to exaggerate any kind of threat, but, I mean, it might certainly reach more than 500 that may be directly impacted. I do not know what you are doing to try and deal with that particular observation from the GAO report.

Secretary THOMPSON. Senator, we are trying to do a lot of things, as I tried to reply to Senator Gregg.

Senator KENNEDY. Yes. This was a very good one that you are talking about. Of course, what you are using is re-program money. That was not new money.

Secretary THOMPSON. That was not new money. That was re-program money.

Senator KENNEDY. From health agencies to fund it. I think the points that you make, I thought were enormously interesting. I was unaware about how you are using the Postal Service. That is very creative, and that certainly sounds enormously worthwhile and valuable, but we have to try and look globally about what is happening, I think too. You have got the surge capacity. You have also the cuts in CDC that are taking place, which is the agency which has enormous responsibilities in this as well. You have got the real cuts that are coming up that have been recommended in the CDC. As I understand, this budget funding cuts are by $350 million, a reduction of 8 percent, and obviously the CDC has some of the world's best scientists, and many of them have to work in some substandard facilities that are enormously challenging. As we say, the money is not going to solve everything, but there are very, very important areas, particularly I think in these areas which have been identified here in the hospital, surge capacity, which need additional kinds of attention and priorities and funding.

I thank the Chair. This is an important undertaking, and this has been very, very helpful in terms of getting a better picture. Ms. Gerberding, I want to join in welcoming you as the Chairman has. We have got a very outstanding health team here, and is there a comment that you want to make about how you are getting this out in terms of the CDC, particularly since you have such responsibility, I guess two-thirds of the money going through the State? What can you do to get the States to be more responsive?

Dr. GERBERDING. Thank you. As you know, we are starting from a very deep hole in rebuilding our State public health infrastructure and the local public health infrastructure. We would like to be

appreciative of the tremendous progress, but we agree completely that we still have important tasks that are being accomplished yet. In the existing cooperative agreement program that CDC is accountable for, we had performance metrics based on the capacity of States to fulfill certain criteria, 16 of them. Those were relatively broad categories of capacity with very little specificity, and we had difficulty quantifying the level of preparedness.

As we are preparing the next cycle of funding for the next 5-year grant program, we are working with our partners to develop some very specific performance indicators. For example, it is highly likely we will have a performance indicator that addresses regional integration of the planning process, a performance indicator that specifically addresses a quantitative surge capability within the medical care system, and we think by making the expectations explicit, we will have much better information to recognize where a State or region is not measuring up, and then we can go in with our technical support and with Secretary Thompson's resources from the other departments at HHS to try to help people be successful.

The goal is to achieve the stated functionalities, and I think by being explicit about what is necessary, measuring the progress toward getting that done, and then supporting improvements with whatever we need to do to overcome the barriers, we will be able to sit in front of you with a lot more specificity in the future.

Senator KENNEDY. It sounds very promising.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you. Following up on that, are you doing that nationwide or are you picking places? Are you picking like New York, Washington?

Secretary THOMPSON. Before Senator Kennedy leaves, I am sorry, Senator Gregg, but I wanted to—Senator Kennedy, you wanted to know about the Democratic convention. We are putting a lot of medical personnel, a lot of equipment up there. We are moving the push packages and things necessary. We already have deployed a lot of medical equipment and doctors to the Boston area, and we are also doing a lot of things that the convention has requested of us, and we have already complied.

We have some sensitive things that we are doing that I would have my staff come up and brief you or your staff, if you wanted to. I would rather not do it in an open meeting.

Senator KENNEDY. That is very encouraging, and I think people in Boston will be very much relieved and appreciative of those efforts.

I see Dr. Fauci——

Dr. FAUCI. Senator, I just wanted to point out when you talk about regions, we have the research endeavor which is related in many ways to the delivery of care, but not directly, but when we put our regional centers of excellence in bio defense and emerging diseases, it was with the thought of having the best scientific minds, capabilities, and resources to be available to the delivery of health care so that when something happens, at least you have the scientists geared. One of our best regional centers is in the New England area, located in Boston.

Senator KENNEDY. Yes.

Dr. FAUCI. We serve that regional area and cooperate and collaborate not only with the CDC, but with the State and local health departments.

The CHAIRMAN. Of course, it should be in Hanover, but that is all right.

Senator KENNEDY. Thank you, Mr. Secretary, for mentioning that. I think that is enormously important and very reassuring. Secretary Ridge was up there this past weekend with our Mayor. There has obviously been increased anxiety because of the recent kinds of announcements. This is very, very constructive and very important, and we are grateful to you for your leadership.

I thank the Chair.

The CHAIRMAN. Thank you, Senator.

Returning to your question, your point that you are setting up these new basically benchmarks and procedures for getting to those benchmarks, are you sort of doing demonstration efforts so that we pick up the real critical areas that we know are critical, New York City, Washington, Los Angeles, first or are we doing this nationwide?

Dr. GERBERDING. The cooperative agreement starts in 2005, and so right now we are preparing the grant guidance for that next 5-year cycle of funding, and that applies to the entire set of jurisdictions that we are responsible for. It is the 50 States and the cities and territories that are directly funded by CDC.

The CHAIRMAN. You do not think we should just get started in a few places to test the exercise?

Dr. GERBERDING. Well, we actually have been doing that, and specifically, there are some lessons learned from good performers who are already looking at their state of readiness from this direction. What we are trying to do is learn from the experience that we have had already over the last 5 years and figure out what is working and what is the capacity of the States that are particularly excelling in certain areas and transfer that experience to the other locations. It is actually very difficult to define preparedness, as you can imagine, and so there is no place to go to look to identify what constitutes a highly prepared State.

For one thing, it is a process, and you can always imagine a scenario one step beyond your level of preparedness. We have taken some stretch indicators, and we are working them on a pilot basis to see whether or not they are feasible and make sense in some of the most critical jurisdictions.

The CHAIRMAN. Well, I would just like to suggest you start with the Capital area, because the GAO report was devastating relative to this area, and obviously New York is a priority target.

Can we get back to this antibody issue? Where do we stand with the vaccines and specifically the smallpox vaccine which has been represented may never get through FDA approval, although we have a single purchaser? The anthrax, I know you mentioned you were going out with an RFP, but is that a vaccine that prevents it, or is it just an antidote if you have been exposed to it?

Dr. FAUCI. Thank you, Mr. Chairman. Let me address the issue that you just brought up as well as yesterday when we had the discussion, and that has to do with the licensability or not of the canvass product that is in clinical trial for which we have already put

the product into the stockpile. That is the cell culture-based vaccine that uses the same seed virus in many respects that the New York Public Health has used in the dry vacs, which is the classic one that we have used for decades and decades. That, because of the detection of adverse events of an inflammation of the heart, which we call myopericarditis, in what appear to be, even though numbers were small, a rate that might have been greater than the rate that we saw with the previous observations, it was put on clinical hold. It has not been declared unlicensable. This is not an uncommon event when you see adverse events. The FDA, because this is clinical trial directed towards licensure, the degree of intensity with which you follow individuals for adverse side effects is much greater than when you just distribute a vaccine, as was done with the military when they distributed over a half a million dose—not doses. A half a million people were vaccinated.

The answer to your question is that, indeed, it has not been declared not licensable. The data are being reviewed by the Data and Safety Monitoring Board as well as by the FDA and they will then either proceed or not. If they do, it is likely that they will modify the consent form to make these most recent findings aware. The answer to your question is it has not been deemed unlicensable.

With regard to the next generation smallpox, that the one that we know from considerable experience in the field, not only internationally, but with patients who have cancer and HIV, that particular candidate is being researched right now, and it looks pretty good not only from a safety standpoint, but from the fact that we have applied in the direction of the two-animal model that the FDA holds. I am not saying this will be used by them, but we have done the experiments in the monkey model with money pox and in a mouse model with a lethal vaccinia challenge using the attenuated vaccinia, and it has shown to protect in both of those species. That is pretty good news as we go along with the clinical trial.

With regard to the recomitant protective antigen vaccine that we have contracts out for, as you know, that is a contract with Vaxgen and Evecia, and in that arena, we have now been in phase one trials in both of those contracts, and we have gone into phase two trial with the Vaxgen product, and right now, we are getting good immunigenicity and safety looks good. We are well on the road towards the landmarks and benchmarks that we discussed with this committee before with the RPA.

The last one, to just give you some follow-up, we are still on track with the ebola vaccine. I had mentioned the protected moneys, and we are now in clinical trials in a human. For the three big ones that we spoke about, smallpox, anthrax, and ebola, I believe we are on track.

The CHAIRMAN. Good.

Senator Alexander.

OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thank you, Mr. Chairman. Excuse me for being late to the hearing. We had an opportunity at 10 o'clock to have a briefing by Tom Kean and Lee Hamilton about the 9–11 Commission, and I wanted to hear the first part of that before I came here. I do not want to go over material you have already gone

over, but I would like to ask one question, if I may, based on what I just heard.

In the first place, the 9–11 Commission, I look forward to reading it over the next 2 or 3 months, but I will say I am impressed with the way the report has been presented, with the quality of the leadership by Chairman Kean, and Lee Hamilton, with the unanimous recommendations and with what they presented to us. I think it deserves enormous attention by those of us in Congress and by the American people.

Mr. Hamilton, who said he had worked with every leader of the Central Intelligence Agency since the Lyndon Johnson Presidency, said there were four major failures that the Commission found, and I want to ask you a question about one of them. The first one he said was the failure of imagination, that we did not imagine that people would do to us what the 9–11 terrorists did. Two was a failure of policy. Three was a failure of capabilities. And four was a failure of management.

In your testimony, you talk about policy, capabilities, management, and the things you are working on. I want to ask Secretary Thompson, because he, like I, has been around a while in different jobs, about the failure of imagination. I have thought many times back to the middle of the 1990s, for example, when I was the candidate for the President of United States—not too many people knew that, but I was at the time. It never once occurred to me in 1994, 1995, and 1996, never once occurred to me that if I were to be elected, that I might be faced with the proposition of a group of people flying an airplane into the World Trade Center and that I might have to make a decision within 5 minutes about whether to shoot down a commercial airline filled with Americans, never occurred to me.

I thought maybe that was because I just was not as sophisticated as some others. I have asked everybody else who ran that year, including Dick Luger, chairman now of our Foreign Relations committee. He was even talking in 1995 and 1996 about terrorism. It never occurred to him. My question would be what are we doing, what are you doing to help our country deal with this failure of imagination? Because if we do not imagine the possibility to begin with, all the policy, all the capabilities, all the management will not make that much difference. I am not sure that we can imagine the most awful thing and then relate it every day to the American people. I imagine in 1995 and in 1996, if I would have stood up in Cedar Rapids, Iowa or Plymouth, New Hampshire and said, "I am prepared as President to deal with the possibility that someone will fly an airplane or two or into the World Trade Center, into the Pentagon, maybe into the U.S. Capitol, and I will shoot down U.S. airliners", they might have just carted me off to the loony bin. They certainly would not have put me in the White House based on something like that.

I am not talking about going around and scaring the American people about every possibility, but what can we imagine and do that would keep us from having a failure of imagination about all the possibilities that are presented to us as we deal with what Mr. Hamilton and Governor Kean said is the overriding threat to our

Nation for the rest of our lifetimes and probably for a time thereafter?

Secretary THOMPSON. Well, first off, thank you for the question, Senator Alexander, and thank you very much for your imaginative question. First off, what we have done, I have asked you to come over and I really would like to have you come over and see it. I could show it up on the screen, but it does not do it justice, come over and see our war room, our information room. We have developed, I think the best—Senator Gregg has been over there—the best visionary war room to track in diseases in storms and bioterrorism kinds of attacks in America and the world, and we have set up simulated exercises which we do constantly, simulated exercises on food poisoning, simulated exercises on an anthrax attack, simulated exercise on smallpox, all of these type of things which are absolutely important, and I think it would be a very good education for you to come over and see it. I think you would walk out of there very impressed by what we have been able to build and what we are able to accomplish and what we are able to follow.

Anyway, everybody that has been through it, and there have been thousands, have indicated the same conclusion, that it is visionary.

The second thing is that what we try and do, we try to take a look at, Dr. Fauci's expertise, try and say what sort of a counterterrorism agent do you have to have, what sort of way could they mutate or change that smallpox virus and how would we be able to respond to that if they did that, what would be the way we could respond if a new type of anthrax or any kind of a virus that has been genetically changed, how would we be able to do that, and Dr. Fauci has put together a great team that is looking at all of the potential possibilities and is doing research on that. That is what BioShield is all about, is to be able to get us prepared, to be able to push and pull for new research against threats that may take place.

The 19th Century diseases that we never thought could be weaponized now can be weaponized and can be used as a tool of terrorism, and Dr. Fauci is doing a great job. Dr. Gerberding, on the other hand, in CDC, we are taking a look. What we are doing is we are putting biosensors—we have got biosensors in several communities, which is highly sensitive, but they are biosensing, and they will be able to pick up agents, and then we are developing a new program called BioSensitive which is going to allow for that information to be sent down to CDC in a particular area, what are the medicines people are buying, is there a real run on Doxycycline or Cipro, and that would be a real quick alert and we would be able to get that information.

We are hooked up now to 121 laboratories throughout America and 90 percent of all the health departments. We will be able to get that information out immediately, saying in this particular area there is a huge increase on the purchase of Cipro, what is going on in the emergency wards in that particular hospital or that region to give us an idea.

The third thing we are trying to do is trying to determine as regards to food that is coming in, which is my biggest concern as the Secretary, to be able to stop any kind of threats to our food supply

that is coming in. We have a lot of food that is imported from around the world, and this has always been my biggest concern, what would happen if some kind of food stock was poisoned, how would we be able to detect that, how would we be able to prevent that, and we have set up a lot of different kinds of teams in order to respond to that. We put together, I think, a great group of experts on bioterrorism that are planning and trying to come up with ways to do it.

I think we are doing a good thing. We are not going to be able to determine everything that the terrorists could hit, but we are trying to put up plume modelings and any kinds of floor exercises, table top exercises, dealing with food poisoning, and we are trying to find ways how we are able to respond. Milk, for instance, we are asking to be able to increase the temperature of the pasteurization of milk, because that could be something the terrorists could hit on the farm, and so we are trying to think ahead as to where they might be able to hit us and how we would be able to respond.

Secretary ALEXANDER. Thank you, and I will look forward to the visit.

Secretary THOMPSON. I would hope you would. Thank you.

Senator ALEXANDER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Dodd.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. Thank you, Mr. Chairman, and like Senator Alexander, we were both in the same meeting trying to make decisions to be here and be there simultaneously, and this report has just come out, and I think all of us are very impressed with the work of Tom Kean and Lee Hamilton. I had the pleasure of serving with Lee Hamilton for a number of years in the House of Representatives, and they and their fellow commissioners, I think did a very fine job.

It is a sad tale, indeed, as Tom Kean laid out at the initiation of his remarks, that if you go back and if someone had just presented in one or two pages, just a litany of the things that had occurred, all of which were highly publicized events, and laid them out, in retrospect looking back, the question is why did not all of us in society take more note of this? It seems quite obvious in retrospect that there was a very determined group of people that hate us, and that is a hard thing for Americans to come to terms with, that there are people who hate us and are going to use whatever means available to them to do as much damage to innocent people as possible; and, in fact, with a little less than $500,000 on 9–11 they killed 3,000 people within an hour.

As Senator Alexander has pointed out, the failure of imagination is, I think, one of the problems.

Let me come back to earth a little bit. Certainly Senator Alexander and I work on children and family issues, and the Chairman does. When we adopted the Bioterrorism Preparedness Act in 2002, I asked to be written into that proposal to create a National Advisory Committee on children and families, NACCT as it is called, which required the committee to report to you, Mr. Secretary, within a year of the bill's passage, the preparedness of our health care system to respond to terrorist attacks as they specifically relate to

children and what changes might be needed to our health care and emergency medical response systems to meet the special needs of children.

There are 70 million people in this country under the age of 18, 22 million under the age of 5 in the United States, and obviously we talk about protecting bridges and highways and roads and things, but children have special needs, unique needs, I think we have all come to recognize. Certainly as we develop prescription drugs and the like, we begin to understand that the needs of children, physiologically and so forth, are different than adults.

This report was made available to the Department in June of last year, June 2003. What I would like to know is to what extent the Federal Government has worked to implement the recommendations included in the report. There are five of them specifically in this report. I will not go over all of them, but in the letter dated June 12, 2003 and the summary of the report, they talk very specifically here about a review of current Department of Health and Human Services programs and guidance to require that a specific focus be placed on meeting the needs of children and families; decisions of terrorism-related programs and initiatives should be linked to confirmation that children's needs have been specifically accounted for; structures within the Department should be created to ensure continued oversight and adequate response to needs of children and families; significant new pediatric and physiological initiatives are needed to address the needs of the Nation's children and families in light of their continued threat to terror events; and, number five, addressing the needs of children and families in the face of terrorism should be recognized as an essential part of America's security response.

Added to this, and I will just add the second question for you here, another aspect of the preparedness, in fact, is to ensure that health and safety of our children in the event a terrorist attack occurs with regard to vaccines and the formulations and dosages different from adults, what is the status of stockpiles, the ability to fill these needs of children?

I know States have done a lot. My own State in Connecticut has taken certain steps, but I am not clear that we have really done much at the national level a year after this report was submitted to the Department.

Secretary THOMPSON. Senator, we have done a lot. As you know, we issued the report on time, and we had certain conclusions drawn and suggestions. We are in the process of implementing the work on each one of the things that you have mentioned as well as many other things. Our stockpile does have things set up just for children, for doses and for ventilators and so on in each one of the 12 stockpiles across America that are strategically located. We have actually put in medicines and vaccines strictly for children under the age of 18 and for infants, and that is already in place and has already been completed. It does not mean that we are not looking for many other ways and other suggestions on how we might be able to honor the request of Congress, and I think we are doing that.

Julie, did you have anything further that you wanted to add?

Dr. GERBERDING. In addition to the stockpile issues, CDC is in the process of developing life stage goals, and so for children, there are some very specific opportunities to define the preparedness goals for that population as there are for infants, but part of the preparation and planning efforts ongoing include preparation of families and households and specific advice about, for example, what should you do if your child is in your school and you are at work and there is terrorism attack or what family mechanisms and routines are available to ensure that even our children, of people who work at CDC, what is the plan if the parent has to stay at CDC to responsibly respond to terrorism threat, is there a plan for child care.

The specific elements and recommendations about how families can prepare for themselves and the safety of their children are something that the department has been working on in conjunction with Homeland Security and the Red Cross, and I think we can provide you with some very specific examples of the attention that has been given to this issue over the last year.

Senator DODD. I would like to see those if I could.

Secretary THOMPSON. Senator Dodd, and also 9–11, we had to do a lot of counseling of SAMHSA up in New York, a lot with children, and we have taken that experience and built it into future protocols, if that would take place in SAMHSA, because children really need some intense counseling immediately after a terrorism attack and also a continuation of counseling thereafter. We are building plans for that.

Senator DODD. Am I to understand that we already do have stockpiles of vaccines specifically designed to accommodate children's needs?

Secretary THOMPSON. Yes.

Dr. GERBERDING. Can I just add one thing?

Senator DODD. Yes.

Dr. GERBERDING. We have a registry of people who were affected by the World Trade Center events in New York. We have already almost 50,000 people in that registry now, and we have noticed that we do not have the number of children that we were anticipating. Specific efforts are underway as we speak to try to encourage children's participation in the registry so we can understand better what their needs really are.

Senator DODD. Dr. Fauci, any point on this at all?

Dr. FAUCI. The only point I can make with regard to children is that we are very sensitive to the idea that when we are testing drugs, that we need to make sure that we include children in the umbrella of particularly paying particular attention to the extra safety issues you have with children, because we are going to have to administer drugs and vaccines to children as well as to adults. That is an important part of the research endeavor.

Senator DODD. On this committee and others over the last several years, we have worked very hard, Senator DeWine and I having authored the initial legislation that set up the program that would encourage private sector development of drugs designed specifically for children and then, of course, more recently the requirement that the FDA move in this area, and I think we all recognize there are have been real advantages. What has been amazing is

how much has been developed in a relatively short amount of time, although you are talking about an audience population, while it is large, relatively small numbers of the population based on illnesses on and so forth, it is a real rather small constituency, if you will, patient group; but, nonetheless, in the area of terror, we are talking about just innocence being automatically affected, and having the ability to provide those vaccines should not be beyond our imagination—is that you end up with a bio attack, that children are going to be affected very directly, and our ability to respond to their health care needs is something we should not look back on and wonder why we did not get it right. That is why we insisted upon that report at the time.

As I say, I have very great respect for the protecting of our bridges and highways, but I really hope we keep focused on these kids.

Secretary THOMPSON. Thank you.

The CHAIRMAN. Thank you, Senator Dodd.

We have a vote on. There are three votes in a row. What I would like to suggest is first I want to thank Secretary Thompson, Dr. Gerberding, and Dr. Fauci. We appreciate your time. We appreciate the job you have, which is a very difficult one, and you are certainly doing yeomen's work, and we thank for it. You have great successes, which I do not think should go unnoticed, which is of course the SARS, reaction to SARS, reaction to West Nile, the movement in the area of getting the vaccines up and running, and the many things that you outlined, Secretary, but we do have a long way to go and we want to help you.

If you have language which you think we need to consider relative to making sure that these funds go out on a threat-based purpose and that there is a regional awareness and a regional management and that you can step in and make sure that occurs, we would be interested. I would be interested in looking at it, anyway.

Senator DODD. Can I say, Mr. Chairman, too, with regard to children issues, if you think we need stronger language and other things regarding children, I would really like to know that. I think our colleagues would as well. If there are gaps someplace in here, I would like to know that.

The CHAIRMAN. I think what we are going to do is we are going to adjourn the hearing until about a quarter of twelve. Hopefully all the votes will be completed then. We thank this panel for participating.

Then we are going to hear from members of the Homeland Security team and then some folks who are on the front lines. We will be back at a quarter to twelve.

Thank you.

[Recess.]

The CHAIRMAN. We are going to start the hearing again. I appreciate the forbearance of the witnesses relative to the Senatorial schedule. Unfortunately these votes were scheduled after this hearing was scheduled.

We are going to begin this panel with hearing from the Homeland Security Agency, which obviously has primarily responsibility in a variety of areas relative to an attack, a terrorist attack involv-

ing public health or biologic agents, that affects public health and obviously would be driven by biologic agents.

We are going to hear from Eric Tolbert, who is the Director of the Response Division of Emergency Preparedness and Response Directorate of the Department of Homeland Security, and Andy Mitchell, who is Deputy Director of the Office of Domestic Preparedness in the Department of Homeland Security.

Why don't we start right off, and which of you folks want to testify or are you both testifying? Who has a statement?

Mr. TOLBERT. I think we both have a statement.

The CHAIRMAN. Okay. Great.

STATEMENT OF ERIC TOLBERT, DIRECTOR, RESPONSE DIVISION, FEDERAL EMERGENCY MANAGEMENT AGENCY, DEPARTMENT OF HOMELAND SECURITY

Mr. TOLBERT. Thank you, Mr. Chairman.

My name is Eric Tolbert. I am the Director of the Response Division for FEMA in the Department of Homeland Security. I am pleased to be here today on behalf of Secretary Ridge and Under Secretary Mike Brown to discuss our Nation's readiness for dealing with the public health response to a terrorist attack during high profile events.

The Department of Homeland Security has been charged with ensuring the safety and security of all national special security events, such as the Group of 8 Summit earlier this year, the State of the Union Address, the State funeral of President Ronald Reagan, and the upcoming Democratic and Republic National conventions. The Secret Service is in charge of the overall design and implementation of the NSSC planning, and FEMA's role is to coordinate the emergency management activities associated with these events and provide any needed response and recovery assets.

It is important to note, however, that our efforts are in support of the State and local governments. We do not supplant, rather we supplement their resources and their activities and their assets. In the case of the upcoming political conventions, the department has assembled numerous Federal, State, and local agencies to put in place an unprecedented level of security and response assets. FEMA's Emergency Management Institute conducts specially tailored training programs for the Federal, State, and local agencies involved in national special security events, and recently we conducted two of these integrated emergency management courses in preparations for our upcoming NSSEs, including the Super Bowl. For the past Olympics, we conducted seven integrated emergency management courses in Utah, Georgia, and California related to the Olympics, and we have done the same for World Cup Soccer, Pan Am games. The list goes on, including the four major cities for the last political conventions.

We have a long history of assisting State and local governments and working collaboratively and developing capability to prevent and respond to events that may occur in those venues. I would reiterate that we work in partnership with State and local organizations, and the department has invested substantial resources and numerous personnel over the past several months to ensure a safe

and secure event for both the Boston and New York communities and all delegates attending the conventions.

Regarding the department support for the conventions, we have overall activities in support of Boston and New York for the conventions, and I can provide additional detailed information as you would desire to give you a snapshot of the types of capabilities that we are bringing to bear on the two conventions. We have been involved for many months in the planning and coordination in the areas of venue protection, air space security, communications, emergency equipment, credentials, and training. We are in the process of deploying specialized teams to detect explosives and weapons of mass destruction and hazardous materials. We have in place comprehensive waterside coverage and surveillance on and over the water. We have assistance for security personnel and x-ray equipment for examining suspicious packages entering a convention facility and scanning commercial vehicles and delivery trucks, such as food service providers, as they enter the convention sites. We conduct security and vulnerability assessments at the affected commercial and general aviation and private airports and enhancements to aviation security near convention sites.

We have also distributed radiation detection units to State and local law enforcement with operational responsibilities for the convention, and we have deployed air monitoring equipment. In addition to the standing BioWatch program, we have deployed additional portable units to the venues to detect airborne biological pathogens during the duration of the conventions.

Regarding FEMA support for the conventions, we are responsible for coordinating the emergency management activities and providing needed response and recovery assets. We do that from the interagency community. Specifically in preparation for the DNC, the Boston Emergency Medical Service system evaluated their available resources and threat information in order to be prepared to adequately respond to a mass casualty incident, including an incident involving weapons of mass destruction occurring during the convention. The city of Boston has requested supplemental assistance for responding to the medical aspects of a mass casualty incident, and FEMA maintains resources and capabilities that can be activated and deployed to support a mass casualty incident.

Resources that will or can be deployed or placed on a standby status to support these include our national disaster medical system, a network of specialized teams that provide the gamut of medical assistance, everything from medical support to humans to animals. We will even be providing some protection for security dogs and other types of animals involved in ensuring and preventing events from occurring in these venues. We will have an array of medical personnel from both Homeland Security and HHS, prepositioned disaster supplies.

The list really goes on and on as to the types of capabilities. We are literally spending millions of dollars preparing for and having the right resources in place to support these operations.

Again, it is all about collaborative effort. We work months in advance for these planned events with the local emergency personnel. We look creatively at what the requirements may be. We look at the capabilities that they have both locally and regionally, and

then when there is a gap, our mission is to provide those additional resources.

Thank you for the opportunity, Mr. Chairman. I look forward to answering any questions that you have.

[The prepared statement of Mr. Tolbert follows:]

PREPARED STATEMENT OF ERIC TOLBERT

INTRODUCTION

Mr. Chairman and Members of the Committee, my name is Eric Tolbert and I am the Response Division Director for the Federal Emergency Management Agency (FEMA) of the Department of Homeland Security (DHS). I am pleased to be here today on behalf of Secretary Tom Ridge of DHS to discuss the Nation's readiness for dealing with public health response to a terrorist attack during high profile events.

DEPARTMENT OF HOMELAND SECURITY

The Department of Homeland Security consolidated 22 previously disparate agencies under one unified organization. Eighteen months ago, no single Federal department had homeland security as its primary objective. DHS now fills that role and is integrating its resources to meet a common goal. Our most important job is to protect the American people and our way of life, and we now have a single, clear line of authority to get the job done. Through our extensive partnerships with State, local and tribal governments and the private sector, as well as other Federal departments, we are working to ensure the highest level of protection, preparedness and response for the country and the citizens we serve, including people with disabilities.

The Homeland Security Act of 2002 and Homeland Security Presidential Directive-5 (HSPD-5) state that the Secretary of the Department of Homeland Security is the "principal Federal official for domestic incident management" with responsibility for "coordinating Federal operations within the United States to prepare for, respond to, and recover from terrorist attacks, major disasters, and other emergencies."

DHS has been charged with ensuring the safety and security of all National Special Security Events (NSSEs). The Group of Eight Summit, the State of the Union Address, and the activities surrounding former President Ronald Reagan's Memorial Services were all designated as National Special Security Events, as are the upcoming Democratic and Republican National Conventions. The U.S. Secret Service, also part of DHS, is in charge of the design and implementation of NSSE planning, and FEMA is responsible for incident management, and will be in charge of coordinating emergency management activities and providing any needed response and recovery assets. Planning and coordination for these events begin at least a year in advance, and FEMA's Emergency Management Institute conducts a course specifically geared to those persons and agencies—Federal, State and local—involved in an upcoming NSSE.

In the case of the upcoming political conventions, the Department of Homeland Security has assembled numerous Federal, State and local agencies to put in place an unprecedented level of security and response assets. Working in partnership with these State and local organizations, the Department has invested substantial resources and numerous personnel to ensure a safe and secure event for the Boston and New York communities, and all delegates attending the conventions.

Among the preparedness activities of DHS agencies:

• The U.S. Secret Service has conducted comprehensive security assessments of all primary convention venues as well as hotels, hospitals, airports and other sites related to the convention. It has also coordinated multiple interagency training exercises and tested operational security plans to verify command and control protocols and procedures.

• The U.S. Secret Service has performed a tremendous amount of advance planning and coordination in the areas of venue protection, airspace security, communication, emergency equipment, credentialing and training, and began in June 2003 to develop the security plan for the Democratic National Convention to be held in July of 2004.

• Immigration and Customs Enforcement Border and Transportation Security (BTS) will deploy Explosive Detector Dog teams, Weapons of Mass Destruction (WMD)/HAZMAT technicians, intelligence and undercover agents, uniformed officers, bicycle and motorcycle officers, emergency response teams and a sizable num-

ber of Special Agents. It will also provide Mobile Command Vehicles (MCV) to serve as highly advanced communication centers for multiple law enforcement agencies. ICE BTS has significantly increased Federal Air Marshal coverage on scheduled airline flights to and from the greater Boston area.

• As the primary Federal maritime law enforcement agency, U.S. Coast Guard personnel will provide comprehensive waterside coverage on and over the water, coordinating closely with State, local and other Federal maritime law enforcement assets. Numerous Coast Guard units and personnel will be involved in this event including boat crews, law enforcement boarding teams, pilots and aircrew, support personnel and a wide variety of Coast Guard assets. Coast Guard helicopters will assist in security zone surveillance and enforcement as well as air interdiction efforts. The U.S. Coast Guard will establish a Waterside Security Unified Command Center to manage waterside security operations.

• Customs and Border Protection will provide inspectors officers to assist security personnel as well as operate a mobile x-ray unit to examine suspicious packages entering a Convention facility. It will also provide x-ray equipment to scan commercial vehicles and delivery trucks such as food service providers as they enter the convention sites.

• The Transportation Security Administration has conducted security and vulnerability assessments at affected commercial, general aviation and private airports as well as additional actions to enhance aviation security near convention sites.

• During the conventions, the Department's Homeland Security Operations Center (HSOC) will provide timely sharing of any threat information, intelligence, situational awareness and operational information pertinent to the security of the event through the Homeland Security Information Network (HSIN). HSIN provides real-time connectivity and information sharing among all DHS components and State and local partners.

• For the Democratic National Convention, the Information Analysis and Infrastructure Protection (IAIP) Directorate is working with the State of Massachusetts Office of Public Safety to distribute radiation detection pagers to State and local law enforcement personnel with operational responsibilities for the Convention.

• In coordination with the U.S. Secret Service, the Department's Science and Technology Directorate is deploying air-monitoring equipment to detect airborne biological pathogens during the duration of the Democratic National Convention.

• The Interagency Modeling and Atmospheric Analysis Center (IMAAC) provides a single point for the coordination and dissemination of Federal dispersion modeling and hazard prediction products that represent the Federal position during an incident of national significance. The IMAAC is operational and prepared to provide support if it is required.

FEDERAL EMERGENCY MANAGEMENT AGENCY

DHS/FEMA is the lead agency responsible for coordinating emergency management activities and providing any needed response and recovery assets for the upcoming political conventions. Like numerous DHS and other Federal agencies, FEMA has been working closely with the city of Boston and the Commonwealth of Massachusetts for quite some time in preparation for the Democratic National Convention. FEMA has also been planning for the upcoming Republican National Convention.

In preparation for the Democratic National Convention, the Boston Emergency Medical System evaluated available resources and threat information in order to be prepared to adequately respond to a mass casualty incident, including a WMD incident, occurring during the Convention, which will occur July 26–29, 2004.

FEMA maintains resources and capabilities that can be activated and deployed to support a mass-casualty incident. Due to the sensitive nature of releasing specific details for such events we are unable to do so. Resources that will be either forward deployed or standing by to respond are:

• Disaster Medical Assistance Teams;
• National Medical Response Teams;
• Veterinary Medical Assistance Teams;
• Disaster Mortuary Operational Response Teams;
• Burn Specialty Teams;
• Medical/Surgical Response Team;
• Numerous additional specialized medical personnel;
• Pre-Positioned Disaster Supplies to support mass care operations;
• Urban Search & Rescue task forces to support rescue operations; and
• Mobile Emergency Response Support (MERS) capabilities to support command/control/communications.

DHS agencies are cooperating closely to be ready for the upcoming conventions, just as they have for past NSSEs. Beyond this, they are coordinating assets with other Federal departments, including the Department of Health and Human Services, but most importantly, with State and local government agencies, such as police, emergency management, emergency medical services, public health, public and private hospitals, National Guard, and so on—those on the front line of emergencies.

CONCLUSION

The mission of DHS is very clear—helping people in need, be it a response to a terrorist attack involving a weapon of mass destruction such as a biological or chemical agent, natural disaster or any other catastrophic event. DHS provides the leadership and capabilities required to prevent, prepare for, respond to and recover from disasters or emergencies of any kind. National Special Security Events present the Department an opportunity to integrate its assets and capabilities in a "real world" situation, and bring together other Federal agencies, as well as our State and local partners, who will always be the first to respond, whether the event is large or small. The complete integration of so many agencies and capabilities into one department has been a huge undertaking, but the result is a Department that is much more effective than the sum of its parts.

The CHAIRMAN. Thank you Mr. Tolbert.

Mr. Mitchell.

STATEMENT OF ANDY MITCHELL, DEPUTY DIRECTOR, OFFICE FOR STATE AND LOCAL GOVERNMENT COORDINATION AND PREPAREDNESS, DEPARTMENT OF HOMELAND SECURITY

Mr. MITCHELL. Thank you, Chairman Gregg. I am pleased to have this opportunity to discuss today the role of the Department of Homeland Security Office of Domestic Preparedness and the role we play in our Nation's efforts to prevent and respond to threats and incidents of terrorism domestically.

As you know, Mr. Chairman, with your significant support ODP was created long before the September 2001 terrorist attacks, and our agency's singular mission is to help State and local first response agencies and personnel prepare for, prevent, and respond to incidents involving weapons of mass destruction and other terrorism-related public safety emergencies. ODP was transferred from the Department of Justice to the Department of Homeland Security under the Homeland Security Act of 2002 in which ODP was assigned the primary responsibility within the Executive Branch of Government for preparedness of the United States for acts of terrorism.

To further improve the delivery of Federal assistance to first responders, Secretary Ridge consolidated two DHS agencies with the compatible missions, the Office of Domestic Preparedness and the Office for State and Local Government Coordination. With this consolidation, Mr. Chairman, the Secretary created the one-stop shop for Federal Homeland Security assistance that State and local stakeholders that have called for since 1998. Through these programs and activities, ODP provides funding, equipment, training, technical assistance, and exercise support for State and local enforcement, firefighters, emergency medical personnel, and other response personnel. ODP focuses on the entire spectrum of Homeland Security, but emphasizes public safety preparedness, both prevention and response, and through the statewide and regional Homeland Security strategies, States and localities define their strategic goals and prioritize their activities to be funded to achieve those goals.

Regarding public health, ODP has historically worked closely with the Department of Health and Human Services and the Center for Disease Control and Prevention to coordinate public health and domestic preparedness initiatives. Our State Homeland Security and area security initiative grants can be used for personal protective equipment for hospital providers, decontamination equipment for hospitals, medical supplies, and pharmaceuticals needed to respond to the WMD event for force protection. To ensure that public health preparedness is a critical component of any comprehensive homeland security program, the CDC under the HHS agencies reviewed the program activities and the template that we developed to guide the States in the development of their statement strategy that the States must submit to receive grant funding.

ODP has also supported the launch of CDC's cities readiness initiative which Secretary Thompson referenced in his testimony. We have worked with them and participated in executive business to the two pilot sites in Chicago and the National Capital area region who provided overviews of the programs and activities that we have in those jurisdictions under the urban area security initiative, and we are helping to identify those interactive collaborative processes that are already in place to ensure there is better coordination of a variety of Federal programs to meet the needs of local jurisdictions. Because of ODP's lead role in working with State and local governments to address their homeland security needs, we do participate as members of the interagency planning group for national special security events.

In support of the Democratic and Republican National conventions, ODP worked closely with the U.S. Secret Service, our partners at FEMA, and a wide host of other Federal and State local officials in the planning for these events. In Boston, ODP planned to conduct three exercises: A senior leaders seminar, table-top exercise, and command post exercise. Subsequent to those exercises, the Secret Service requested that we conduct a principal Federal officials exercise, which will be held in Boston tomorrow.

In New York, ODP has already planned and conducted a senior leaders seminar and table-top exercise, and a command post exercise is scheduled for early in August.

Mr. Chairman, since 1999, ODP has provided significant funding to enhance State and local preparedness nationally. Specifically, New York State has received over $525 million of which approximately $362 million has been allocated to New York City. Massachusetts for that same period of time has received over $138 million of which approximately $42 million has been allocated to the city of Boston. This financial support and other resources provided has enhanced both those jurisdictions' capabilities to prevent and respond to incidents of terrorism and has provided significant support to allow them to achieve the capabilities they need to host these two major events.

ODP has also been given responsibility for leading the effort to implement the Homeland Security Presidential directive. Under HSPDA, President Bush directed the Department of Homeland Security to develop a strategic preparedness measurement system for assessing our Nation's overall preparedness to respond to major in-

cidents including those involving acts of terrorism, and ODP is currently working with input from Federal, State, and local agencies to develop this system. Obviously, part of that coordination involves our close collaboration with our partners at HHS to address the bio preparedness issues element of the national strategy and preparedness goals.

Through these and other efforts, ODP is employing its broad range of resources to ensure that State and local governments and first responders are as prepared as possible to protect the public from any emergency, and we look forward to continuing to work with you, Mr. Chairman, and this committee and the Congress to do anything else that needs to be done. That concludes my statement, and I would be more than happy to answer some questions.

[The prepared statement of Mr. Mitchell follows:]

PREPARED STATEMENT OF ANDREW T. MITCHELL

Chairman Gregg, Ranking Member Kennedy and Members of the Committee, my name is Andy Mitchell, and I serve as the Deputy Director of the Department of Homeland Security's (DHS) Office for Domestic Preparedness (ODP). As you know, the Secretary recently consolidated the Office for Domestic Preparedness and the Office for State and Local Government Coordination in order to move toward the "one stop shop" that stakeholders have called for. On behalf of SLGCP Executive Director Sue Mencer and Secretary Ridge, it is my pleasure to appear before you today to discuss the current status of SLGCP and other issues of critical importance.

On behalf of all of us at DHS, I want to thank all the Members of the Committee for your ongoing support for the Department and for SLGCP. You and your colleagues have entrusted us with a great responsibility, and we are meeting that responsibility with the utmost diligence. I also want to thank you, Mr. Chairman, for your foresight and leadership in supporting and developing many of the programs that comprised SLGCP long before the September 2001 terrorist attacks.

As you are all aware, ODP within SLGCP is responsible for preparing our Nation against terrorism by assisting States, local jurisdictions, regional authorities, and tribal governments with building their capacity to prepare for, prevent, and respond to acts of terrorism. Through its programs and activities, ODP equips, trains, exercises, and supports State and local homeland security personnel—our Nation's first responders—who may be called upon to prevent and respond to terrorist attacks. We also will work with these entities to take into consideration the needs of unique groups in our emergency planning efforts, including those of people with disabilities.

Mr. Chairman, ODP has established an outstanding track record of capacity building at the State, local, territorial, and tribal levels, by combining subject matter expertise, grant-making know-how, and establishing strong and long-standing ties to the Nation's public safety community. Since its creation in 1998, ODP has provided assistance to all 50 States, the District of Columbia, the Commonwealth of Puerto Rico, and the U.S. territories. Through its programs and initiatives ODP has trained over 550,000 emergency responders from more than 5,000 jurisdictions and conducted nearly 400 exercises. And, by the end of Fiscal Year 2004, ODP will have provided States and localities with more than $8.1 billion in assistance and direct support.

Our core mission is to address homeland security and terrorism preparedness issues on a very broad scale. This focus is on the Nation, on regions, on States, cities and specific events such as the upcoming political conventions. Our programs are designed to provide a framework through which officials at the local and State levels of government may work together to identify their current capabilities, gaps and shortfalls. This approach allows jurisdictions to prioritize and to set goals.

ODP has a number of assistance programs. Two key programs include the State Homeland Security Grant Program (SHSGP) and the Urban Areas Security Initiatives (UASI) Program.

Through its Urban Areas Security Initiative (UASI) program, ODP requires States to work with communities selected according to classified criteria that include threat and risk, presence of critical infrastructure and population density. We require UASI participants to form inter-jurisdictional working groups who undertake assessments of local capabilities that are used to craft plans, or strategies, for that area's preparedness efforts. It is our goal to provide program participants with an over-arching strategy that may be used to advance their level of preparedness.

These working groups have been used by other Federal agencies, including the Federal Department of Health and Human Services (HHS), to "access" these communities so that their specific area of expertise may be applied. We are pleased with this result and feel that we are well on our way to establishing a framework that is useful to States, localities and the Federal Government.

Our programs focus on the provision of planning tools, training, equipment acquisition and exercises. As you know Mr. Chairman, at your direction, we executed the congressionally mandated Top Officials (TOPOFF) exercise program in the year 2000 and again in 2003. These exercises were designed to include all levels of government in simulated crisis through which best practices and lessons learned could be gleaned. These exercises included biological, chemical and radiological scenarios and have provided all levels of government with useful insight as we prepare for occasions such as the recent G–8 Summit in Sea Island, Georgia, and the upcoming Democratic and Republican National Conventions in Boston and New York, respectively.

These National Special Security Events (NSSE), as designated by the U.S. Secret Service, are high-profile events that would result in both symbolic and practical consequences should they be disrupted by terrorists. As such, these events require a greater than usual degree of support and participation from Federal agencies, including the Department of Homeland Security.

ODP provides targeted assistance for designated NSSEs, to include training, technical assistance, and exercises. Our Training Division offers courses that are specifically targeted for an NSSE. ODP also provides technical assistance to facilitate the sharing of lessons learned and training from previous NSSEs. For example, during the planning for the G-8 Summit in Georgia, representatives from the Royal Canadian Mounted Police were flown in to share lessons learned from the G-8 Summit hosted in Canada. ODP's Exercise and Evaluation Division provides a series of exercises that increase in scope and complexity. The first two exercises in this series, a Senior Leaders Seminar and Tabletop Exercise, are discussion-based activities. The exercise series culminates with the conduct of an operational Command Post Exercise which is a final test and check of communications and interoperability between the command centers (i.e, FBI's Joint Operations Center, Secret Service's Multi-Agency Coordination Center, etc.) before the actual NSSE. ODP is currently working with the DHS Integration Staff (as part of the Security Planning Initiative) to develop an annex that outlines the capabilities ODP can provide for special events that are not designated as NSSEs.

Throughout its history ODP has worked to improve how it serves its State and local constituents. For example, in Fiscal Year 2003, application materials for the Department's State Homeland Security Grant Program—under both the Fiscal Year 2003 Omnibus Appropriations Bill, and the Fiscal Year 2003 Supplemental Appropriations Bill—were made available to the States within 2 weeks of those bills becoming law. Further, over 90 percent of the grants made under that program were awarded within 14 days of ODP receiving the grant applications.

During Fiscal Year 2004, ODP's record of service to the Nation's first responders continues. All of the 56 States and territories have received their Fiscal Year 2004 funding under the Homeland Security Grant Program. This includes funds to support state-wide preparedness efforts under the State Homeland Security Grant Program, the Law Enforcement Terrorism Prevention Program, and the Citizen Corps Program. These awards represent over $2.1 billion in direct assistance.

Further, 50 urban areas designated under the Fiscal Year 2004 Urban Areas Security Initiative have been awarded funding. This represents $671 million in support to high-density population centers with identifiable threats and critical infrastructure. In addition, the Department has identified 30 of the Nation's most used urban transit systems and has provided $49 million to enhance the overall security of these systems. All 30 of these transit systems have received their Fiscal Year 2004 funds.

Much of how the States and territories distribute and utilize Homeland Security Grant Program funds is influenced by the results of the State Homeland Security Assessments and Strategies. As you know, each State, the District of Columbia, the Commonwealth of Puerto Rico, and the territories were required to submit their assessments and strategies by January 31, 2004.

These assessments and strategies, Mr. Chairman, are critically important to both the States and the Federal Government. They provide a wealth of information regarding each State's vulnerabilities, capabilities, and future requirements, as well as each State's preparedness goals and objectives. They provide each State with a roadmap as to how current and future funding, exercise, training, and other preparedness resources should be directed and targeted, and they provide the Federal Government with a better understanding of needs and capabilities. I am happy to

report that all assessments and strategies have been received and reviewed by an intra-DHS review board comprised of representatives from major Department components and accepted by ODP.

During Fiscal Year 2005, ODP will continue to provide States and localities with the resources they require to ensure the safety of the American public. The funds requested by the President for Fiscal Year 2005 will allow ODP to continue to provide the training, equipment, exercises, technical assistance, and other support necessary to better prepare our communities.

DHS's mission is critical, its responsibilities are great, and its programs and activities impact communities across the Nation. We will strive to fulfill our mission and meet our responsibilities in an effective and efficient manner. And we will, to the best of our abilities, continue to identify where and how we can improve. Part of our responsibility, part of the Department's responsibility, Mr. Chairman, is the recognition that we can always improve what we do and how we do it. And we can never be too safe or too secure.

This critical mission was recognized by the Congress with the passage of the Homeland Security Act of 2002, and the creation of the Department of Homeland Security. And since the Department's creation, we have worked continuously with the Congress to determine how better to fulfill our common goal of a more secure America.

Close coordination between States, localities, and regions, is critical to an effective and rational distribution of homeland security resources, and is consistent with currently existing ODP funding initiatives, such as the Urban Areas Security Initiative or UASI Program.

ODP is also continuing its efforts to develop preparedness standards and to establish clear methods for assessing State and local preparedness levels and progress. As you will recall Mr. Chairman, on December 17, 2003, the President issued "Homeland Security Presidential Directive (HSPD)-8." Through HSPD-8, the President tasked Secretary Ridge, in coordination with other Federal departments and State and local jurisdictions, to develop national preparedness goals, improve delivery of Federal preparedness assistance to State and local jurisdictions, and strengthen the preparedness capabilities of Federal, State, territorial, tribal, and local governments. HSPD-8 is consistent with the broader goals and objectives established in the President's National Strategy for Homeland Security issued in July, 2002, which discussed the creation of a fully integrated national emergency response capability. Inherent to the successful implementation of HSPD-8 is the development of clear and measurable standards for State and local preparedness capabilities.

The standards that will result from HSPD-8 implementation build on an existing body of standards and guidelines developed by ODP and other Federal agencies to guide and inform State and local preparedness efforts. Since its inception ODP has worked with Federal agencies and State and local jurisdictions to develop and disseminate information to State and local agencies to assist them in making more informed preparedness decisions, including capability assessments, preparedness planning and strategies, and choices relating to training, equipment, and exercises.

Earlier this year, the Secretary delegated to ODP the responsibility for the implementation of HSPD-8. This designation by the Secretary is consistent with ODP mission, as provided under the provisions of the Homeland Security Act, to be the primary Federal agency responsible for the preparedness of the United States for acts of terrorism. And ODP, together with Secretary Ridge, other Department components, Federal agencies, and State and local governments, firmly believe that the successful implementation of HSPD-8 is essential and critical to our Nation's ability to prevent, prepare for, and respond to acts of terrorism. In March, the Secretary approved these key items: first, a strategy for a better prepared America based on the requirements of HSPD-8; second, an integrated, intra- and inter-governmental structure to implement HSPD-8; and third, an aggressive timeline for achieving HSPD-8's goals and objectives. Implementation of HSPD-8 involves the participation of Federal, State, and local agencies, and, among other things, will result in the development and dissemination of clear, precise, and measurable preparedness standards and goals addressing State, local, and Federal prevention and response capabilities.

In closing Mr. Chairman, let me re-state Secretary Ridge's commitment to support the Nation's State and local emergency response community, and to ensure that America's first responders receive the resources and support they require to do their jobs. This concludes my statement. I am happy to respond to any questions that you and the Members of the Committee may have. Thank you.

The CHAIRMAN. Thank you very much.

I guess my first question is there is a lot of concern out in the community of the first responders that the dollars are not coming out fast enough, and according to the statistics which were cited earlier, they do not appear to be coming out fast enough. No 2004 dollars have come out—this might have been appropriate to the Secretary of HHS. Sixty-two percent of the 2003 dollars are not out. This is in public health. Fourteen percent of the 2002 dollars are not out. Why is this happening and where is the hang-up, and are those dollars, when they are coming out, going out to the States on a threat-based assessment or are they going out on formula that allows towns with less of a threat to be receiving dollars that might better be used for towns that have a higher threat?

Mr. MITCHELL. For the two primary grant funds that ODP administers, the State Homeland Security Grant Program, which is the based grant program that provides funds to the States, and those funds currently go out under the Patriot Act authorized formula which provides a base for each State, and the balance of those funds are currently distributed on a population basis. Under the Urban Area Security Initiative, which provides a range of funds that are targeted based on a variety of threats and other criteria that the department develops, those are discretionary funds that are allocated to large urban areas based on threat, presence of critical infrastructure, and population density.

There is a combination of the two grant program funds that do provide, we think, funding to meet the large jurisdictions' needs based on a threat and risk basis. We have also proposed in the 2005 budget that all funds that we administer, including the State Homeland Security grant program, that we use up a variety of criteria to include threat, risk, and other things to allow us to allocate those funds as well. It is an evolutionary process, but we think we have made significant progress to date on helping or providing the Secretary and Department the authorities we need to allocate funds to those jurisdictions that do have the highest risk and have the greatest need.

The CHAIRMAN. How about the flow? There is some concern that States are not getting the money down to the communities, communities are not asking for the money in time. Where are the places where the process is being slowed?

Mr. MITCHELL. It varies, Mr. Chairman. We deal with 56 States, territorial governments, and the District, and there are probably 56 various reasons as to why. In some cases, it is existing rules and regulations on procurement. In some cases, the States are required to have the funds appropriated by their legislature before they can obligate them. In some cases, the local governments have the same requirement for city councils or county commissioners to approve or authorize fund expenditures. There are a variety of reasons. There are no simple, easy solutions, but Secretary Ridge did appoint a committee to look at this, a working group, and that report was submitted to our office on issues that affect or impede State and local government ability to expeditiously and effectively receive and allocate these funds.

We are looking at the recommendation on that, and we think there will be some significant improvements we can make based on the recommendations from that committee.

The CHAIRMAN. To what extent are the problems at our level?

Mr. MITCHELL. I am happy to say that on our end, from the Federal end, we have very tight time lines in which to allocate our funds, and we have obligated all of our funds for 2004 under the Urban Area Security Program, and there is one remaining State under the State Homeland Security Program that we are still awaiting some information, but we have obligated all of our funds, and we generally can do that within a week to two weeks of the submission of the application as long as the State's application is complete. We are providing technical assistance and trying to identify areas where we can go out and assist the States.

I think one of the challenges that we face is this is an enormous amount of money going through a system that is in its infancy at best. The ability to plan and analyze and prioritize requirements for homeland security is an extraordinarily complex challenge, and I think we are seeing improvements at the State and local level in their abilities to do that, but I still think that is one of the challenges we do face—helping build that infrastructure at the State and local level, to help them make better informed decisions and to more expeditiously allocate and disburse these funds.

The CHAIRMAN. Well, I appreciate that, and having observed it in anecdotal ways, it does seem to me that some of these funds are ending up with an LEA situation where the dollars are being spent for blue lights instead of on an orchestrated process, and I suspect that is the formula funds that are going out on the basis of population.

Mr. MITCHELL. Obviously, equipment is a major area where the State and locals allocate their funds, but the States are required to develop strategic plans that have multiple year priorities, and we encourage them—although we cannot mandate, we strongly encourage them to build, to design their strategies on regional basis, building on existing mutual aid and response systems that are already in place and to not just try to provide a certain level of funding to every jurisdiction so that every jurisdiction gets a grant. We hear a lot of that. We hear from a lot of Mayors that their cities have never gotten a grant, and our position is if the States are doing this properly and they are developing regional response capabilities, a lot of jurisdictions never will get a grant, but they will certainly benefit from enhanced response capabilities that are being created that will allow more robust and sustainable response within the regions that the States have established.

Again, there are always two sides at least to every story. We are trying to work with both the localities and the Governors to reach some agreement and find out how we can make this process even more effective.

The CHAIRMAN. Good, and I hope that we can get legislation in the appropriations bill to make it more threat-based in my opinion.

Mr. MITCHELL. Yes, sir.

The CHAIRMAN. Which may work against New Hampshire, for example, but that is the way it should be distributed.

Mr. Tolbert, so we have an event. It is a public health event. It is in a subway system, say here in Washington. How do we get the people from the subway to the hospital? The traffic situation is a disaster. It was proved after 9–11 it is a disaster, and almost on

any evening, you can expect it to be a disaster. Have we structured a process for the physical event of moving people and have we tested it in a real world real-time situation?

Mr. TOLBERT. There are numerous mass casualty plans being developed around the country down to the specific cities. The continuum of care begins, though, at the patient, wherever the patient is. A lot of the capacity being built utilizing homeland security funds are actually in building mobile capabilities that can be deployed to the victim, and from that point where you have executed initial stabilization, at that point then they are stabilized for transportation.

Transportation is only one of the areas of concern. Certainly that is local specific as to the capabilities for transportation, but we are looking at more innovative ways on a more strategic basis as to how we can provide medical casualty transportation, which is one of the components of the national disaster medical system that I referred to earlier. We are not only looking at the local area casualty movement capabilities, but we are looking strategically at how we can move them from the impacted area where we have a large scale mass casualty incident with saturation of medical facilities out to outlying hospitals. That is one of the priorities the Department is focusing on now.

The CHAIRMAN. I appreciate that and I understand we are doing paper practices. I guess my concern is it is more than the casualties. It is just human nature of wanting to get out of the area, the jamming of the phone systems, the overwhelming of the cell phone capability which occurred in the 9–11 scenario.

Say there with was another 9–11 type of scenario in Washington. Would we be in any better position today to move the traffic out, to have people communicate by telephone, and have the different jurisdictions, Maryland and Virginia, cooperate with the District of Columbia? According to the GAO, we are not in a whole lot better position. Do you think we are?

Mr. TOLBERT. I think from a coordination and communication standpoint, the region is far better prepared than it was in 2001. There are redundant communication systems that tie the entire network together, the entire region, the local governments, the State agencies, the Federal agencies, and that system is tested on a very routine basis. We collaboratively work with the District and the surrounding region of the National Capital region to develop more robust capabilities, planning. In fact, Secretary Thompson referred earlier to the cities readiness initiative, and have already begun preliminary discussions.

The CHAIRMAN. How do you respond to the GAO report which essentially said that the Capital region—and I do not think it is probably unique. New York may actually have things in a better management structure, but I suspect there are not too many places who are much better off. I am not picking on the Capital region because it is unique. In fact, my concern is that it is not unique. How do you respond to the GAO report which essentially said that the coordination is not there, that the interoperability of systems is not there, and that the ability to handle a massive movement of people, either because they are injured or because they are trying to get out of the way or get away, we cannot do it, and the communica-

tion systems would essentially break down for the average person who was trying to get out of town and trying to figure out where his kids are or her kids are and communicate?

Mr. TOLBERT. Disasters by their nature tend to be chaotic, and certainly we have a lot of room for improvement. It will require continuing dedication on the part of all levels of government nationally and especially within the National Capital Region to develop better capabilities, but I do know that we have made significant strides in not only evacuation planning and communication with the public, but we have also made greater strides in looking at alternatives to immediate evacuation. One of the findings that we know from a science and technology standpoint is that evacuation is not necessarily the best answer or the best protective action to execute.

The CHAIRMAN. But it is the natural human reaction.

Mr. TOLBERT. It is, but a lot of investment is being made, especially in the Federal agencies and the local agencies, in developing better plans for in-place sheltering and developing better capacity. In fact, FEMA has recently completed enhancements within our own building with better plans, better training, better equipment in place to ensure that we can in-place shelter until it is appropriate to go into the environment.

The CHAIRMAN. Well, I guess I would like to get a written response, if possible, from the Department to the GAO report. Maybe you have already done that and I have not seen it, but that is what I would like to get, because they were pretty negative on where we are, and then I would like to take it to the next step. Is the Capital Region unique? Are the GAO points unique to the Capital Region, or is this something that we have got to worry about in other areas and what is the process, the systemization, that is being put in place to address these concerns? Is that possible?

Mr. TOLBERT. It is a national problem where we have high density population in all of the major urban areas, and I believe that the effort, especially related to the urban area security initiative is significantly complementing the local regional capability and planning. It certainly requires collaboration. You have to have early coordination, early warning, and specifically in the NCR and I know in other areas around the country, there are great strides being made in the communications capability to ensure that when we have an event, that there is timely sharing of information and coordination on the emergency actions. Certainly, it will be a multiyear activity to ensure that we have robust capabilities nationally, but they are very complex problems and there are not very easy solutions where we have literally tens of millions of people congregated in high-density population centers.

The CHAIRMAN. I think we all understand that. We all understand that we are never going to get this perfect and probably will not get it to a position where it is even close to perfect, but there are some things we can correct or at least try to correct. For example, it is startling to me that 2½ years, almost 3 years after 9–11, we still have in the Capital area an incompatibility of communications and basically willingness to be cooperative between Virginia, Maryland, and District of Columbia in the case of a crisis of significant proportion. I mean, that is just startling.

Now, maybe it is time for HSA, since it has now been set up and you are in position to do something like this, to ask for the legislative authority to—basically when that type of cooperation is not occurring between States or districts—to come in and bang heads together and say this is the way it is going to be and you are going to do it and I have the legislative authority to do. Whatever the process is, we have got to resolve that. I mean, that is a resolvable event. Clearly, we are not going to be able to handle the fact that 10,000 people suddenly want to leave the city or a hundred thousand people want to leave the city and there are only three bridges going west.

That is not resolvable, but other things are. I guess my concern is how are we handling the ones that might be resolvable when we know they are there, when we have reports saying they are there today. If you have got ideas on that, we are interested in them.

I thank you for your time and I appreciate your participation in this hearing. I appreciate the work you are doing, by the way. I do not want to understate the fact that you folks have gotten up to speed in a very difficult climate very quickly and that you are working hard and what you are doing is so important and we appreciate it. We appreciate the hours you put in.

Mr. TOLBERT. Thank you, Senator.

Mr. MITCHELL. Thank you, Senator.

The CHAIRMAN. Okay. I do want to stress that my concerns are meant as concerns and that I very much admire the efforts made by the Homeland Security Agency and HHS in these areas.

If we could have the next panel join us, we are going to have four witnesses who are on the front lines, first responder situations to a large degree: Ms. Susan Waltman, who is the Senior Vice president and General Counsel of Greater New York Hospital Association, which obviously has a huge role in any event; Mr. Mike Sellitto, who is Deputy Fire Chief in charge of special operations here in Washington, DC., who again is right out there on the front lines; Dr. Ricardo Martinez, a board-certified emergency physician and is chairman and the founder of the Medical Sports Group. He is basically responsible for the NFL's ability to handle events, especially the Super Bowl. Their experience is unique and we want to hear about it; and Dr. George Thibault, who is serving as Vice President of Clinical Affairs at Partners Healthcare Systems since 1999, and he is a professor of medicine at Harvard and a specialist in this area. His input will be very helpful to us.

Why don't we just start with Chief Sellitto and move down the panel, if you would give us your thoughts.

STATEMENT OF MIKE SELLITTO, DEPUTY FIRE CHIEF, WASHINGTON, DC.

Mr. SELLITTO. Good afternoon, Chairman Gregg and Members of the Subcommittee. I am Michael Sellitto, Deputy Fire Chief in charge of special operations for the District of Columbia Fire and EMS. I am pleased to be here today to offer testimony on how D.C. Fire and EMS prepares to keep the citizens and visitors to the District of Columbia safe during special events.

The Special Operations Division has planning responsibilities for all special events in which fire, EMS, or special support is required.

As Deputy Chief of Special Operations, I oversee our hazardous materials response and technical rescue units, and I am responsible for preparations to a WMD event.

Planning for special events in the District is a constant activity. There are hundreds of events in the District each year, ranging from the festivals and celebrations held in every community nationwide to the specialized events such as the Presidential Inaugural that is held only in the Nation's capital. D.C. Fire and EMS was a key partner for the World War II Memorial dedication and the recent funeral of former President Ronald Reagan. We regularly share in the planning of the State of the Union addresses, and we are currently preparing for the upcoming Presidential Inauguration.

D.C. Fire and EMS uses an all-hazards approach to planning for major special events. Each event is unique and has its own special set of circumstances. Some of the factors we consider include the VIP attendance, the level of security screening for attendees, the crowd size, threat intelligence, the nature of the event, weather, and event-specific hazards such as fireworks. A unified command presence is established at all major special events to ensure command and control of assets is a coordinated effort. In this way, we can be sure that the appropriate assets are already in place for unplanned events should they occur. The ultimate goal, of course, is that everyone goes home safely at the end of the day.

The Department sits on the Mayor's special events task group which meets regularly to review proposals for events. This group of representatives from local and Federal agencies has responsibility for ensuring that special events are conducted in a safe and secure environment. This task group and D.C. Fire and EMS have been planning successfully for special events in the District for years. Since September 11th, that level of planning, cooperation, and coordination has improved and expanded.

Often Federal agencies are the lead agency responsible for security or for property hosting the event. Events on U.S. park land are coordinated with the National Park Service, and we provide support as requested by the U.S. Capitol Police and the U.S. Secret Service. We work closely with the FBI, FEMA, DOD, DOE, and HHS. The relationships developed through these planning groups have greatly benefited D.C. Fire and EMS. We know the players involved from each participating agency, Federal and local. This is extremely important in the event of any unplanned incidents. In such an event, these players would need to work together quickly to determine appropriate incident response. The strong relationships developed prior to unplanned events makes this possible.

We also have very strong relationships with other Fire and EMS Departments in the National Capital region. The Washington Metropolitan Council of Governments Fire Chiefs Committee and subcommittees are invaluable for developing regional coordination and response. A standardized incident command system has been adopted. There are standing mutual aid plans, mutual aid operations plans, and field operations guides.

Many additional regional concerns are being addressed and supported by the urban area security initiative grant moneys. A regional incident management team has been developed which allows

specially trained members from area departments to provide incident support to any jurisdiction in need. The region has an 800 megahertz radio system that is shared by most surrounding jurisdictions. This allows for direct communications between mutual aid partners.

In response to the attacks of September 11th, the District Government focused great efforts on assessing and revising city emergency plans. The result is a new and always improving District response plan that sets out the framework for District Government response to public emergencies in the Metropolitan Washington area. The District has identified 15 emergency support functions within the plan. Washington, DC Fire and EMS has lead responsibilities for three functions: fire fighting, urban search and rescue, and hazardous materials. We have substantial support roles in two others: mass care and health and medical services.

Prior to September 11th, certain response capabilities in the department were already being improved. Since then, with the assistance of Federal funding, capabilities have been further enhanced in apparatus, technical equipment, and training.

The Department of Homeland Security funding has allowed much of this to be accomplished, freeing up local funds to be used for other enhancements such as staffing not permitted under DHS guidelines. D.C. Fire and EMS has added many medical and response vehicles to our fleet since September 11th. This increased fleet is available for emergency response to and support of special events. Some other equipment placed in service and upgrade since September 11th includes enhanced medical equipment on all EMS units, stockpiles of medical equipment for use during early stages of a biological incident, mark one kits and front line response units, and the placement of detection and screening equipment on units across the District. We have increased our decontamination capabilities in response to WMD through equipment and training. Training is essential to D.C. Fire and EMS. Since September 11th, we have undertaken training of additional personnel in all technical areas, including hazardous materials, operations, WMD incident response, and advanced medical procedures.

This brief overview highlights some of the areas of the department's readiness for major special events in the District and any potential unplanned WMD events and other emergencies. Our capabilities and readiness are always in practice and always improving.

This completes my oral testimony. Thank you again for this opportunity to be here today, and I am happy to answer any questions from the committee.

[The prepared statement of Mr. Sellitto follows:]

PREPARED STATEMENT OF MICHAEL SELLITTO

Good morning Chairman Gregg and Members of the Committee. I am Michael Sellitto, Deputy Fire Chief in charge of Special Operations for the District of Columbia Fire and Emergency Medical Services Department. I am pleased to be here today to offer testimony on how DC Fire/EMS prepares to keep citizens and visitors to the District of Columbia safe during special events.

The Special Operations Division has planning responsibilities for all special events for which fire, emergency medical services and/or specialized support is requested or required. As Deputy Chief, Special Operations, I oversee planning, training, and response of the DC Fire/EMS hazardous materials and technical rescue

teams including urban search and rescue, high angle, trench collapse, structural collapse, confined space, and water rescue. I am also responsible for DC Fire/EMS preparations for response to any WMD incident.

SPECIAL EVENTS IN THE DISTRICT OF COLUMBIA—GUIDING PRINCIPLES

Planning for special events in the District of Columbia is a regular activity for many agencies in DC Government. There are always special events happening in the District ranging from the festivals, athletic events, and block parties of every community in the Nation to specialized events, such as Presidential inaugurals or the recent WWII Memorial Dedication, that are held only in the Nation's capitol. DC Fire/EMS was involved in planning for the recent funeral for former President Ronald Regan, and regularly participates in planning for State of the Union Addresses. We are currently planning for the upcoming 2005 Presidential inaugural, with representation on twenty-five (25) planning committees, a number that will grow as the event draws closer.

DC Fire/EMS uses an all hazards approach to planning for major special events. Each event is unique and has its own special set of circumstances to be considered. The level of protection provided for each event has many variables. The factors that are considered include, but are not limited to, VIP attendance, the level of security screening provided for attendees, the number of attendees, threat intelligence directed at the event, the nature and/or sponsor of the event, projected weather extremes, and event specific hazards such as fireworks. A Unified Command presence is established at all major special events to ensure the command and control of assets is a coordinated effort. In this way, we can be sure that the appropriate assets are already in place for unplanned events, should they occur. The ultimate goal, of course, is that everyone goes home safely at the end of the day.

COORDINATION AND INTEROPERABILITY BETWEEN AGENCIES AND JURISDICTIONS

In the District, the Mayor's Special Events Task Group meets regularly to review proposals for events. This group of representatives from local and Federal agencies has responsibility for ensuring that special events are conducted in a safe and secure environment. This Task Group and DC Fire/EMS have been planning for special events in the District for many years. Since September 11, the level of planning, cooperation, and coordination has improved and expanded.

In the District, Federal agencies very often are the lead agency responsible for security or are the lead agency on whose property the event occurs. Events on U.S. parkland are coordinated with the National Park Service Special Events Office, and we provide support as requested by the U.S. Capitol Police Special Events Office, and to the U.S. Secret Service Planning Committee for any National Special Security Events or those that require coverage for Secret Service protectees. DC Fire/EMS regularly works closely with the FBI, FEMA, DOD, DOE, and HHS. The planning meetings have the goal of developing action plans, which are utilized to plan and direct operations during an event.

The relationships developed through these planning groups greatly benefits DC Fire/EMS. We know very well the players involved from each participating agency, Federal and local. This is extremely important in the event of any unplanned incidents, independent of or associated with major special events. In such an event, these "players" would need to come together quickly to determine an appropriate incident response. The strong relationships developed prior to unplanned events makes this possible.

We also have very strong relationships with other Fire/EMS departments in the National Capital Region (NCR). The Metropolitan Washington Council of Governments Fire Chiefs Committee and subcommittees are invaluable for developing regional coordination and response. A Standardized Incident Command System has been adopted in the region; there are standing Mutual Aid Plans, a Mutual Aid Operations Plan and Field Operation Guide.

Additional regional issues are being addressed and are supported by Urban Area Security Initiative monies. In conjunction with the National Fire Academy, a regional Incident Management Team (IMT) has been developed, which allows specially trained members from the NCR to provide incident support in the planning, command, operation, logistics and finance areas to any jurisdiction in need—whether for a planned, or unplanned event. The NCR has an 800 MHz radio system that is shared by most of the surrounding jurisdictions. This allows direct communications between the mutual aid partners.

SOME LESSONS LEARNED

DC Fire/EMS is always assessing our response to incidents and our plans for special events. Past experience shows us that including increased Incident Command and use of an Incident Management Team from the early planning stages of special events is valuable. As noted earlier, this allows for needed assets and command structures to be in place prior to any unplanned incident that could emerge during a major special event. Another important lesson is the value of working with health agencies to provide nurses and physicians onsite during major special events. This decreases the need for transport to hospitals, increases the level of pre-hospital care available to special event attendees, and stages nurses and physicians closer to potential casualties of an unplanned incident.

DC FIRE/EMS RESPONSIBILITIES IN THE DISTRICT RESPONSE PLAN

In response to the attacks of September 11, the District of Columbia government focused great effort to assess and revise city emergency plans. A Domestic Preparedness Task Force was formed with representatives including, among others, heads of District agencies with public safety and emergency functions. The Task Force and the District's Emergency Management Agency developed the new District Response Plan. This Plan sets out the framework for District government response to public emergencies in the metropolitan Washington area. The District has identified 15 Emergency Support Functions (ESFs) that supplement the Basic Response Plan. Each ESF has it's own purpose and scope with operating responsibilities and identified lead and support agencies. DC Fire/EMS has lead responsibilities for three ESFs: ESF #4—Firefighting, ESF #9—Urban Search and Rescue, and ESF #10—Hazardous Materials. The Department has a substantial support role for two other ESFs: ESF #6—Mass Care, and ESF #8—Health and Medical Services.

SOME ENHANCEMENTS AT DC FIRE/EMS SINCE SEPTEMBER 11, 2001

Prior to September 11, certain response capabilities were already being enhanced with the growing threat of the possibility of a terrorist attack. Since September 11, with the assistance of Federal funding, capabilities have been further enhanced in areas of response apparatus, technical equipment, response training and staffing. Department of Homeland Security funding has been received in a timely fashion, allowing many of these enhancements to be accomplished. This has freed up local funding to be used for other enhancements, such as staffing, which have not been permitted under DHS funding guidelines.

Specifically for increased response capabilities, the following assets have been added to DC Fire/EMS apparatus fleet since September 11:

- 12 Ready Reserve Ambulances (ALS capable)—placed in service with certified administrative or recalled personnel when needed,
- 2 Mass Casualty Trucks—each equipped to handle fifty patients,
- 2 Ambusses—capable of transporting ambulatory & non-ambulatory patients,
- 1 WMD Response Truck—to provide support equipment for WMD events,
- 1 Radiation Response Truck—to provide additional monitoring screening and decontamination at a radiological event,
- 10 Ready Reserve Engines—placed in service with recalled personnel, and
- 3 Ready Reserve Ladder Trucks—placed in service with recalled personnel.

DC Fire/EMS rewrote its "Mobilization Plan" after September 11, to address concerns for additional personnel recall procedures, staffing guidelines, and the use of decentralized "Area Commands."

The increased fleet is also utilized to support special events as needed, which allows DC Fire/EMS to maintain our normal level of service to District residents as a whole, while also providing the necessary enhanced coverage to special event sites.

Other equipment placed in service and upgraded since September 11 includes:

- State-of-the-art chemical detection equipment on various units,
- Biological screening equipment on our Hazardous Materials Unit,
- Radiation detection equipment citywide,
- Enhanced medical equipment on all of our EMS units,
- Stockpiles of necessary medical equipment are on-hand for sustained response during the early stages of a potential biological incident, and
- Mark 1 kits (nerve agent antidote) have been placed in front line response units.

Additional decontamination capabilities include:

- Decontamination tents,
- Tent heaters,
- Water heaters,

- Redress, and
- Necessary support equipment.

All members of DC Fire/EMS have been trained in gross decontamination techniques, which are utilized in the event of a WMD incident.

Training is essential to DC Fire/EMS's ability to carry out our mission. Since September 11, DC Fire/EMS has undertaken an enhancement program that has trained additional numbers of personnel in all technical areas, including training for:

- all uniformed members to the hazardous materials operations level, NFPA 472 Standard,
- all EMS personnel to NFPA 473 Standard, * 200 hazardous materials technicians,
- 120 rescue technicians,
- Specialist training programs, such as those offered by the Department of Homeland Security, Office of Domestic Preparedness, including:
    - COBRA live agent training,
    - Incident Response to Terrorist Bombings live explosives course, and
    - Nevada Test Site WMD Radiological/Nuclear Course,
- Advanced EMT training for EMS personnel, which enables all EMS personnel to administer seven (7) medications and use advanced airway techniques.

Included, as attachments to this prepared testimony, are documents that help to illustrate the type of response, special event planning, and incident command structure in place in the DC Fire and Emergency Medical Services Department. The attachments are focused on EMS Special Operations, WMD response, and EMS Incident Command.

DC Fire/EMS takes very seriously the mission to protect life and property through fire suppression, hazardous materials response, technical rescue, fire prevention and education, and pre-hospital care and transportation services to people within the District of Columbia. The Department's readiness for major special events in the District, any potential unplanned WMD events, and other emergencies are always in practice and always improving.

This completes my prepared testimony. Thank you again for the opportunity to be here today. I am happy to answer any questions from the committee.

DISTRICT of COLUMBIA
FIRE AND EMERGENCY MEDICAL SERVICES

June 2003 **Bulletin 13-A**

EMS Special Operations Units

Policy and Procedures

Mission Statement:

The mission of the EMS Special Operations Units is to provide dedicated EMS support to the Incident Commander at Special Operations responses i.e., Mass Casualty Incidents, Hazardous Material Incidents, 2nd Alarm fire or greater incidents, Collapse Rescue, Law Enforcement Support and Special Events.

EMS Units:

Rapid Response Units 12 & 13 and Medic 15 are assigned to the Special Operations Battalion. These units are equipped with specialized equipment that will assist with patient care at Special Operations Incidents. The EMS Supervisor assigned to the Special Operations Battalion is responsible for responses, training coordination, equipment issues and liaison with other government agencies. The Mass Casualty Units (MCU), the Ambulance Buses (Amb-Bus), Decon Support Unit and Trailer and the 12 Code Red Units (EMOP units) located E12, E24 and the Training Academy.

Additionally the following units are associate units that work routinely with Special Operations Units, EMS 16, Medic 1, Medic 3, *Ambulance 2 & 24*.

EMS Response:

The closest Rapid Response unit and associate unit, (an EMS transport unit and supervisor) if available, will automatically be dispatched on all Haz Mat Task Force alarms involving victim exposure / casualties, all technical rescue calls (see dispatch guide), 2nd Alarm fire or greater ~~incidents, Multiple / Mass Casualty Incidents and law enforcement incidents requiring EMS Support.~~ The EMS Special Operations Supervisor will be notified (SO1 or 2) and they will respond as necessary.

Operations:

EMS Special Operations units will operate under the incident command system, providing defensive patient care: i.e., triage of rescued patient(s), patient care during decontamination, rescue operations and provide personnel for treatment area(s) during Multiple / Mass Casualty Incidents, 2nd Alarm fire or greater incidents, and, at the direction of the incident commander. Additionally, personnel assigned to Rapid Response Unit 12 will be responsible for maintaining medical profile records and coordinating pre & post entry vitals signs on Hat Mat Team members (this function call be provided by Rapid Response Unit 13, Medic 15 or an associate unit).

Special Events:

Special Operations coordinates EMS coverage for several hundred special events throughout the year, utilizing EMOP unit(s) staffed with overtime personnel and / or occasional unit(s) from the 911 fleet for short-term event(s) less than four (4) hours.

An EMS Supervisor from Special Operations will serve as the site supervisor and FEMS liaison with other government agency. All units operating on a Special Events will utilize channel A11, 12 or 13 (SPEV1, 2 or 3).

Training:

All personnel and members assigned to the EMS Bureau will be required to pass a basic awareness course in the following: Hazardous Material Awareness (both NFPA 472 & 473). This will ensure that all personnel and members are familiar with the responsibilities of the EMS sector at special operations incidents.

Members assigned to EMS Special Operations units will be EMT-Paramedics with the following certifications:
DC Certified Paramedic
National Fire Protection Agency (NFPA) 472 level II operations level training
NFPA 473 level II operations
Department of Justice WMD training (TERT) when available
Self Contain Breathing Apparatus (SCBA) training
Confined Space Rescue training (operations)
Structural Collapse Rescue
Trench Collapse Rescue
Rope Rescue Training

EMS Officer Responsibilities (Special Operations EMS Officer or associated EMS Officer):

Works closely with the appropriate OIC, coordinates the following activities

1. Coordinates pre and post entry medical examinations on team members as necessary.
2. Obtains and maintains updated product information and treatment mode from both Chemtrec and Poison Center.
3. Coordinates with Medical Control Hospital (Hospital 08) for patient care and the Clearing House Hospital (Hospital 02) for patients' transports.
4. Keeps EMS Director, EMS Chief and his staff updated on the incident.

Treatment Guidelines:

1. Treatment of patients will be consistent with the District of Columbia Adult / Pediatric protocols.

2. Rescue personnel will evacuate victims; EMS personnel will perform triage at the hot / warm zones in Haz Mat incidents.
3. EMS personnel will deploy as directed by the incident commander to provide patient care to victims that are not immediately removable to a safe area to sustain the patient's life and limb.
4. Medical screening of Haz Mat personnel will be consistent with Haz Mat Unit procedures.
5. Quarterly, members assigned to Rapid Response Unit 12, will complete medical screening forms on appropriate Haz Mat Unit members (EMS Platoon No. 1 will be responsible for Fire Platoon No. 1, etc).

DISTRICT OF COLUMBIA FIRE & EMS DEPARTMENT

October, 2001 Bulletin No. 67

Guidelines for Response to Weapons of Mass Destruction Incidents

PURPOSE

To provide information and initial guidance to incident commanders and company personnel responding to terrorist incidents involving nuclear/radiological, biological or chemical weapons of mass destruction.

SCOPE AND POLICY

The prevention of terrorism is primarily a law enforcement function. However, the fire service is the primary resource for rescue and emergency medical services in the aftermath of a terrorist act. The District of Columbia Fire and EMS Department's role in response to incidents involving weapons of mass destruction (WMD) should initially be limited to rescue activities, victim decontamination, delivery of emergency medical services, initial perimeter control, evacuation assistance, product identification, and fire suppression activities. The incident commander should perform a quick initial hazard and risk assessment of the situation before fire and EMS units are deployed into any hazardous areas. Fire and EMS units may be deployed into hazardous areas if immediate rescue needs are evident. Once immediate rescue needs have been completed, fire and EMS units should be withdrawn from the hazard area until a comprehensive hazard and risk assessment has been completed and the risks to fire and EMS personnel have been minimized. Fire and EMS personnel should not be assigned tasks that are normally performed by law enforcement personnel. The Hazardous Materials Unit, however, may be deployed to assist law enforcement agencies in the collection and identification of chemical, biological, and nuclear/radiological material.

INCIDENT COMMAND CONSIDERATIONS

Command, Control, and Communications:

1. Establish a command post upwind/uphill from the incident in an area that does not interfere with the operational aspects of the incident.
2. Place Level III Accountability in effect.
3. Utilize specially trained/equipped companies/units where appropriate (First Battalion companies, Rescue Squads, and Rapid Response units have been equipped with chemical/biological personal protective equipment (PPE)
4. Notify Communication Division that WMD materials may be involved.
5. Declare a Mass Causality Incident if indicated.

6. Request Mutual Aid/Federal assistance if indicated (see resource list).
7. Request needed additional resources early in the incident: HazMat Unit, HazMat Task Force, Rescue Squads, Cave In Task Force, Special Operations Chief, Air Unit, Metro Unit, Decon Support Unit, Mass Casualty Unit, Rehab Unit, and specialized EMS Units.
8. Request a police official at the command post.
9. Request update/information from police official and coordinate actions with law enforcement agencies.
10. Establish Multi Agency Command (MAC).
11. Stage resources.
12. Establish/maintain cell phone line with Communication Division and secure hard line telephone if possible.
13. Request additional Command Staff.
14. Minimize personnel committed to any hazard zone.
15. Request law enforcement agencies sweep incident site/staging areas/command post location for secondary devices.
16. Coordinate with other agencies to provide food/shelter for displaced victims.

Personal Protective Equipment:

1. Utilize personnel with chemical protective gear (level A or B) when indicated.
2. Minimally require full firefighting gear including **SCBA** on all incidents until determined otherwise.
3. Use additional personnel equipped with chemical PPE when available (most First Battalion companies, Rescue Squads and the HazMat Support Unit carry additional chemical PPE).
4. Utilize the Air Unit, Metro Unit, Mutual Aid Air Units, etc. to maintain respiratory protection through the use of SCBAs.
5. Consider the use of Supplied Air Respirators (air carts), which are carried on some Rescue Squads, to maintain respiratory protection for personnel working in decon areas, etc.
6. Authorize the use of Air Purifying Respirators (APRs) only after receiving specific recommendations from technically qualified and competent personnel

Scene Safety:

1. Request police agencies to sweep for secondary devices (MPD, U.S. Capitol Police, US Park Police, and US Secret Service have bomb dogs and other detection devices).
2. Deny entry and establish initial isolation zone using DOT Emergency Response Guide.
3. Utilize the HazMat Unit to identify/establish hot/warm/cold zones.
4. Determine downwind hazard areas.
5. Evacuate or shelter in place utilizing police agencies where possible.
6. Establish safe refuge area for ambulatory victims.

7. Minimize number of responders committed to hazardous areas.
8. Avoid direct contact with ambulatory victims, including those in safe refuge areas, until after decontamination.
9. Providing directions and instructions to victims through the use of the apparatus PA systems or bullhorns from the Mobile Command Unit or Field Command Unit.
10. Utilize police agencies to control perimeter line and bystanders (MPD, U.S. Capitol Police, U.S. Park Police, U.S. Secret Service, Federal Protective Service, etc.).
11. Utilize police agencies to secure emergency vehicle egress and ingress route.
12. Secure antidote kits for responders from EMS if available (agent specific).
13. Use detection equipment to validate zone location/delineation.
14. Establish rehab area/ rotate crews.

Decontamination:

1. Promptly begin Mass Decontamination if incident warrants such action.
2. Establish separate decontamination corridors for emergency responders and civilians.
3. Prioritize victims for decontamination.
4. Protect victim privacy whenever/however possible.
5. Utilize privacy tents/showers/water heaters/tent heaters, which are available through the HazMat Unit and the Decon Support unit.
6. Provide redress for decontaminated victims available from the HazMat Unit/Decon Support Unit and the Mass Casualty Unit.
7. Guard against hypothermia in cold weather incidents.
8. Consider using building sprinkler heads for decontamination showers when appropriate.
9. Contain water runoff from decontamination efforts if practical, but remember that run off containment is secondary to life concerns.
10. Use detection equipment to check decontamination efforts.
11. Request National Medical Response Team (NMRT),formerly called MMST, to assist with decontamination.
12. Consider the need for decon at other sites as many victims may flee the scene before being deconned and may attempt to report to medical facilities such as clinics and hospitals on their own.

Casualty Management:

1. Have EMS establish triage/treatment/transportation areas and casualty collection points upwind/uphill from the incident site.
2. Ensure that victims are decontaminated prior to being transported.
3. Secure antidote kits if available (agent specific) from EMS Units.
4. Request mutual aid EMS Units.

5. Consider alternative means of patient transport (metro busses, vans, subway system, etc.).
6. Notify hospitals of suspected WMD agent/agents involved.
7. Utilize HazMat trained EMS personnel (EMS 16, RR12, and RR21) in hazardous areas.
8. Use detection equipment to insure that only clean patients are being transported from the incident scene.
9. Provide decontamination assistance to hospitals (First Battalion companies) to assist with self-referring victims if available.
10. Request NMRT team (formerly called MMST) to assist with patient care and antidotes/pharmaceuticals.
11. Leave deceased victims in place to preserve the crime scene.
12. Consider the use of Federal Disaster Mortuary Teams (DMORT) teams to handle deceased victims in mass casualty incidents.

Public Information Officer:

1. Coordinate information release with other involved local and Federal agencies.
2. Have technically competent people (collapse/HazMat/special operations/etc.) accompany PIO to assist in explaining technical issues.
3. Establish media area.

Hazard Identification:

1. All incidents should be tested for chemical, biological, nuclear/radiological, and explosive material, **do not assume anything.**
2. Consider that more than one agent may be involved.
3. Utilize the HazMat Task Force for hazard identification.
4. When possible have law enforcement agencies rule out explosives before committing any units.
5. All staging, triage, treatment, transportation, casualty collection points, command post, and rehab areas should be checked for hazards and secondary devices.
6. Request assistance with hazard detection/identification from mutual aid hazardous material units, police agencies, military units, FBI, DOE, etc.).

Environmental/Public Health/Crime Scene Concerns

1. Contain run off from decontamination efforts and fire control activity if practical.
2. Double bag decontaminated victims clothing and personal effects.
3. Remind all response personnel that WMD incidents are crime scenes.
4. Disturb scene as little as possible.
5. Coordinate with law enforcement agencies to maintain crime scene.
6. Defer to Federal officials (EPA, DOE, Health and Human Services, etc.) for environmental and public health issues.

OPERATIONAL CONSIDERATIONS

Staging:

With the exception of the First Due Engine Company, all other units dispatched on a WMD incident should initially stage at one location a minimum of 2 blocks upwind and uphill of the reported incident. If explosive material is involved, units should stage a minimum of 1500 feet from the incident. Units should not stage in direct line of sight of the incident and should position their apparatus behind buildings or natural barriers and away from glass windows. As more information about the incident becomes known, staging distances may be increased or decreased. As the incident expands, consideration should be given to using multiple staging areas to facilitate concurrent fire and EMS operations. A request should be made to law enforcement agencies to have the staging areas swept for secondary devices as soon as possible. Incident Commanders are reminded that there are a number of law enforcement agencies and military units in Washington, D.C. that have the capability to perform sweeps for explosive or suspicious devices.

Detection and Recognition:

While the HazMat Unit has the capability to detect some WMD agents there are limitations to this detection capability. Biological agents are very difficult to detect even with sophisticated detection equipment. The HazMat Unit is currently equipped with only very basic biological detection devices (Smart Tickets), which are agent specific and are currently available for only a very limited number of agents. The HazMat Unit has detection capability for nuclear/radiological incidents. This detection capability would have to be expanded through outside assistance (mutual aid/Federal assistance) in an actual incident. The HazMat Unit has a number of detection devices for chemical agents. There is, however, no single detection device that will detect all chemical agents and there are also operational limitations to detection equipment. For example, the M256A1 detector kit can detect nerve, blood, and blister agents but does not detect choking agents such as chlorine. Additionally, the M256A1 detector can take up to 15 minutes to use. Other chemical detection equipment such as the Cam/ICAM, Saw Minicad, and the APD 2000 are able to detect specific classes of chemical agents faster than the M256A1 but are not as sensitive to these extremely toxic agents. Considering that the members operating this detection equipment would normally be outfitted in Level A chemical suits, the actual time from on-scene arrival to the detection of chemical agents could be substantial.

The recognition of signs and symptoms exhibited by victims exposed to chemical warfare agents can also be utilized as an initial means of agent identification. This is critically important in chemical incidents because decontamination of chemical casualties should be undertaken as soon as possible to have a meaningful effect. In most cases recognition of signs and symptoms of exposure to biological or radiological agents would not be an on-scene detection option because of the delay in the onset of symptoms in these types of incidents. A nuclear detonation would be an exception to this broad

generalization. The following two tables present signs and symptoms that would be present following exposure to chemical warfare agents. The recognition of these signs and symptoms may provide the first indication of the type of incident that responders are challenged with. Additionally, the initial signs and symptoms presented by victims of chemical agent exposure may be the most important indicator for the need for decontamination, and decontamination efforts should not be delayed while more definitive identification efforts are undertaken. Two tables with signs and symptoms for chemical agents are provided. Table 1 lists the signs, symptoms, and characteristics of chemical agents as well as the Department of Transportation identification number and guide number for the specific agents. Table 2 is a Hazardous Material Task Force checklist that utilizes observation and questioning of victims to preliminarily determine the most probable chemical agent that victims may have been exposed to.

TABLE 1

Signs and Symptoms of Chemical Warfare Agent Exposure

Agent **CLASS** Symbol/Name	Signs/Symptoms	Characteristics	DOT ERG2000	
			ID #	Guide #
Nerve GA (Tabun) GB (Sarin) GD (Soman) VX	Pinpoint pupils Dimness of vision Runny nose/salivation Tightness of chest Difficulty breathing Twitching or paralysis Vomiting Loss of consciousness Urination/defecation Death	Respiratory dose effective within seconds to minutes Skin dose effective in minutes to hours Extremely toxic lethal agents	2810	153
Blister H HD HN (Also called Mustard)	Reddening of skin Blisters Eye pain and reddening Coughing Airway irritation	Eye effects may appear in a few hours, respiratory effects and blisters in 2-24 hours. Can be lethal in large doses	2810	153
Vesicant L (Lewisite)	Immediate pain or irritation of skin Other symptoms similar to the mustard agents	Immediate pain. Other symptoms in about 12 hours. Can be lethal in large doses	2810	153
Vesicant CX (Phosgene Oxime)	Immediate burning Weal-like skin lesions Eye and airway irritation	Immediate pain. Other symptoms shortly thereafter. Lethal in large doses	2811	154
Blood AC (Hydrogen Cyanide) CK (Cyanogen Chloride)	Cherry red skin or lips Rapid breathing Dizziness Nausea, vomiting Headache Convulsion Death	Can cause death in 6-8 minutes	1051 1589	117 125
Choking CG (Phosgene) Chlorine	Eye and airway irritation Dizziness Tightness of chest Delayed pulmonary edema	In very high doses, can result in death after several days	1076 1017	125 124

TABLE 2

DISTRICT of COLUMBIA FIRE and EMS DEPARTMENT
HAZMAT TASK FORCE
CHEMICAL AGENT VICTIM INTERVIEW

The following questions will help determine which chemical warfare agent the victim may have been exposed. Answer questions 1 to 5 based on your observations of the patient, and 6 to 19 on the patient's responses. Check ( ) ***all open boxes*** next to each question that has an ***affirmative*** response. After all questions have been answered, add the number of marks in each column. The column with the most marks indicates the most probable agent; Nerve, Blister, Choking, Blood, or Pepper.

1. Are the victim's respirations over 20 per minute?					
2. Is the victim drooling?					
3. Has the victim urinated?					
4. Is the skin getting red or purple?					
5. Does the victim have blisters?					
6. Are you having trouble breathing?					
7. Are you having any problem with your eyes?					
8. Do you have gas pains in your stomach?					
9. Have you vomited?					
10. Are you dizzy?					
11. Did you smell pepper?					
12. Did you smell chlorine like at a swimming pool?					
13. Did you smell hay?					
14. Did you smell bitter almonds?					
15. Did you smell garlic, onions, or mustard?					
16. Did you smell geraniums?					
17. Did you smell fruit?					
18. Did you smell camphor or "moth balls"?					
19. Did you smell sulphur or rotten eggs?					
Add the marks in each column.	NERVE	BLISTER	CHOKING	BLOOD	PEPPER

Personal Protective Equipment:

The Department has equipped a number of companies with chemical protective suits, chemical resistant boots, and chemical resistive gloves. This equipment is intended for use in the warm zone on incidents involving WMD material. While this equipment provides protection from chemical and biological agents, it does not protect the responders from exposure to most radiation sources. Time, distance, and shielding measures should be utilized to protect response personnel in incidents involving radioactive material.

A study conducted by the U.S. Army Soldiers Biological Chemical Command titled "*Guidelines for Incident Commander's Use of Fire Fighter Protective Ensemble (FFPE) with Self Contained Breathing Apparatus (SCBA) for Rescue Operations During a Terrorist Chemical Agent Incident,*" indicates that **standard PBI firefighting gear with SCBA can provide some protection in WMD incidents involving chemical warfare agents.** This study offers two general principles. The first general principle is, **"Standard PBI turnout gear with SCBA provides a first responder with sufficient protection from nerve agent vapor hazards inside interior or downwind areas of the hot zone to allow 30** minutes rescue time for known live victims." The second general principal is, **"Self-taped turnout gear with SCBA provides sufficient protection in an unknown nerve agent environment for a 3-minute reconnaissance to search for living victims (or a 2-minute reconnaissance if HD [blister agent] is suspected."** Incident Commanders should be aware that this study assumes the following. "Rescue entry occurs after vapor concentration has peaked (assumed approximately 10 minutes after release of agent)" and " The firefighter performing reconnaissance will exhibit no more than threshold symptoms of nerve agent exposure (dim vision, headache, eye pain)."

Respiratory Protection:

SCBAs are a critical component of respiratory protection and should be worn in all WMD incidents whenever possible. The Department has equipped some units with Air Purifying Respirators (APRs) with the NBC canister filter (C2A1). These APRs should only be utilized when specifically authorized by the Incident Commander. Incident Commanders should be fully aware of the fact that APRs **do not** provide universal respirator protection and there are significant limitations to their use. APRs **do not** provide adequate protection in atmospheres that are classified as Immediately Dangerous to Life and Health (IDLH), which includes oxygen deficient atmospheres. APRs should **not** be utilized in the hot zone. Additionally, APRs should only be utilized when the agent or agents have been identified and it has been determined that the NBC canister filter provides protection from the specific agents identified. Incident Commanders should authorize the use of APRs only for use in the warm zone in full-scale incidents that overwhelm the Department's ability to maintain respiratory protection with the use of SCBAs. Guidance should be sought from the HazMat Unit or other technically competent authority before authorizing the use of APRs. Once authorized, only trained personnel should use APRs.

Positive Pressure Ventilation:

Positive Pressure Ventilation (PPV) fans can be useful in incidents involving chemical warfare agents. PPV fans can be utilized to reduce chemical agent vapors in structures thereby increasing the level of protection afforded to rescue personnel and reducing further exposure to any incapacitated victims. Negative pressure ventilation using PPV fans is also an option when victims are present in interior rooms with the doors closed. PPV operations can potentially create extremely hazardous downwind hazards and Incident Commanders should carefully evaluate this risk prior to authorizing the use of positive pressure ventilation

Decontamination:

The purpose of victim decontamination in WMD incidents is to remove chemical/biological agents or radioactive material/debris from the victim thereby limiting further exposure. Decontamination also serves to protect the emergency responders, the medical community, and the general public from secondary contamination and allows the victim to be processed through the emergency medical system without extraordinary precautions. The prompt removal of WMD agents from the victim is more important than the method of removal and the fire service will find that in most cases flushing and showering with water will be the most expeditious method to decontaminate large masses of victims. Decontamination flushing/showering times are incident specific and are influenced by agent type, level of contamination, clothing type and other factors with recommended flushing/showering times being 2 to 3 minutes under ideal situations. A high volume, low-pressure application of water is the preferred method. Water runoff should be contained if practical, but becomes a secondary issue in incidents where immediate mass decontamination is indicated and runoff containment is not practical or delays the decontamination process. Privacy issues are major concerns for many people and steps to provide privacy should be vigorously undertaken. Both the HazMat Support Unit and the Decon Support Unit carry privacy tents. Water heaters and tent heaters are also available and should be used in mild/cold weather to prevent hypothermia.

Chemical Incidents:

In incidents involving chemical agents, victim decontamination should begin immediately ~~(within minutes) to be most effective. The initial signs and symptoms presented by the~~ victims exposed to chemical agents maybe the most important indicator of the need for decontamination, and decontamination efforts should not be delayed while more definitive identification efforts are undertaken. Decontamination should be accomplished by the removal of the victim's clothing (at least to the undergarment level), followed by flushing/showering with water. The removal of a victim's clothing contaminated with chemical agents is very important as up to 80 percent of the contamination maybe removed by disrobing. The wetting of clothing contaminated with liquid agent prior to its removal may facilitate the transfer of the liquid agent to the skin and should be avoided.

Biological Incidents:

In biological incidents, the need for victim decontamination may or may not be indicated. Since biological agents are relatively slow acting and have relatively long incubation periods, (1-5 days for anthrax and 7-17 days for smallpox), the decision to decontaminate victims can be minimally delayed while incident information is gathered/evaluated and public health officials contacted. Victims should remain at the scene in a separate area removed from the reported source of exposure while the need for decontamination is determined. Normally, victim decontamination would only be indicated in incidents where there was a known or suspected dissemination site and where victims came in physical contact with the suspected agents. Physical contact with agents could result from exposure to spray/aerosol devices or the handling of the suspect material. When indicated, decontamination should be accomplished by first wetting victims down with their clothing on to minimize the re-aerosolization of biological agents. Outer clothing should then be removed and double bagged, and the victim should shower with soap and water. If available at the incident site the use of fixed facility showers should be considered. In the unlikely event that mass decontamination is indicated and there are no/inadequate fixed facility showers available, victims should be processed by mass decontamination methods.

Nuclear/Radiological Incidents:

The need for decontamination in nuclear/radiological events is also incident specific. Radiological detection devices should be employed to determine if victims are contaminated with radiological material. When indicated, the purpose of victim decontamination is the removal of radioactive material/debris from the victims clothing, shoes, skin, hair, etc. thereby eliminating further exposure. A nasal swab should be taken from each victim prior to decontamination. This nasal swap should be bagged and tagged with the victim's name so that later medical analysis can determine the potential level of respiratory exposure the victim may have been subjected to. Decontamination should be accomplished by first wetting victims down with their clothing on, so that the radioactive material/debris will adhere to the victims clothing. Clothing should then be removed and showering/flushing begun to remove any remaining contamination from the skin and hair. Water runoff from decontamination efforts in nuclear/radiological incidents should be contained if at all possible due to the potential long-term environmental contamination.

Mass Decontamination Methods:

Normally, decontamination of victims is handled by the HazMat Task Force, which has access to portable decontamination showers, privacy tents, water heaters, tent heaters, redress, and runoff containment pools. Additionally, most First Battalion companies are also equipped with portable decontamination showers. In the event that large numbers of victims need to be decontaminated in a short period of time and the normal

decontamination process becomes overwhelmed, the following methods should be utilized:

1. Master Stream Decontamination

The application of a high volume, low pressure water spray utilizing an arrangement of ladder pipes, wagon pipes, monitor nozzles, and 2 ½" fog nozzles attached directly to pump discharges can be configured to provide a very effective decontamination corridor. The actual configuration will be dependent on the specific apparatus used and the following is a basic example of how this could be accomplished. Two engine companies would be positioned approximately 15 feet apart and a decontamination corridor between the apparatus would be formed. Two and one half-inch (21/2") fog nozzles, set at a wide fog pattern, would then be attached to the pump discharges. A truck company would be positioned inline with one of the engine companies and a fog nozzle placed on the ladder pipe. The ladder would be slightly elevated and rotated to provide a downward fog pattern in the corridor created by the placement of the two engine companies. Hydrant pressure only should be enough to provide a high volume; low-pressure shower and care should be exercised to prevent injuries from over pressurization. Additional companies may be similarly added to this corridor as well as deploying wagon pipes and monitor nozzles with the desired effect being a very thorough drenching of the ambulatory victims as they are processed through this decontamination corridor. Firefighters operating Master Stream Decontamination sites should utilize chemical protective PPE if available, but may utilize full firefighting gear including respiratory protection if the decontamination site is upwind of the incident site and no direct contact is made with the ambulatory victims until after they have been decontaminated. Utilize butyl gloves if available from the HazMat Support Unit or other source.

2. Covered Wagon Decontamination System

The Corridor Decontamination System utilizes fire apparatus and salvage covers to create a privacy barrier and corridor to process victims through for decontamination. This procedure is accomplished by parking fire apparatus approximately 12 feet apart and parallel to each other, and then suspending and securing a rope (lifeline) across the top of the apparatus in several places. Salvage covers are then draped over the ropes to provide a privacy screen with an opening to process victims. A salvage cover may also be deployed to cover the top opening when operating around tall buildings to provide maximum privacy. Victims are processed through this corridor by attending firefighters who decontaminate the victims by hosing them down with a small line after they have had their clothing removed and bagged. This system is suitable for non-ambulatory victims. Firefighters operating Corridor Decontamination System sites should wear chemical protective gear with respirator protection because of their direct contact with contaminated victims.

3. Improvised Decontamination Systems

A gated wye with a playpipe directly attached to one of the discharges can be connected to a 21/2" opening on a hydrant. By adjusting the angle of the gated wye as well as the fog pattern on the playpipe, an effective stream for decontamination can be formed when the hydrant is opened. Sprinkler heads in parking garages etc. can also be activated to serve as decontamination showers if the location is suitable and the water runoff does not create additional problems.

4. Technical Decontamination

Technical Decontamination is the system of decontamination that is normally employed by the Hazardous Material Unit. This system consists of several manned rinsing and flushing stations as well as containment pools and will be set up by Hazardous Material Task Force companies who are familiar with this equipment. This system, or an abbreviated version, should be employed as the primary method to decontaminate Fire and EMS personnel who have made entry to the hot zone or who have otherwise become contaminated. This decontamination system should be deployed separately from the main civilian decontamination corridors to insure that members making hot zone entries, or who have otherwise become contaminated, will have an unimpeded and expeditious means to be decontaminated.

Multiple Decontamination Sites:

In a WMD incident many victims may attempt to flee the area and independently seek emergency medical care at area hospitals, clinics and other medical facilities. Few of these facilities have decontamination equipment or the protective gear to safely decontaminate victims. First Battalion companies that have been equipped with portable decontamination showers may be dispatched directly to these facilities to conduct decontamination of self-referring victims.

INITIAL ON SCENE ACTIONS

First Due Engine:

1. With the exception of the First Due Engine Company, all other units dispatched on a WMD incident should initially stage at one location a minimum of 2 blocks upwind/uphill of the reported incident. If explosive material is involved, stage a minimum of 1500 feet away.
2. The First Due Engine Company shall cautiously approach the incident scene from upwind/uphill and shall stop a minimum of 500 feet from the incident site or where casualties or damage are first encountered and shall begin serving as a reconnaissance company.
3. A general size up report from this location shall be given to the Incident Commander.

4. All of the First Due Engine Company's personnel shall don full firefighting gear including SCBAs and attempt to gather as much information as possible about the incident without directly exposing company personnel to suspected hazards. If necessary, this company may approach closer to the incident scene to obtain more information but should always maintain enough distance so as not to become part of the incident. Direct contact with victims and unknown liquids should be avoided. From this position, the First Due Engine Company should notify the assigned Incident Commander of the following:

    a. Conditions found on arrival.
    b. Apparent need for rescues.
    c. Gross estimated number of victims.
    d. Need for emergency medical services.
    e. Fire control problems.
    f. Signs and symptoms of victims (per signs/symptoms chart).
    g. Need for victim decontamination.
    h. Information from victims (without making direct contact).
    i. Information from law enforcement agencies if already on the scene.
    j. Accounts from bystanders as to what they observed.
    k. Building collapse and structural stability problems.
    l. Recommendations for ingress and egress routes.
    m. Additional information as requested by the Incident Commander.
    n. Deny entry and safely isolate the area while awaiting orders from the Incident Commander.

Incident Commander:

The Incident Commander will size up the incident utilizing all available information and will determine the strategic deployment of Fire and EMS personnel. Refer to the Incident Command Considerations in this Bulletin for guidance on appropriate actions. Immediate consideration should be given to the following suggested actions:

1. isolate area/deny entry
2. request additional resources
3. direct ambulatory victims to a safe refuge area
4. conduct snatch and grab rescue operations if feasible
5. identify agent or agents through signs and symptoms and detection devices
6. begin victim decontamination
7. ~~establish triage/treatment/transportation areas~~
8. reevaluate hazard area/ evacuate downwind if indicated

ADDITIONAL RESOURCES

An actual WMD incident with mass casualties will quickly overwhelm the response capability of the District of Columbia Fire and EMS Department. Additional assistance from fire, EMS, and hazardous material units should be immediately requested through our mutual aid agreements with our surrounding jurisdictions. Additionally, the NMRT team should be activated. The following is a partial list of additional resources that may be needed in a WMD incident. This resource list is in addition to resources such as the American Red Cross and the Federal Emergency Management Agency, which would normally be requested in any large-scale disaster. The response time for the deployable assets listed below vary greatly but generally most resources have lengthy response times (2-24 hours) unless they are pre-deployed for special events or specific credible threats. The authorization for deployment of some of these assets may require a formal disaster declaration by city and federal officials.

U.S. Marine Corps Chemical Biological Incident Response Force (CBIRF)
Can provide a response force for WMD incidents that can provide assistance in victim decontamination, agent identification, downwind hazard prediction, medical treatment, casualty reconnaissance, patient evacuation, ordinance disposal, and security.

Chemical/Biological Rapid Response Team (C/B-RRT)
Can provide a response force to detect, neutralize, dismantle and dispose of chemical or biological weapons and related material. This team is preceded by the Technical Escort Unit's Chemical Biological Response Team, which is then augmented by this larger response force.

U.S. Army Technical Escort Unit (TEU)
Can provide a small response force (usually 4 men) that has the capability of rendering safe, disposing, sampling verification, mitigating hazards and identifying weaponized and non-weaponized chemical, biological and hazardous materials.

Centers for Disease Control and Prevention (CDC)
Can provide assistance in assessing incident effects and developing strategies for public health aspects of an emergency as well as making recommendations to protect the health of emergency workers. The CDC through the Emergency Response Coordination Group of the National Center for Environmental Health can provide assistance in the identification of chemical and biological contaminates

Disaster Medical Assistance Team (DMAT)
These response teams can provide medical support for mass-casualty incidents. As part of the National Disaster Medical System these teams are designed to provide medical attention to the sick and injured when the local emergency response system becomes overwhelmed.

U.S. Department of Energy (DOE)
The DOE maintains a number of radiological response assets such as the Aerial Measuring System, which can detect, measure, and track radiological material in an emergency to determine contamination levels.

Nuclear Emergency Search Team (NEST)
This response team, which is part of the U.S. Department of Energy (DOE) response assets, can provide on-site technical assistance on incidents involving nuclear or radiological material. This team is able to search for, locate and identify devices or materials; move, render safe or disable devices; and mitigate damage from device detonations.

Environmental Protection Agency (EPA)
The EPA can provide assistance in monitoring and assessment, protective action guidance, and help with coordinating federal cleanup responses. The EPA also maintains fixed and mobile labs for chemical, biological and radiological analysis.

U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID)
Can deploy an Aeromedical Isolation Team capable of caring for and transporting patients with diseases caused by either biological warfare agents or infectious diseases requiring high containment

National Urban Search and Rescue Response System (US&R)
US&R teams can respond to disasters to locate and rescue victims of structural collapse. There are 27 teams nationwide, with two teams (Fairfax County, VA and Montgomery County, MD) located in the Washington, DC area.

Disaster Mortuary Teams (DMORTS)
DMORT teams are part of National Disaster Medical System and can provide personnel to identify and process deceased victims.

DISTRICT OF COLUMBIA FIRE & EMS DEPARTMENT

October, 2001 Bulletin No. 68

Standard Operating Guidelines for Response to Bombing Incidents

PURPOSE

To provide information and initial guidance to incident commanders and company personnel on bomb threats and bombing incidents.

POLICY

The Fire and EMS Department's role in bombing incidents as well as bomb threats should be limited to the delivery of rescue activities, emergency medical services, fire suppression activities, assisting the police with initial perimeter control, and evacuations. The decision to deploy Fire and EMS units in these types of incidents shall be made by the Incident Commander. Incident Commanders shall perform a quick initial risk assessment of the situation and may deploy Fire and EMS units into the area if immediate rescue needs are evident. Communication and coordination with law enforcement agencies shall be established and maintained to ensure the maximum degree of safety for Fire and EMS responders. Once rescue activities have been completed, Fire and EMS units should be withdrawn from the area until a more comprehensive risk assessment has been completed and the risks to Fire and EMS personnel have been minimized.

Fire and EMS personnel should not be utilized to conduct searches for explosive devices or be involved in any activities that involve the movement or disarmament of explosive devices. Law enforcement or military units shall conduct these types of activities. The Hazardous Material Unit may however, be deployed to assist law enforcement agencies in determining if the incident site has been contaminated with chemical, biological or radiological material. Self contained breathing apparatus shall be utilized at all bombing incident sites until it has been determined that this level of respiratory protection is not needed. All emergency responders should be constantly aware of the possibility that primary and secondary explosive devices may be present at incident sites as well as staging areas. Incident Commanders should consider that secondary devices might be located in the obvious areas for staging and command post locations. Consider locating the staging area and command post in a second choice location until the preferred areas are swept for secondary devices.

Bulletin No. 68
October, 2001

BOMB THREATS

Dispatch:

The minimum response to a bomb threat shall be (1) Engine Company, (1) Truck Company, Rescue Squad, Battalion Chief, EMS Unit, and EMS Supervisor.

Staging:

Units shall stage at one location, a minimum of 1500 feet from the incident. This distance may be increased or decreased as more information about the specific threat becomes known. Use the table provided by the FBI for guidance in determining appropriate standoff distances. Units should not stage in direct line of sight of the incident and shall position themselves, if possible, behind buildings or natural barriers and away from glass windows. Incident Commanders may consider staging units at fire stations once contact with police officials have been established.

Communications:

1. If a suspected device is located at the incident site or a device is detonated while units are in staging, all officers and members shall not transmit on mobile or portable radios within 500 feet of the incident site. Additionally, Mobile Data Terminals (MDTs) shall not be activated within 500 feet of the incident site. All Department issue portable and vehicle mounted cellular phones, as well as personal cellular phones must be turned **OFF** when operating within 500 feet of the incident.
2. While in the **staging** area, mobile and portable radios, Mobile Data Terminals (MDTs), and cellular phones may be used.
3. After the incident scene and staging areas have been swept for primary/secondary devices, normal radio operation can resume.

Actions:

1. The Battalion Chief or Chief's Aide shall make contact with a police official on the scene in order to determine the current situation.
2. Communication and coordination with law enforcement agencies shall be maintained throughout the incident.
3. No Fire and EMS units shall be deployed from the staging area unless directed by the Battalion Chief.
4. Establish Level 3 Accountability.
5. Fire and EMS resources may be deployed to assist law enforcement agencies with evacuations and initial perimeter control if the situation warrants.
6. Request for assistance from law enforcement agencies may be granted consistent with the Department's limits on the involvement of Fire and EMS personnel in bombing incidents.

Bulletin No. 68
October, 2001

BOMBING INCIDENTS

Dispatch:

The minimum response to a bombing incident shall be a Box Alarm assignment including a Cave-In Unit Task Force, HazMat Task Force, Mass Casualty Unit, EMS Unit, EMS Supervisor, and the Safety Officer.

Staging:

Units, with the exception of the first due engine company, shall initially stage at one location a minimum of 1500 feet from the incident. Units shall not stage in direct line of sight of the incident and shall position themselves, if possible, behind buildings or natural barriers and away from glass windows. As more information about the incident becomes known, staging distances maybe increased or decreased. Consideration should be given to multiple staging areas to facilitate concurrent operations. Request to law enforcement agencies to have the staging areas searched for secondary devices should be made as soon as possible. Incident Commanders are reminded that there are a number of law enforcement agencies in Washington, D.C. that have the capability to sweep for explosive devices.

Communications:

1. Members shall not transmit on mobile or portable radios within 500 feet of the incident site.
2. Department issue portable and vehicle mounted cellular phones as well as personal cellular phones must be turned **OFF** when operating at or within 500 feet of the incident.
3. Mobile Data Terminals (MDT) must **not** be activated within 500 feet of the incident.
4. Field command phones can be used at the incident site
5. Attempt to secure hardwire telephone lines.
6. Utilize runners to communicate between companies at the incident site until a sweep for secondary devices has been completed.
7. Consider using secure communication equipment for command level personnel if available from Federal sources.

Initial On Scene Actions:

1. The first due engine company shall cautiously approach the area and shall stop a minimum of 500 feet from the incident scene or where debris/damage is first encountered.
2. A size-up report from this location (at least 500 feet from the scene) shall be given on the tactical channel per current radio procedures

3. The first due engine company shall then contact the Battalion Chief and give a more detailed reconnaissance report covering the following items:
    a. obvious rescues
    b. number of apparent victims and need for emergency medical services
    c. fire control problems
    d. building collapse and structural stability problems
    e. information from law enforcement authorities if already on the scene
    f. recommended ingress and egress routes
    g. evacuation needs
    h. perimeter control needs

Incident Commander:

The Battalion Chief will size up the incident utilizing the information received from the first due engine company and will then determine the level and extent of the deployment of Fire and EMS personnel and equipment.

Actions:

1. The Battalion Chief or Chief's Aide shall make contact with a police official on the scene in order to determine the current situation.
2. Communication and coordination with law enforcement agencies shall be maintained throughout the incident.
3. Perimeters and exclusionary zones shall be established.
4. Ambulatory victims shall be directed away from the immediate incident site to minimize exposure to secondary devices.
5. Snatch rescues may be undertaken if in the opinion of the Battalion Chief the risk is warranted.
6. Determine if the incident site has been contaminated with chemical, radiological or biological contaminates. The Hazardous Material Unit may be deployed to assist law enforcement agencies in making this determination.
7. If the incident site has been contaminated with chemical, radiological, or biological material, take the following actions:
    a. notify all involved agencies
    b. determine appropriate levels of personal protective equipment
    c. reevaluate perimeters
    d. begin appropriate decontamination of victims and emergency responders
    e. notify receiving hospitals
    f. request specialized resources
    g. refer to "Weapons of Mass Destruction" bulletin for additional guidance
8. Require personnel to wear full personal protective equipment including SCBA until determined otherwise.

9. No Fire and EMS units shall be deployed from the staging area unless directed to by the Battalion Chief.
10. Egress and ingress routes shall be established to facilitate victim and responder movement. Assistance in securing these routes may be requested from law enforcement agencies.
11. Request needed specialized resources, both from within the Department as well as those resources available through mutual aid agreements.
12. If needed, notify Communication Division of a mass casualty incident so that hospital resources will be on increased readiness.
13. Minimize number of responders committed to hazard areas.
14. Control utilities (electric, natural gas) in damaged area if necessary with assistance of the utility companies.
15. Maintain the crime scene and provide needed assistance to law enforcement agencies.

Personal Protective Equipment:

Members operating at the bombing incidents shall initially wear full protective equipment including SCBA. This level of personal protective equipment maybe increased or decreased depending on whether chemical, biological or radiological contaminants are involved. Consider using First Battalion Companies if higher levels of personal protective equipment are required.

Media:

Request for information about the incident should be coordinated with other involved agencies. If the Fire and EMS Department is involved in specialized activities such as structural collapse or hazardous materials, a technically competent Department member should assist the public information officer with technical questions.

Additional Resources:

There are a number of specialized resources that are available to assist in bombing incidents. Both Montgomery County, Maryland and Fairfax County, Virginia maintain Urban Search and Rescue Teams that could be of assistance in structural collapse incidents and are readily available through our mutual aide agreements. The National Medical Response Team (formerly called MMST) could provide medical assistance in bombing incidents as well as decontamination in chemical, biological and radiological incidents. In a major event, numerous federal assets are available through the Federal Response Plan. The Communication Division should direct requests for federal assistance to the District of Columbia Emergency Management Agency. The Federal Bureau of Investigation will serve as the lead federal agency in the crisis management phase of a terrorist bombing incident. Assistance in obtaining federal resources may be provided by this agency.

Bulletin No. 68
October, 2001

FBI Bomb Threat Stand-Off Table

Provided by the FBI National Capital Response Squad/Joint Terrorism Task Force

Threat Description	Explosive Capacity *1 (TNT Equivalent)	Building Evacuation Distance *2	Outdoor Evacuation Distance *3
Pipe Bomb	5 LBS/ 2.2 KG	70 FT/ 21 M	850 FT/ 259 M
Briefcase/ Suitcase Bomb	50 LBS/ 22.7 KG	150 FT/ 46 M	1,850 FT/ 564 M
Compact Sedan	500 LBS/ 227 KG	320 FT/ 98 M	1,500 FT/ 457 M
Sedan	1,000 LBS/ 450 KG	400 FT/ 122 M	1,750FT/ 534 M
Passenger/ Cargo Van	4,000 LBS/ 1,814 KG	640 FT/ 195 M	2,750 FT/ 838 M
Small Moving Van/Delivery Truck	10,000 LBS/ 4,536 KG	860 FT/ 263 M	3,750 FT/ 1,143 M
Moving Van/ Water Truck	30,000 LBS/ 13,608 KG	1,240 FT/ 375 M	6,500 FT/ 1,982 M
Semi-Trailer	60,000 LBS/ 27,216 KG	1,570 FT/ 465 M	7,000 FT/ 2,134 M

All personnel must either seek shelter inside a building (with some risk) away from windows and exterior walls, or move beyond the Outdoor Evacuation Distance.

*1 Based on maximum volume of weight of explosive (TNT equivalent) that could reasonably fit in a suitcase or vehicle.

*2 Governed by the ability of an unstrengthened building to withstand severe damage or collapse.

*3 Governed by the greater of fragment throw distance or glass breakage/falling glass hazard distance.

Note that pipe and briefcase bombs assume cased charges which throw fragments farther than vehicle bombs.

DISTRICT OF COLUMBIA
FIRE AND EMERGENCY MEDICAL SERVICES DEPARTMENT

March 2003 **F.D. BULLETIN NO. 70**

First Responder Radiological Guidelines

The intent of this bulletin is to:

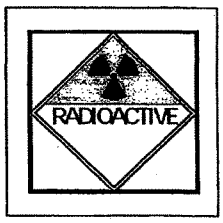
- Provide initial personal protective actions
- Provide guidance as to when to utilize radiological detection equipment
- Provide basic operating instructions for First Responder detection equipment
- Provide guidance as to permissible radiation limits
- Provide guidance at when to "declare an incident"

First Responder Actions

Arrival on Scene:

On incidents dispatched or suspected of being radiological events, follow basic hazardous materials response guidelines, including approach upwind, stop a safe distance away, and utilize binoculars to attempt to identify hazards. The DOT Emergence Response Guide (ERG), carried by all units, contains radiation information in various guides.

Note: Treating medical problems of victims should take priority over radiological concerns, after taking necessary steps to safeguard yourself. Do not delay rescue or transport of a seriously injured, contaminated patient, however if transported to a hospital with possible contamination, the hospital must be notified. To prevent further spread of contamination, victims shou ld be wrapped in a sheet prior to transport.



Radiological Detection Equipment shall be utilized:

- Anytime a unit comes upon the aftermath of any type of explosion
- Any response to a facility which is known to use and/or store radiological materials

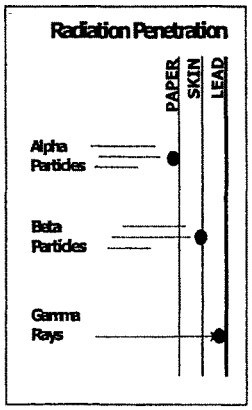
- Anytime a unit responds to a site and/or vehicle and discovers radiological placards or markings
- Anytime circumstances dictate further investigation.

Two major concerns regarding radiation are:

- Radioactive sources which are intact and emitting radiation, however can be easily isolated.
- Radioactive sources which have been dissipated as particle contamination, which can spread beyond the original source, and cause external contamination (skin & clothing) and internal contamination (inhaled).

Personnel Protective Actions:

- Don respiratory protection until the possibility of airborne radiation contamination is eliminated in suspected incidents (SCBA)
- APR w/NBC canister can be utilized in non-IDLH environment only or when directed by IC based on Hazmat survey of air quality. However, when no SCBA is available, place APR in service.
- Don Tychem SL suit (Go bag) which can be easily deconned. Running gear should be used as a last resort, unless there is a fire hazard.
- Establish control zone
- Use ALARA principles; keep potential radiation exposures "As Low As Reasonably Achievable".
- Time, Distance & Shielding (TDS) principles should be utilized:
    - Time: The shorter the time in a radiation field, the less the radiation exposure.
    - Distance: The farther a person is from a source of radiation, including uphill and upwind, the lower the radiation dose.
        - Example:
            - 100mR/hr at 10ft
            - reduces to 25mR/hr at 20ft
            - reduces to 6.25mR/hr at 40ft
- Shielding: Whenever possible, shielding offered by barriers (vehicles, walls, PPE, etc.) can reduce radiation exposure.



The three main types of radiation are:

- Alpha – particles cannot travel more than a few inches. Will not penetrate the skin. However, if ingested through eating, drinking or breathing contaminated material, they become an internal hazard, causing damage to internal organs.
- Beta – travel further than alpha, however will not penetrate through the skin. Can enter the body through open wounds or ingestion. Normally considered a slight hazard, however large amounts for long periods of time can cause skin burns.
- Gamma – pure energy and the most penetrating type of radiation, capable of passing through most materials. Gamma can travel a mile in open air. This creates a problem for responders, as gamma rays can attack all tissues and organs.

Measurement of Radiation

This information is being supplied in a simple format, without attempting to give the in-depth meanings of the different measurements utilized. This information is supplied so as to understand the readings reflected on meters utilized within the Department.

R = RAD/REM (1R) mR = milli RAD/REM (.001R)
All values are expressed in the dose per hour. Accordingly, at a rate of 60 R/hr, if you made an entry to save a victim and were in the zone for 2 minutes for the extraction, you would receive a dose of 2/60 of the rate or 2 rem.

DCFEMS ESTABLISHED LIMITS	
Normal background (naturally occurring) radiation levels	**0 -.05 mR/hr**
Request for Haz Mat Unit for further investigation (1x setting)	**0.1 mR/hr**
Request for Haz Mat Task Force & declare incident (1x setting)	**0.5 mR/hr**
Hot Line Established (1x setting)	**0.5 mR/hr point**
Turn back dose rate (except lifesaving)	**10 R/hr**
Turn back dose rate (even for life saving)	**200 R/hr**

FDB 70

EPA Emergency Action Dose Guidelines Page 4

Dose Limit (whole body)	Emergency Action Dose Guideline for Activity
5 rem	All activities
10 rem	Protecting major property
25 rem	Lifesaving or protection of large populations
> 25 rem	Lifesaving or protection of large populations – Only by volunteers who understand the risks

If you look at the 25 rem dose and compare it with the 200 R/hr turn back above – you can go into an area just below 200 R/hr and operate within limits for approximately 7 ½ minutes. (200/25 = 60/x minutes) However ALARA principles should always be utilized, and distance and shielding will decrease this exposure.

Initial exposure limiting protective actions:

- **.5mR/hr** should be established as the initial exclusion zone
- Establish Level III Accountability with a single entry point/check point
- **10 R/hr** is the turn back dose rate **except for life saving**
- **200 R/hr** is the turn back dose **even for lifesaving**
- Any personnel evacuating the hot zone shall be held at the checkpoint until checked for contamination with a Ludlum meter to determine the need for decon (except those requiring immediate medical attention).

Request for Hazardous Materials Response:

- A reading of **0.1mR/hr** or higher should be investigated further by requesting the Hazardous Materials Unit.
- An incident shall be declared for any readings of **0.5mR/hr** or higher. This shall cause the response of the Hazardous Materials Task Force, for further evaluation.
    - Emergency Management should be notified through communications, and this action should cause other essential notifications to be made, including a request for the D.C. Radiological Response Team

Issued Equipment

All radiation equipment should be inspected and tested weekly (Sunday) and drilled on monthly by each platoon.

Radiological Survey Equipment Ready Checks

Prior to the use of any radiological equipment, an equipment check must be performed that involves the following:

1. Check the instrument for obvious physical damage.

    A. Look at the face of the detector for punctures or cracks and condensation under the faceplate.

    B. Check the main body for cracks and an uneven seal at seams.

    C. Check the cables for tight connections, kinks in cable coverings, and damage to male/female connectors.

2. Make sure the instrument is calibrated.

    A. Has the calibration date expired?

    B. Is the meter out of calibration?

3. Check the power source.

    A. Check the charge of the batteries.

    B. Ensure that the contacts are clean.

4. Perform a check with a source or natural background radiation.

    A. Small radioactive check sources may not be available.

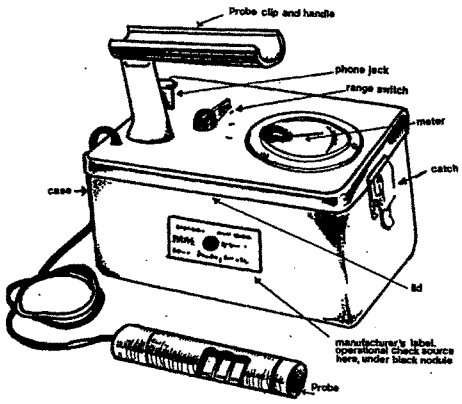
    B. Some meters can only be used with high levels of a source and cannot be used with natural backgrounds.

    C. Ensure that the readings obtained with background seem reasonable.

5. Review operation of survey equipment prior to entry.

First Responders

- Model CD V-700 low-range (0-50mR/hr) gamma detector. Can also detect high energy beta with the probe window open (within a few yards of source).

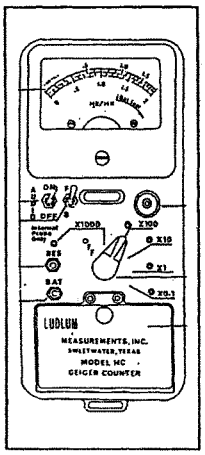


Scale Readings	
x1	0 - 0.5mR/hr
x10	0 - 5 mR/hr
x100	0 – 50 mR/hr

Check for fresh batteries (batteries should not be stored in meter). Turn on setting the selector to 10x. Allow 30 seconds warm up time. Check operation of meter placing probe with window open on check source on side of instrument. Check background radiation be moving selector to 1x and observe readings. Readings can now be observed as possible source is approached and increases in readings are observed. The headset can be utilized to listen to increases in meter activity when visual observance is not practical. (Refer to "Transport of Radioactive Materials", 3/00, for more detailed information).

~~**Haz Mat Unit, Rescue Squads & Special Operations (some Law Enforcement)**~~

- Sensor Technologies Pager-S gamma detectors
  - Note: The sources listed below may set off your pager. These readings may be normal background radiation. Pager-s readings of 1-3 are common. A reading of 6 or higher on the Pager-s is over the normal limit for background and should cause further investigation.
- APD2000 with Rad function (gamma radiation in mR)
- Ludlum Model 3 Survey Meter w/44-9 GM Pancake Probe (alpha, beta, gamma)



Haz Mat Unit & Special Operations

- Sensor Technologies gamma & neutron pager detectors

Haz Mat Unit

The Haz Mat Unit has a variety of detection devices that are above the capabilities of the detection equipment carried by firefighting companies and rescue squads. They carry equipment for that can detect alpha, beta, gamma and neutron radiation, along with identifying the isotope involved.

Radiological Surveys

Radiological surveys are performed to determine the extent of any existing health hazards, to establish control zones (hot, warm, and cold), and to gather data to determine decontamination procedures.

The following types of surveys may be performed at an incident location:

- Area Survey - Used to determine the fallout patterns on the ground area, levels of airborne activity, or contamination
  patterns to establish control zones.

- Personnel Survey - Used to detect the presence of contaminated material
  on the body's surface, in body openings, or contamination in open wounds.

- Equipment/material Survey - Used to determine decontamination of requirements.

Monitoring Techniques

When monitoring area suspected of being irradiated or contaminated, the monitoring must be done consistently. There are three different types of radiation, and each type requires a different monitoring technique.

Alpha requires the use of the pancake probe. The probe head is held about ¼ to ½ inch from the surface of the object and moved laterally at a rate of one probe-length per second. When utilizing the pancake probe, the screen like side is place toward the surface to be monitored. IT SHALL NEVER TOUCH THE SURFACE. To determine if alpha is present, move the move the pancake probe away form the surface of the object approximately six inches, as the distance increase, the reading shall become lower. If the reading remains constant there is a possibility of another type of radiation.

Beta requires the use of the pancake probe. The probe head is held about ¼ to ½ inch from the surface of the object and moved laterally at a rate of one probe-length per second. When utilizing the pancake probe, the screen like side is place toward the surface to be monitored. IT SHALL NEVER TOUCH THE SURFACE. To determine if beta is present, move the move the pancake probe away form the surface of the object approximately six inches, as the distance increase, the reading shall remain constant. At approximately six inches turn the pancake probe over so the solid (non screen side) is facing the surface of the object. If the reading remains constant there is a possibility of another type of radiation.

Gamma requires the use of the scintillator probe or hot dog probe . The probe head is held about ½ to 1 inch above the surface of the object and moved laterally at a rate about one to two inches per second with audio output on. IT SHALL NEVER TOUCH THE SURFACE. As the probe is moved away from the surface, readings should decrease along with an associated decrease in the audio tick rate. As the probe is moved toward the surface, readings should increase with an associated increase in the audio tick rate.
Note: Audio tone increases as the survey meter is moved close to the source and radiation becomes more intense. The audio increase or decrease is no indication of the strength of the source.

Presence of Radioactive Materials

Remember that radioactive materials are routinely used in medicine, industry and transported on commercial carriers (air, rail and ground), or through normal mail carriers. As long as these shipments meet all legal transportation shipping requirements and the radiation they give off is consistent with their shipping papers, labeling, or reported use, they can proceed without interference. If you encounter a *suspicious package,* isolate the package and request additional resources.

If you get radiation readings and cannot identify a legitimate reason for it, then you should consider it a potential hazard. Remember, many buildings and most Government buildings contain some of the products below (granite & marble).

- Medical Isotopes – These might be in a person's bloodstream or implanted as pellets and might trigger your pager. If the situation warrants, consider discretely inquiring about medical treatments the person may have had.
    - Iodine-131
    - Iodine-125
    - Molybdenum-99
    - Thallium
    - Technicium-99

- Items & products that may contain radioactive materials:
  - Agricultural products
  - Bananas (potassium-40)
  - Antique items (red, orange, yellow ceramic glaze & emerald green glass)
  - High quality optical lenses (camera lenses)
  - Radio-Luminescent Products (watches, clocks, instrument gauges
  - Dental ceramics
  - Irradiated gemstones
  - Lantern mantles
  - Polishing powders
  - Propane tanker trucks
  - Smoke detectors (Am-241)
  - Television sets
  - Thoriated aluminum (Th-232)
  - Thoriated tungsten arc-welding electrodes (welding rod)
  - Concrete, Feldspar, Fertilizers, Granite, Marble, Monazite sand, Sandstone, Slate
- Common Naturally occurring radioactive materials (gamma emitters):
  - Potassium (K-40)
  - Radium (Ra-226)
  - Thorium (Th-232)
  - Uranium (U-238)
- Sources commonly used in industry (may be of concern if misused)
  - Americium (Am-241)
  - Barium (Ba-133)
  - Cesium (Cs-137)
  - Cobalt (Co-57)
  - Cobalt (Co-60)
  - Iridium (Ir-192)
  - Radium (Ra-226)
  - Thorium (Th-232)
  - Soil density gauges & well logging sources (neutron sources)
- Isotopes of Major Concern:
  - Plutonium (Pu-239)
  - Enriched Uranium (U-235)
  - Uranium (U-233)
  - Neptunium (Np-237)

Decontamination

- Do not delay urgent medical care to carry out victim decontamination
- Always use respiratory protection when performing decon to avoid inhalation of re-suspended particles
- Use light weight disposable garments, including gloves while working
- Do not waste effort trying to contain contaminated water
- Do not allow monitoring and decontamination to delay evacuation from high or potentially high exposure areas
- Remove and bag outer clothing if evidence of contamination. Secure bags with contaminated clothing in an appropriate container.
- Wash all exposed skin & hair, or have victims shower
- Monitor decon line for contamination, including alpha
- Dry decon is best for small numbers, wet decon may be considered for large numbers of victims

Required Reading Material:

- "Transport of Radioactive Materials" by Federal Emergency Management Agency, March 2000
- Department of Transportation "Emergency Response Guidebook"

The above required reading should be the topic of a monthly drill, along with weekly inspection and testing of the issued equipment.

- Additional information is available in the EPA "Manual of Protective Action Guides and Protective Actions for Nuclear Incidents"
- Excellent independent study courses are offered through FEMA/EMI such as Radiological Incident Management and Radiological Emergency Response

Emergency Contact Numbers:

Emergency Management Agency	202-727-6161
Department of Energy, Office of Emergency Operations, Washington, DC	202-586-8100
Federal Bureau of Investigation (additional Federal assets)	202-278-2000

Critical Incident Stress Debriefing (CISD):

Any incident that involves exposure of employees to radioactive sources should be followed by a critical incident stress debriefing. The Department of Health has a Health Physicist who can be brought in to explain the long-term effects of radiation exposure.

SECTION 16

ISSUE DATE: 10-2001

REVISION DATE:

EMERGENCY MEDICAL SERVICES (EMS)

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Emergency Medical Services (EMS) Branch

Definition

The EMS Branch Structure is designed to provide the Incident Commander with a basic expandable system for handling any number of patients in a multi-casualty incident. One or more additional Medical Group(s) may be established under the EMS Branch Director, if geographical or incident conditions warrant. The degree of implementation will depend upon the complexity of the incident.

Modular Development

A series of examples of modular development are included to illustrate one possible method of expanding the incident organization.

Initial Response Organization

Initial response resources are managed by the Incident Commander, who will handle all Command and General Staff responsibilities. The first arriving resource with the appropriate communications capability should establish communications with the appropriate hospital or other coordinating facility and become the Medical Communications Coordinator. Other first arriving resources would become Triage Crew.

Reinforced Response Organization

In addition to the initial response, the Incident Commander designates a Triage Unit Leader, a Treatment Unit Leader, Treatment Teams, and a Ground Transport Coordinator.

Multi-Leader Response Organization

The Incident Commander has now established an Operations Section Chief, who has in turn established a Medical Supply Coordinator, a Manager for each treatment category, and a Patient Transportation Group Supervisor. The Patient Transportation Group Supervisor was needed in order for the Operations Section Chief to maintain a manageable span of control, based on the assumption that other operations are concurrently happening in the Operations Section.

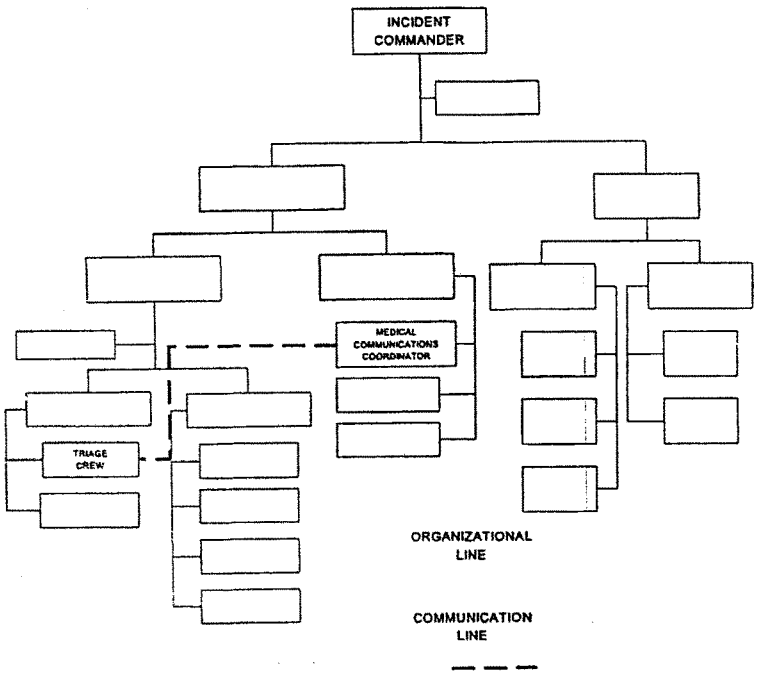
Multi-Group Response

All positions within the Medical Group and Patient Transportation Group are now filled. Air Operations Branch is shown to illustrate the coordination between the Air Transportation Coordinator and the Air Operations Branch. An Extrication Group is freeing trapped victims.

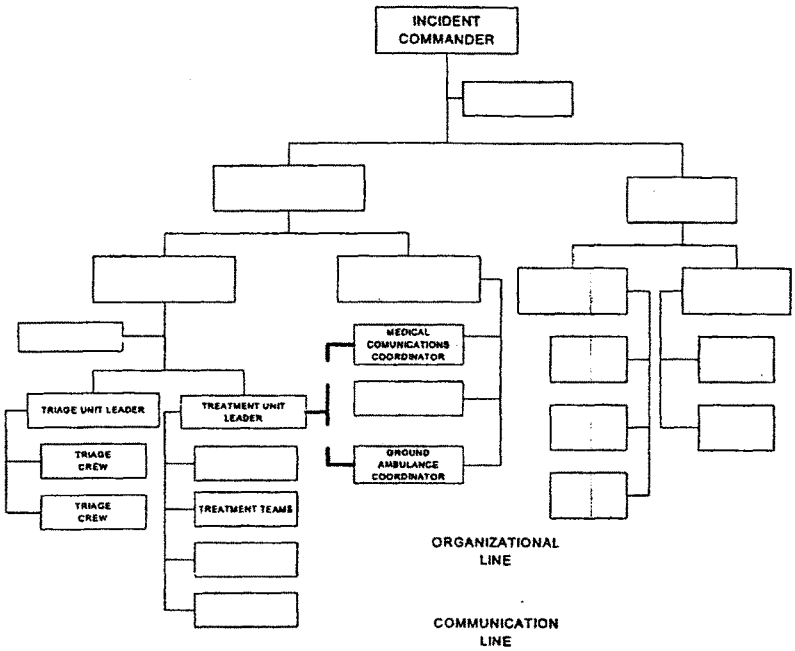
Multi-Branch Organization

The complete incident organization shows the EMS Branch and other Branches with which there might be interaction. The EMS Branch now has three (3) Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities.

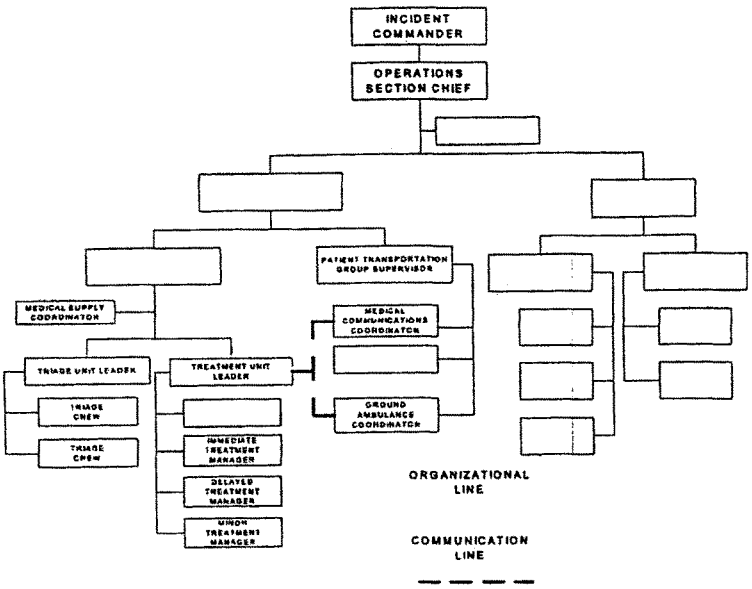
Initial Response Chart



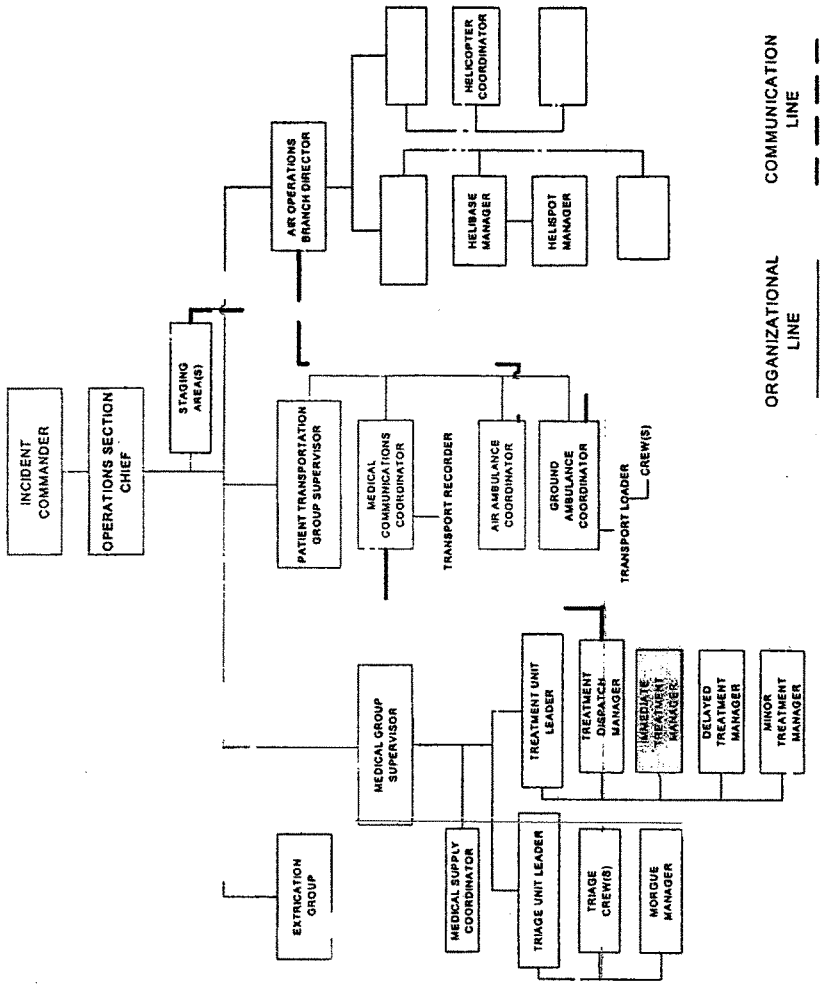
Reinforced Response Chart

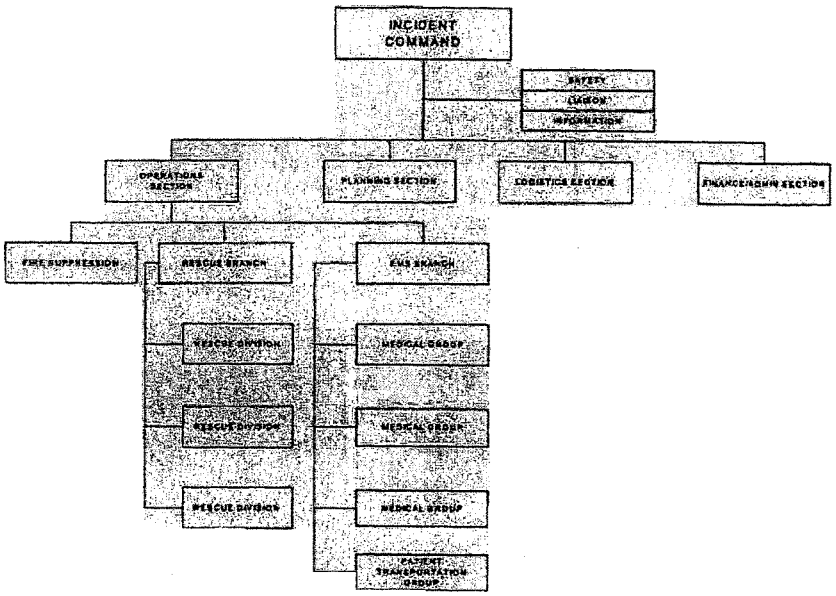


MULTI-LEADER RESPONSE CHART



MULTI-GROUP RESPONSE CHART




INCIDENT COMMAND
SAFETY
LIAISON
INFORMATION
OPERATIONS SECTION
PLANNING SECTION
LOGISTICS SECTION
FINANCE/ADMIN SECTION
FIRE SUPPRESSION
RESCUE BRANCH
EMS BRANCH
RESCUE DIVISION
RESCUE DIVISION
RESCUE DIVISION
MEDICAL GROUP
MEDICAL GROUP
MEDICAL GROUP
PATIENT TRANSPORTATION GROUP

Position Checklists

EMS Branch Director

The EMS Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of Branch planning for the assignment of resources within the Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group and Patient Transportation Group Supervisors.

a. Review Common Responsibilities.
b. Review Group/Division Assignments for effectiveness of current operations and modify as needed.
c. Provide input to Operations Section Chief for the Incident Action Plan.
d. Supervise Branch activities.
e. Ensure that adequate safety measures and accountability procedures are in place.
f. Report to Operations Section Chief on Branch activities.
g. Maintain log of unit activity.

Medical Group Supervisor

The Medical Group Supervisor reports to the EMS Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, and Medical Supply Coordinator. The Medical Group Supervisor establishes command and controls the activities within a Medical Group, in order to assure the best possible emergency medical care to patients during a multi-casualty incident.

a. Review Common Responsibilities.
b. Participate in EMS Branch/Operations Section planning activities.
c. Establish Medical Group with assigned personnel; request additional personnel and resources sufficient to handle the magnitude of the incident.
d. Designate Unit Leaders and Treatment Area locations as appropriate.
e. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
f. Request law enforcement/coroner involvement as needed.
g. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, lifters, cots).
h. Establish communications and coordination with Patient Transportation Group Supervisor.
i. Ensure activation of hospital alert system and local EMS/health agencies.
j. Direct and/or supervise on-scene personnel from agencies such as Coroner's Office, Red Cross, law enforcement, ambulance companies, county health agencies, and hospital volunteers.
k. Ensure proper security, traffic control, and access for the Medical Group area.
l. Direct medically trained personnel to the appropriate Unit Leader.
m. Maintain log of unit activity.

Triage Unit Leader

The Triage Unit Leader reports to the Medical Group Supervisor and supervises Triage Crew/Litter Bearers and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed, the Unit Leader may be reassigned as needed.

a. Review Common Responsibilities.
b. Review Unit Leader Responsibilities.
c. Develop organization sufficient to handle assignment.
d. Inform Medical Group Supervisor of resource needs.
e. Implement triage process.
f. Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
g. Give periodic status reports to Medical Group Supervisor.
h. Maintain security and control of the Triage Area.
i. Establish Morgue.

Triage Crew

Triage Crew report to the Triage Unit Leader and triage patients on-scene and assign them to appropriate Treatment Areas.

a. Review Common Responsibilities.
b. Report to designated on-scene triage location.
c. Triage and tag injured patients. Classify patients while noting injuries and vital signs, if taken.
d. Direct movement of patients to proper Treatment Areas.
e. Provide appropriate medical treatment (ABCs) to patients prior to movement as incident conditions dictate.

Treatment Unit Leader

The Treatment Unit Leader reports to the Medical Group Supervisor and supervises the Treatment Managers and the Treatment Dispatch Manager. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and coordination of patient treatment in the Treatment Areas and directs movement of patients to loading locations.

a. Review Common Responsibilities.
b. Review Unit Leader Responsibilities.
c. Develop organization sufficient to handle assignment.
d. Direct and supervise Treatment Dispatch, Immediate, Delayed, and Minor Treatment Areas.

Treatment Unit Leader (continued)

e. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
f. Request sufficient medical caches and supplies as necessary.
g. Establish communications and coordination with Patient Transportation Group.
h. Ensure continual triage of patients, documentation, and tagging of patients as needed throughout Treatment Areas.
i. Direct movement of patients to ambulance loading area(s).
j. Give periodic status reports to Medical Group Supervisor.

Treatment Dispatch Manager

The Treatment Dispatch Manager reports to the Treatment Unit Leader and is responsible for coordinating, with the Patient Transportation Group, the transportation of patients out of the Treatment Area.

a. Review Common Responsibilities.
b. Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
c. Establish communications with the Patient Transportation Group.
d. Verify that patients are prioritized for transportation.
e. Advise the Medical Communications Coordinator of patient readiness and priority for dispatch.
f. Coordinate the transportation of patients with the Medical Communications Coordinator.
g. Ensure that appropriate patient tracking information is recorded if not already done or established by the Transportation Recorder.
h. Coordinate ambulance loading with the Treatment Manager and ambulance personnel.

Immediate (Red) Treatment Manager

The Immediate Treatment Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to the Immediate Treatment Area.

a. Review Common Responsibilities.
b. Request or establish Medical Teams as necessary.
c. Assign treatment personnel to patients received in the Immediate Treatment Area.
d. Ensure treatment of patients triaged to the Immediate Treatment Area.
e. Ensure that patients are prioritized for transportation.
f. Coordinate transportation of patients with Treatment Dispatch Manager.
g. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
h. Ensure that appropriate patient information is recorded.

Delayed (Yellow) Treatment Manager

The Delayed Treatment Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to the Delayed Treatment Area.

a. Review Common Responsibilities.
b. Request or establish Medical Teams as necessary.
c. Assign treatment personnel to patients received in the Delayed Treatment Area.
d. Ensure treatment of patients triaged to the Delayed Treatment Area.
e. Ensure that patients are prioritized for transportation.
f. Coordinate transportation of patients with Treatment Dispatch Manager.
g. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
h. Ensure that appropriate patient information is recorded.

Minor (Green) Treatment Manager

The Minor Treatment Manager reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to Minor Treatment Area.

a. Review Common Responsibilities.
b. Request or establish Medical Teams as necessary.
c. Assign treatment personnel to patients received in the Minor Treatment Area.
d. Ensure treatment of patients triaged to the Minor Treatment Area.
e. Ensure that patients are prioritized for transportation.
f. Coordinate transportation of patients with Treatment Dispatch Manager.
g. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.
h. Ensure that appropriate patient information is recorded.
i. Coordinate volunteer personnel/organizations through Agency Representatives and Treatment Unit Leader.

Patient Transportation Group Supervisor

The Patient Transportation Group Supervisor reports to the EMS Branch Director and supervises the Medical Communications Coordinator and the Air and Ground Ambulance Coordinators and is responsible for the coordination of patient transportation and maintenance of records relating to patient identification, injuries, and mode of off-incident transportation and destination.

a. Review Common Responsibilities.
b. Establish communications with hospitals(s).
c. Designate ambulance staging area(s).
d. Direct the transportation of patients as determined by Treatment Unit Leader(s).

Patient Transportation Group Supervisor (continued)

e. Ensure that patient information and destination is recorded.
f. Establish communications with Ambulance Coordinator(s).
g. Request additional ambulances, as required.
h. Notify Ambulance Coordinator(s) of ambulance requests.
i. Coordinate requests for air ambulance transportation through the Air Operations Director.
j. Establish air ambulance helispot with the EMS Branch Director and Air Operations Director.
k. Maintain log of unit activity.

Medical Comunications Coordinator

The Medical Communications Coordinator reports to the Patient Transportation Group Supervisor and supervises the Transportation Recorder, and maintains communications with the hospital alert system and/or other medical facilities to ensure proper patient transportation and destination, and coordinates information through the Patient Transportation Group Supervisor and the Transportation Recorder.

a. Review Common Responsibilities.
b. Establish communications with hospital alert system.
c. Determine and maintain current status of hospital/medical facility availability and capability.
d. Receive basic patient information and injury status from Treatment Dispatch Manager.
e. Communicate hospital availability to Treatment Dispatch Manager.
f. Coordinate patient off-incident destination with the hospital alert system.
g. Communicate patient transportation needs to Ambulance Coordinators based upon requests from Treatment Dispatch Manager.
h. Maintain log of unit activity.
i. Request additional resources as needed.

Patient Transportation Recorder(s)

Position is established when demands of the incident require and the transport function is needed. Works in patient transportation loading area with Treatment Dispatch Manager.

a. Assists Medical Communications Coordinator as needed.
b. Maintains appropriate incident documentation relating to the patients transported from the scene, to include:

Patient Transportation Recorder(s) (continued)

- triage tag/ assigned tag number;
- ensure triage tag/documentation is attached to the patient;
- unit transporting;
- destination hospital;
- number of patients;
- transporting triage status, age, sex, chief complaint; and
- ETA to destination.

c. Provides patient information to Medical Communications Coordinator as needed.

Air/Ground Ambulance Coordinator(s)

The Air/Ground Ambulance Coordinator(s) report to the Patient Transportation Group Supervisor and manage the Air/Ground Ambulance Staging Areas and dispatch ambulances as requested.

a. Review Common Responsibilities.
b. Establish appropriate Staging Area for ambulances.
c. Establish routes of travel for ambulances for incident operations.
d. Establish and maintain communications with the Air Operations Branch Director.
e. Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
f. Maintain records as required.
g. Ensure that necessary equipment is available in the ambulance for patient needs during transportation.
h. Establish immediate contact with ambulance agencies at the scene.
i. Request additional transportation resources as appropriate.
j. Provide an inventory of medical supplies available at ambulance staging area for use at the scene.
k. Request additional resources as needed (Transport Loaders, etc.).
l. Ensure proper coordination is maintained with Staging Area Manager as needed.

Transport Loader(s)

Transport Loader(s) report to the Ground Ambulance Coordinator or Air Ambulance Coordinator as directed. Position is established when demands of the incident require and the transport functions are needed. Works in transportation loading area with Treatment Dispatch Manager.

a. Establish patient loading point in the transportation area (if not already done).
b. Coordinate activities with Treatment Dispatch Manager/Transport Recorder.

Transport Loader(s) (continued)

c. Ensure patents selected for transportation are:
   - Ready for movement; and
   - Loaded on the correct transport unit.
   - Crosscheck Triage Tag information and numbers with Transport Recorder/Medical Communications Coordinator.
   - Provide instructions to vehicle drivers (e.g., directions to designated hospitals, maps, disaster routes, actions to take, etc.).
d. Direct crews assigned as porter teams as needed.
e. Keep Ground Ambulance Coordinator and/or Air Ambulance Coordinator informed as directed.

Medical Supply Coordinator

The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group.

a. Review Common Responsibilities.
b. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.
c. Request additional medical supplies. (If Logistics Section is established, this position would coordinate with the Supply Unit Leader.)
d. Distribute medical supplies to Treatment and Triage Units.
e. Maintain log of unit activity.

Morgue Manager

The Morgue Manager reports to the Triage Unit Leader and assumes responsibility for Morgue Area activities until relieved of that responsibility by the appropriate Coroner's Office.

a. Review Common Responsibilities.
b. Assess resource/supply needs and order as needed.
~~c. Coordinate all Morgue Area activities.~~
d. Keep area off limits to all but authorized personnel.
e. Coordinate with law enforcement and assist the coroner as necessary.
f. Ensure that identity of deceased persons is kept confidential.

Emergency Medical Services (EMS) Glossary

ALS (Advanced Life Support). Allowable procedures and techniques utilized by emergency medical personnel to stabilize critically sick and injured patients(s) who exceed Basic Life Support procedures. Example: Intravenous therapy, cardiac monitoring, advanced airway management, administration of medications, etc.

Black Tag Patient. A patient who, under the START triage system, is deceased.

BLS (Basic Life Support). Basic, non-invasive first-aid procedures and techniques utilized to stabilize critically sick and injured patients(s).

Delayed (Yellow) Treatment. Second priority patient under the START triage system. Patients in this category require aid, but injuries are less severe.

Disaster Tag. A tag used by triage personnel to identify and document the patient's medical condition.

Immediate (Red) Treatment. The highest priority patients under the START triage system. These patients require rapid assessment and medical intervention for survival.

Major Medical Emergency. Any emergency that would require the access of local mutual aid resources.

Medical Group Organizational Structure. This is designed to provide the Incident Commander with a basic expandable system for handling patients in a multi-casualty incident.

Medical Protocols. Policies and procedures approved by the local EMS agency for use by a provider in situations where direct voice contact with medical control cannot be established or maintained.

Medical Team. Combinations of medical trained personnel who are responsible for on-scene patient treatment.

Medic Unit. An ALS equipped vehicle. It would typically include drugs, medications, cardiac monitors and telemetry, and other specialized emergency medical equipment.

Minor (Green) Treatment. Patients, under the START triage system, whose injuries can be considered minor, requiring rudimentary first-aid.

Morgue (Temporary on-incident). Area designated for temporary placement of the dead. The Morgue is the responsibility of the Coroner's Office when a representative is on scene.

Multi-Casualty. The combination of numbers of injured people and types of injuries going beyond the capability of an entity's normal first response.

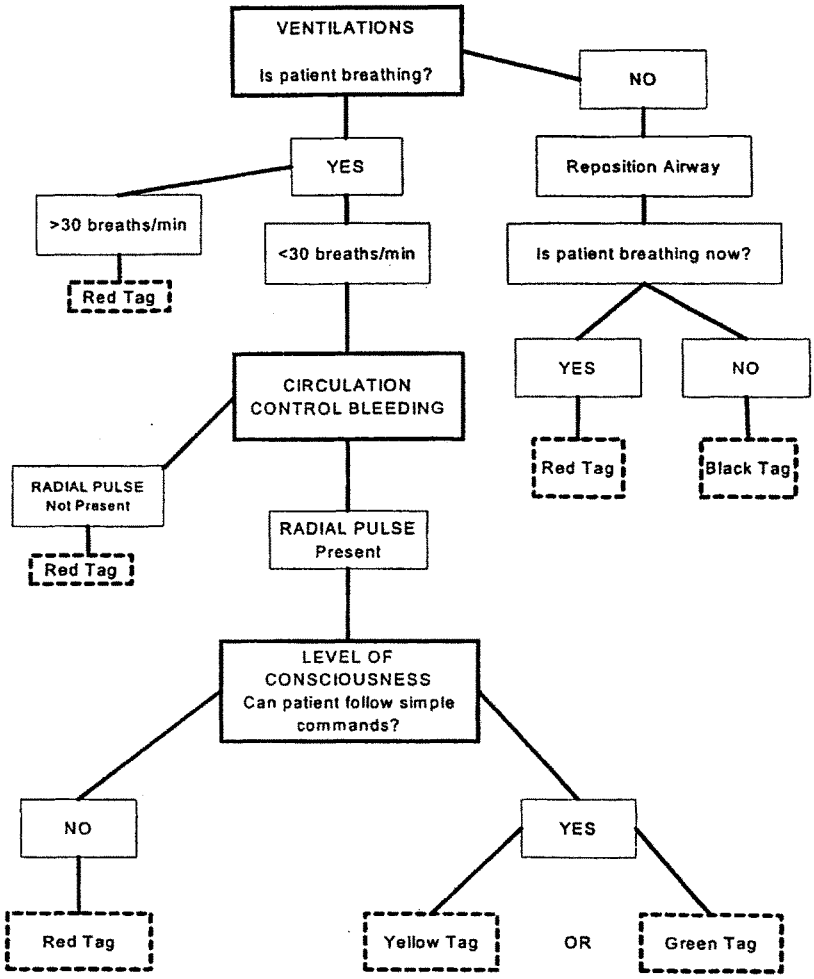
EMS Glossary (continued)

START. Acronym for "Simple Triage And Rapid Transport." This is the initial triage system that has been adopted by the Metropolitan Washington Council of Governments.

Triage. The screening and classification of sick, wounded, or injured persons utilizing the START triage system to determine priority needs in order to ensure the efficient use of medical personnel, equipment, and facilities.

Triage Crew. Responsible for utilizing the START triage system to assess patients on-scene and assigning them to the appropriate Treatment Areas.

START TRIAGE SYSTEM FLOW CHART



16-18

The CHAIRMAN. Thank you, Chief.
Dr. Thibault.

GEORGE E. THIBAULT, M.D., VICE PRESIDENT, CLINICAL AFFAIRS, PARTNERS HEALTHCARE

Dr. THIBAULT. Thank you. Good afternoon. My name is George Thibault. I am the Vice President of Clinical Affairs at Partners Healthcare and Professor of Medicine at Harvard Medical School.

Partners is a not-for-profit integrated health care system in eastern Massachusetts that includes two major teaching hospitals of Harvard Medical School, the Massachusetts General Hospital and the Brigham & Women's Hospital, four community hospitals, a psychiatric teaching hospital, three rehabilitation hospitals, several nursing homes, a non-acute care service, community health centers, and over a thousand community primary care physicians. I am also representing the Conference of Boston Teaching Hospitals. On behalf of all our physicians, nurses, care givers, and the patients that we serve every day, I want to thank Senator Gregg and Senator Kennedy, who I got to speak to earlier, and the Members of the Committee for the opportunity to testify and for their interest in this very important issue.

I will briefly summarize the testimony that I have submitted, touching on three areas. First is our general commitment to emergency preparedness, specifically what have been done at Partners since September 11, 2001, and then make some concluding remarks about what some of our needs and concerns are.

We and the other Boston teaching hospitals have been fortunate to build on a long history of effective collaboration with each other and with other first responder agencies in our area. Emergency preparedness for catastrophic events such as infectious disease outbreaks, mass casualty accidents, storms, and chemical disasters has always been an essential part of our medical readiness. Since September 11, 2001, however, hospitals preparing for potential incidents and emergencies that are unprecedented in their magnitude and potentially impacting a much greater number of victims. The threat of terrorism and the use of weapons of mass destruction like chemical and biological weapons and even nuclear disasters require hospitals to be prepared and to manage previously unthinkable scenarios which have impacted every aspect of emergency planning and hospital operations, and I can say it truly has become part of our day-to-day existence in a way that it never was before.

Our hospitals have responded. On September 11, 2001, Massachusetts hospitals cleared hundreds of beds in anticipation of receiving victims, which of course we never received. Since September 11th, Partner as a health care system has organized itself to be better prepared. We have worked together as a system to be able to effectively respond to challenges ahead. We have invested significant resources in every aspect of our hospital operations and infrastructure. Since September 11th, we estimate we have conservatively estimated an investment of over $6 million above and beyond what we would have done for normal operations. Against that investment of $6 million, we have received $230,000 of HRSA funding. I can say, having done an informal poll of the other Bos-

ton teaching hospital, the ratio of investment to return has been about the same.

Areas in which we have invested include the following, and these are all very important: communication systems, including the development of alternative communication systems in the event of failure or overload; disease surveillance efforts, including systems to facilitate disease reporting and access to experts, improved patient tracking systems, radiation detection, tests for detection of chemical agents, and identification of biological agents; protective equipment for medical staff; hospital facility infrastructure for lock down and protection of patients and staff; drug and pharmaceutical supplies for protection against biological, chemical, and nuclear attacks; training and drills for our medical personnel. We have invested enormously in training for all of our medical personnel, physicians, nurses, administrative staff, support staff; vaccination efforts for smallpox; and, very importantly, managing the mental health needs of patients and staff during a crisis.

These are ongoing and continuing investments. I can say in many ways, they have made us better health care facilities. We are better prepared to respond to ordinary emergencies as well, and the education and the investment has positioned us to serve our public well, but, nonetheless, these are additional investments above and beyond our normal expenditures.

Our hospitals and medical staff remain deeply committed to maintaining and enhancing our preparedness efforts as events dictate. We estimate that we will continue to make as a system an investment of $2 million to $3 million a year to keep ourselves current and to continue to upgrade our facilities in every one of these areas. Our local public health agency, the Massachusetts Department of Public Health, has played an important role in setting up regional planning structures for the State, and the Boston Health Commission has been an indispensable partner in working with the Boston teaching hospitals to design a dependable disaster response that meets the needs of our situations in our community.

We are very grateful for the work that has been done at the Federal level, and I have enjoyed hearing the testimony today and appreciate the great efforts that have gone in, the great efforts of this committee and of our Senator Kennedy our own congressional delegation; however, we can say that additional resources are needed. I have already alluded to the ratio between investment and the return at this time.

We continue to carry out our fundamental missions of training the next generation of physicians and identifying and implementing new medical treatments and making new discoveries and, of course, caring for all patients who come to our doors or emergency rooms regardless of their ability to pay. All of our hospitals are facing enormous fiscal challenges. We continue to need to make significant investments in information technology and other patient-related technologies in order to provide the safest and most efficient care for all of our patients. These additional investments in emergency preparedness compete with those necessary investments for patient care that we need to make on a daily basis.

We must remember that hospitals are, in fact, first responders to any attack or any biological threat. We will plan an essential

role in any disaster, and I want to assure you we are ready to do that and welcome that responsibility, but maintaining or enhancing our ability to care for emergency victims will be critically dependant on having adequate financial resources to maintain the state of preparedness that we must achieve and sustain for our future.

I thank you very much for this opportunity to testify. We look forward to working closely with you, and I look forward to answering any of your questions.

[The prepared statement of Dr. Thibault follows:]

PREPARED STATEMENT OF GEORGE E. THIBAULT, M.D.

Good morning. My name is Dr. George Thibault and I am the Vice President of Clinical Affairs for Partners HealthCare, which is a non-profit, integrated system of health care providers in Massachusetts that includes two major Harvard teaching hospitals, the Massachusetts General Hospital and Brigham and Women's Hospital in Boston; four community hospitals; a psychiatric teaching hospital; a rehabilitation teaching hospital; non-acute services; and several community health centers. I am also representing the Conference of Boston Teaching Hospitals.

On behalf of our physicians, nurses and other caregivers, and the patients we serve each day, I want to thank the Chairman of the Committee, Senator Judd Gregg (R-NH), the ranking member, Senator Ted Kennedy (D-MA), and the Members of this Committee for inviting us to testify today on our Emergency Preparedness efforts and our readiness to respond to a terrorist event in Massachusetts.

I appreciate the opportunity to inform you of the kinds of efforts our medical and other staff have undertaken throughout our hospitals since September 11, 2001, and to illustrate the ongoing resource needs of our hospitals.

HOSPITAL COMMITMENT TO EMERGENCY PREPAREDNESS

Partners founding hospitals, Massachusetts General Hospital and Brigham and Women's Hospital in Boston, as well as our community and specialty hospitals have undertaken significant emergency planning initiatives since September 11, 2001. Indeed, we and the other Boston teaching hospitals have been fortunate to build on a long history of effective collaboration with Boston's other first responder agencies.

Emergency preparedness for catastrophic events such as infectious disease outbreaks, mass-casualty accidents, storms and chemical disasters have always been an essential aspect of Boston's hospital readiness planning.

Since September 11, 2001, however, hospitals have been preparing for potential incidents and emergencies that are unprecedented in their magnitude and potentially impacting much greater numbers of victims. The threat of terrorism and the use of weapons of mass destruction like chemical and biological weapons and nuclear disasters require hospitals to be prepared to manage previously unthinkable scenarios which have impacted every aspect of emergency planning and hospital operations.

Our hospitals have responded.

Back on September 11th, Massachusetts hospitals cleared hundreds of beds in anticipation of receiving victims from the September 11th disaster. In the aftermath of the devastating Rhode Island fire in February of 2003, the Emergency Departments and the physicians and nurses of Massachusetts General Hospital and Brigham and Women's Hospital, along with Shriner's Hospital in Boston, provided essential support to the relief effort of Rhode Island's hospitals and we provided burn care to victims as the only verified burn centers in Massachusetts.

Our medical staff was privileged to care for these patients and to work with them and their families in the face of extraordinary challenges.

PARTNERS INVESTMENTS

Since September 11, 2001, we have reformed and enhanced our management and operational responses to emergency planning and responded effectively to a new set of challenges.

We have invested significant resources in every facet of our hospital operations and infrastructure. Since September 11, 2001, we have invested over $6 million in preparing for an expanded array of catastrophic public health emergencies. In 2004, we received our first and, to date, our only award of Federal HRSA funding for emergency preparedness—approximately $230 thousand dollars across all of our hospitals.

Areas in which we have invested include:

1. Communication Systems (including development of alternative communications systems in the event of failure or overload);
2. Disease Surveillance Efforts (including systems to facilitate disease reporting and access to experts; improved patient tracking systems; radiation detection; and tests for detection of chemical agents and identification of biologic agents);
3. Protective Equipment for medical staff;
4. Hospital facility infrastructure for lockdown and protection of patients and staff;
5. Drug and Pharmaceutical supplies for protection against biologic, chemical and nuclear attacks;
6. Training and Drills for our Medical personnel;
7. Vaccination Efforts against Smallpox; and
8. Managing the mental health needs of patients and staff during a crisis.

Examples of our efforts include:

- Completely revamping our emergency preparedness management infrastructure across all of our hospitals;
- Extensively training and drilling thousands of staff under an all-hazards emergency command system designed to link closely with the command structure of Police, Fire, and EMS organizations in each community;
- Retooling our hospital and supporting facilities' infrastructure, such as:
    - Bolstering lockdown and security to protect patients and staff and shelter-in-place until other Federal or State resources arrive;
    - Improving access control and security screening at our hospitals;
    - Improving our power supplies and storage of fossil fuels for uninterrupted power in the event of a disaster;
    - Building and equipping specialized rooms for patient isolation;
    - Installing specialized filters and ventilation systems to manage biological disasters;
    - Increasing large water volume capability through water purification equipment in order to protect our water supply;
- Additional pharmaceuticals for biological, chemical and nuclear response;
- Preparing a smallpox vaccination program across the network that established a core group of vaccinated staff committed to rapid post-event response;
- Participating in and leading region-wide emergency preparedness efforts in organizations across eastern Massachusetts.

PREPARING FOR THE DEMOCRATIC NATIONAL CONVENTION

In recent months, the Boston teaching hospitals have been particularly focused on preparedness for the Democratic National Convention, the increase in visitors to Massachusetts during that time, and the possibility of a large-scale emergency. Our medical and professional staffs have been training and drilling for every type of emergency response, and have undertaken two full surge capacity drills involving all of our hospitals as well as other providers whose facilities would be used for off-loading patients in the event of large-scale need.

CONCLUSION

Our hospitals and medical staff remain deeply committed to maintaining and enhancing our preparedness efforts as events dictate. In hospital fiscal year 2005 and beyond, Partners hospitals alone expect to spend approximately $3 million a year to maintain our response capabilities.

Our local public health agency (Massachusetts DPH) has played an important role in setting up a regional planning structure for the State, and the Boston Public Health Commission has been an indispensable partner in working with the Boston teaching hospitals to design a dependable disaster response system that meets the needs of our institutions and our community.

While we are grateful for the work they have done and the tremendous support we've received from Senator Kennedy and our Congressional delegation, greater resource support is needed to maintain and enhance our ability to care for the victims of chemical, biological and other potential terrorist attacks and to train and protect our own staffs to meet the demands of this post-9/11 world.

An informal survey of the Boston area teaching hospitals determined that we have invested, conservatively speaking, more than $10 million in Emergency Preparedness since 2001. To date, those responding to the survey have received approximately $300 thousand ($287K) toward those investments.

In the meantime, our fundamental responsibilities to train the next generation of physicians, to identify and implement new medical treatments and cures, and to care for patients continues.

Hospitals are first responders and will play an essential role in any disaster. Maintaining or enhancing our ability to care for emergency victims will be critically dependent on having adequate financial resources to maintain the State of preparedness that we must achieve and sustain for our future.

Again, thank you for the opportunity to testify. We look forward to working with you in the future.

The CHAIRMAN. Thank you, Dr. Thibault.

Ms. Waltman.

SUSAN WALTMAN, SENIOR VICE PRESIDENT AND GENERAL COUNSEL, GREATER NEW YORK HOSPITAL ASSOCIATION

Ms. WALTMAN. Mr. Chairman, thank you very much for inviting us to appear here today. I am Susan Waltman. I am Senior Vice President and General Counsel at the Greater New York Hospital Association which represents the interests of over 250 hospitals and nursing homes, primarily concentrated in the New York region, but located throughout New York, New Jersey, Connecticut, and Rhode Island. Together they provide a vast array of services from the very state-of-the-art tertiary care to the very basic primary care services, because we act as the safety net providers for our communities.

Since September 11th, we have taken on an even greater role service, perhaps a more serious role than that, and that is as the front line defense, I believe front line defense, of the Nation's public health system and disaster response system in an area of the world and an area of the country that is truly one of the highest risk areas together with the Capital Region and some other cities. We undertake that role with all seriousness. We have put in a lot of effort to enhancing our preparedness in the events of September 11th, and the ensuing anthrax attacks which we experienced as well have made us very committed to expanding our imagination and planning for otherwise unimaginable events.

I will try to answer the question that is asked by the hearing, which is, are we prepared, and I think it is answered in part by saying it depends. It truly depends on how, what, and where an event may occur, and I do appreciate that we will understandably always be judged in terms of our preparedness with the hindsight that comes from actual knowledge of the how and the when and the where. The other part of that answer is that we are very well prepared for a wide variety of types of events and certainly better prepared than we were 3 years ago and even more than 1 month ago, and I dare say that we will be even better prepared even so in 1 month for the Republican National Convention, and that is because preparedness is a process. I think you have heard that before today, and we have made it our business to try to learn from every alert, every advisory, and every piece of intelligence, and tried to internalize that in our planning.

The subsidiary question is: Are we prepared for the major events that we are facing, the Republican National Convention and other types of activities? We have worked intensively in preparing for that particular event and other events as well. I think it is perhaps more important to focus on what we do to prepare for the ordinary

day, the day where we do not really anticipate an event, because that is exactly the way September 11th started for us, which was—it was an otherwise ordinary day, and particularly in New York City, we anticipate that something could happen at any time and at any place.

In order to provide a brief overview of how we are preparing, I will go a little bit into how we were prepared before 9–11 and how that was demonstrated on September 11th and what we have done since then. I think you will see that the general theme is that preparedness is a process that must be reviewed and enhanced and practiced every single day. It is also, as you have recognized, an extraordinarily expensive process and one that I think falls very much on the backs of hospitals as the front line of the public health defense system and particularly in an area such as New York where we have that truly extraordinary role that we have assumed.

Before 9–11, we spent a lot of time on preparedness. Our hospitals obviously had already experienced a World Trade Center bombing in 1993. We are host to a lot of major events and we experience a lot of emergencies and disasters. In recognition of the role and the experience, we are viewed as a part of the response system in New York City and always have been. Greater New York has a desk at the New York City Office of Emergency Management, which we staff as though we are a public agency. Whenever they activate, we are there 24–7 to facilitate the health care response on behalf of the city.

We also put in place a very collaborative effort, interestingly, as part of the Y2K preparations, where we met literally every other week to test a variety of scenarios, to work through things that could occur, and it really did, I think, prove to be a very valuable series of relationships that we put in place so that on the morning of September 11th, our hospitals were very well prepared for what they faced that day. You may have seen the pictures in the newspapers. They created triage centers on the street. They cancelled elective procedures. They really made room. They made surge capacity for a large number of patients, and all the while, they were going through their own internal disruptions with respect to loss of electricity, communications, water, steam; and they also faced another phenomenal with large numbers, thousands of individuals walking from hospital to hospital looking for family members, and thus they created counseling centers and family centers in order to accommodate those needs.

The biggest lesson we learned, we were surprised ourselves when we realized that there were over 7,300 different patients who escaped the World Trade Center area, 7,300 people jumping on boats, crossing bridges, and going to over 100 different hospitals. Now, there was not any release contemporaneously of a nuclear biological or chemical agent, something that people were concerned about, but had there been, every single one of those 7,300 patients going to 100 different hospitals would have been potentially exposed or contaminated, and we realized very seriously that we all had to have some basic capability in order to identify and contain those types of events should they occur again in the future, and that has really fashioned the way we have prepared.

Since 9–11, we have created an Emergency Preparedness Coordinating Council, a very descriptive term for a group that gets together very regularly that involves all hospitals, all types of providers, local, State, and Federal agencies who come together very regularly to engage in collaborative planning and collaborative response. In our testimony, we outline the way we approach preparedness from this point forward. We know we are in a high risk area. We know something can happen any time at any place, and that is how we have prepared, and we have literally met every single time since November 2001 to work through a variety of different scenarios, plans, and systems that we can have in place. It is a three-way partnership. It is a partnership among providers, emergency managers, and the public health system that has to go on in every single community because we need each other. We enjoy very good relationships with local, State, and the Federal agencies and get a lot of support from HHS and the Department of Homeland Security.

We pursue an all-hazards approach. We started out studying anthrax and smallpox for the same reasons everyone else did, but we took a step back and we really recognized we need an all-hazards approach and we all need to have good incident command systems because disasters can present in a variety of different ways, and what we really need are the tools to be able to respond to a variety of different scenarios.

We have definitely placed emphasis on enhancing communication two ways: first, knowing exactly who to contact, how to contact them, and for what purposes before a disaster so we can do it well during a disaster and putting in place redundant and effective communication mechanisms. One thing that you have asked about is surge capacity. We developed as a result of our needs during 9–11 a health emergency response data system that is now housed on the State's internet, their web-based system for providers. It collects during an emergency. Of course, we do use it outside of an emergency, but it is absolutely created to gather information with respect to supplies, staff, and bed availability, event-related visits to hospitals, and the patient locator system should we need it again. Now, in order to practice, they collect very regular bed availability data, vaccine supplies, inventories of isolation rooms, so that we have that in advance, but it is now a very effective system that can be used if we have another disaster.

We have 800 megahertz radios. We have redundant means of communicating with each other. We have directories, and we have an excellent syndromic surveillance system that the city health department has created which allows us to identify or allows them to identify, get early warnings with respect to infectious diseases, clusters of diseases, getting emergency department data, virtually seeing 75 percent of all emergency department visits every single day.

You can go through those same issues that we have put in place, all of that, the training, the drills, the collaborative planning, and we are drilling down and we are enhancing them and working through them for preparing for the Republican National Convention as well. We have been involved in meetings and have had meetings with the Secret Service, with FEMA, with Homeland Se-

curity, and other local authorities to make sure all of these are in place, threat alert guidelines, etc., and we guarantee they will be in place for the Republican National Convention.

The issues of expenses, we have a chart in there that indicates that on average, our hospitals have spent about $5.5 million apiece on average in New York City on preparedness. We also indicate in that chart that the total amount they got during the time frame over a 2-year period was $75,000. Each have spent on average $5.5 million and getting $75,000 from the HRSA program, which we appreciate, but it barely scratches the surface. We also have in there that we have unbudgeted but needed projects that probably amount to $12 million per hospital.

There are very scarce resources for this purpose. I would suggest that in a city such as New York City, we assume a very significant responsibility not just on behalf of our community, but on behalf of the entire country and its 800 million residents in New York City, the 40 million people who visit us every year and as the world's financial center. We really do hope that we are able to get more resources to enhance our preparedness.

I am very appreciative of the comments that you have made so far, and I thank you very much.

[The prepared statement of Ms. Waltman follows:]

PREPARED STATEMENT OF SUSAN C. WALTMAN

Mr. Chairman and Members of the Committee: Good morning, and thank you for the opportunity to appear before you today. I am Susan C. Waltman, Senior Vice President and General Counsel of the Greater New York Hospital Association, which represents the interests of over 250 hospitals and continuing care facilities that are concentrated in the New York City region but that are also located throughout New York, New Jersey, Connecticut, and Rhode Island. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions. Together, they provide services that range from state-of-the-art, tertiary care to the most basic primary care, given their roles as safety net providers for many of the communities they serve.

GNYHA's members also serve an additional role, one that has become much more important and much more demanding since September 11, 2001: they are the front line of the public health defense and disaster response systems for one of the highest risk areas in the United States. Unquestionably, GNYHA's members performed admirably on September 11 and during the subsequent anthrax attacks, a reflection of their years of preparedness planning. Those events and the subsequent and growing number of terrorist alerts and warnings have demonstrated how vulnerable we are as a society and how much more we need to do to be fully prepared.

Are We Ready?—The principal question that today's hearing asks is: are we ready for future terrorist attacks? The question must be answered in part by saying that it depends. It depends of course on how, when, and where the attacks may occur, and should an event take place, we will always, understandably, be judged with the hindsight of actual knowledge as to those three factors. The other part of the answer is that we are very well prepared for a wide array of possible attacks and certainly better prepared today than we were 3 years ago or even 1 month ago. And, we become better prepared with each passing day because we have made it our business to learn from each and every event, alert, and piece of intelligence. Indeed, since September 11, GNYHA's members have been working intensively, on their own and more importantly, in close collaboration with each other as well as with local, State, and Federal agencies, to enhance their preparedness. Through these efforts, GNYHA's and its members have forged strong working relationships with each other and with key agencies at all levels of government, relationships that we believe are mutually beneficial and invaluable to our ability to protect our country and its communities.

Are We Prepared for Our Nation's Major Events?—The subsidiary question raised by today's hearing is whether we are prepared for the many major events that our country holds that represent the essence of democracy, our freedoms, and our liberties. The answer is that we are devoting intensive efforts toward preparing

for those specific events, given their significance and the large numbers of individuals who will gather there. But what is perhaps more important to know is what we do each and every day to prepare for an unplanned event, the otherwise ordinary day, such as was the case with September 11, at least up until 8:46 am. It is upon those efforts that we build in order to prepare for events such as the Republican and Democratic National Conventions, our Nation's elections, as well as other major events.

Overview of Testimony—To answer your questions in more detail, I will review the New York City region's preparedness from a health care provider perspective before September 11, how that level of preparedness was demonstrated on September 11, and how preparedness has been enhanced significantly since then. We will then provide information on how we are building upon those efforts to prepare specifically for the Republican National Convention. The consistent message is that preparedness is a continual process that must be constantly reviewed, enhanced, and practiced.

What is also clear is that preparedness is an extraordinarily expensive process, one that is causing GNYHA members to expend scarce resources during a time of severe financial pressures without significant reimbursement in sight. We are hopeful that our hospitals' extraordinary efforts, undertaken because of both their location and their commitment to protecting their communities, will be recognized through increased funding. It is the least our country can do to ensure protection of the Nation's financial center and its 8 million residents, a region that has already been the target of two World Trade Center attacks and four anthrax attacks.

I. EMERGENCY PREPAREDNESS ACTIVITIES BEFORE SEPTEMBER 11, 2001

GNYHA and its members have long been committed to ensuring that the health care system is prepared to respond to a broad range of emergencies, disasters, and attacks that might occur in the New York City region. For years, area hospitals have worked on and improved upon their disaster plans and programs, engaged in regular drills, and constantly reviewed their readiness for many events. Indeed, it is the mission of hospitals to respond to the needs of their communities, and, in a "community" such as New York, we have recognized that any number of disasters and emergencies can occur. GNYHA has in turn supported its members' activities by providing training programs, educational materials, and workgroups for improving preparedness.

Hospitals as an Integral Part of the Region's Response System—GNYHA and its members have also worked closely with area emergency management and public health officials over the years and are considered an integral part of the region's emergency/disaster response system. In recognition of this role, GNYHA has had a desk at the New York City Office of Emergency Management's (OEM's) Emergency Operations Center (EOC) for many years, which GNYHA staffs during major area events, actual emergencies, or anticipated possible emergencies, e.g., heat emergencies. Grouped with local, State, and Federal health and environmental agencies at the EOC, GNYHA is able to address members' needs quickly as well as facilitate the region's health care response to disasters.

The health care sector's preparations for the Y2K transition also helped foster regional collaboration that was helpful to the health care system's response on September 11. During the year 1999, GNYHA brought together its members and area agencies literally every other week for the purpose of developing communication mechanisms, contingency plans, and a framework for inter-hospital/inter-agency coordination. That process proved invaluable on September 11.

II. THE HEALTH CARE SYSTEM'S RESPONSE TO THE WORLD TRADE CENTER DISASTER

The Hospital's Response—On September 11, GNYHA's members demonstrated that they were prepared for the particular disaster that we all faced that day. Area hospitals instantly activated their disaster plans, canceled all elective procedures, freed up thousands of beds in anticipation of large numbers of casualties, reconfigured areas internally to make room for additional patients, and established triage centers on their streets. At the same time, many hospitals found themselves without functioning communication systems, while some also found themselves without electricity and were forced to rely upon emergency generators. Some also experienced drops in water pressure and steam and were forced to seek alternative means to sterilize equipment.

As the day wore on, hospitals were faced with another, perhaps more devastating phenomenon—thousands of family members were walking from hospital to hospital looking for their loved ones. Hospitals therefore established family centers to care for and counsel those individuals and ultimately requested that a patient locator

hotline be established. And, throughout the ordeal, hospitals also acted as safe havens for individuals fleeing from the World Trade Center and even sent employees into neighboring buildings to make sure the elderly were safe. In short, the area's hospitals rose to all of the challenges they faced as a result of the events of September 11.

GNYHA's Response and Coordination on Behalf of Its Members—GNYHA, on behalf of its members, also played a key role on September 11. On the morning of the disaster, GNYHA was called by OEM within minutes of the initial plane crash and was requested to report to New York City's EOC. GNYHA was also in immediate contact with the New York State Department of Health, which directed hospitals to activate their disaster plans and expect mass casualties, a directive that GNYHA immediately communicated to its members by both e-mail and facsimile. Within moments of OEM's call to GNYHA, however, New York City's EOC, which was located at 7 World Trade Center, was evacuated.

Given this situation and the scope of the disaster, GNYHA established a command center at its offices to assist members and to act as a liaison to emergency managers, public health officials, and the public. Within hours, OEM established a replacement EOC at the New York City Police Academy, and GNYHA was able to continue its role of facilitating its members' response efforts from there as well. For weeks thereafter, GNYHA staffed both its desk at OEM and its command center at GNYHA's offices around the clock as the area undertook its recovery from the attacks.

Anticipating possible additional attacks, GNYHA also began to provide members with briefings on identifying and responding to biological and chemical events and to expand GNYHA's e-mail lists. Thus, by the time the first case of anthrax was reported in Florida, GNYHA was able to immediately transmit to members health alerts prepared by the New York City Department of Health and Mental Hygiene that contained key information needed to diagnose and treat anthrax.

The Cost of Responding to the World Trade Center Disaster—The cost of responding to the World Trade Center disaster was significant for hospitals. GNYHA collected cost information from area hospitals and calculated that their total initial costs of responding (or preparing to respond) reached $140 million, a figure that included lost vehicles, such as ambulances; increased overtime, supplies, and staffing; damage to facilities; and stand-by costs associated with creating surge capacity. Hospitals also suffered additional lost revenues in excess of $100 million in the long term as a result of the events of September 11, due in part to the fact that many patients did not want to venture into the city for care. Thus, the total cost of responding—or standing ready to respond—to the events of September 11 was in excess of $240 million for New York City area hospitals alone. We are very appreciative that the Federal Government, with the strong support of Senators Clinton and Schumer, subsequently provided area hospitals with $140 million to reimburse them for a significant portion of these costs, but we believe it is important to underscore the high costs associated with responding to such events from a provider perspective.

The Biggest Lesson Learned: The Need for Every Hospital to Be Prepared—I point out one fact about what happened on September 11 that has materially affected how GNYHA and its members have been preparing for future emergencies. Individuals caught in the disaster ran, they jumped on boats, and they jumped on trains and subways to escape the horror. *As a result, over 100 hospitals in the region saw more than 7,300 patients in their emergency departments for World Trade Center disaster injuries.* Although there was no evidence of a release of biological, chemical, or radiological agents in connection with the attacks, many hospitals chose to decontaminate or wash down patients to protect both patients as well as health care workers. But if there had been a contemporaneous release of some agent, every one of those over 100 hospitals would have received potentially exposed or contaminated patients.

What is the lesson to be learned from this? *Every single hospital must have some degree of capability to respond to disasters of all types.* We cannot, as a system, depend on an orderly distribution of patients to one or more regional disaster centers. It is essential that every hospital have the ability to identify and respond, at least initially, to biological, chemical, and radiological events, which in turn means that significant resources must be devoted to ensuring wide-spread readiness.

III. POST-SEPTEMBER 11 PREPAREDNESS—FOCUS ON INTENSIVE REGIONAL COLLABORATION

Establishment of Emergency Preparedness Coordinating Council—In recognition of the need for broad-based preparedness, GNYHA and its members have

focused intensively on regional collaboration and planning since September 11. To this end, GNYHA created its Emergency Preparedness Coordinating Council in November 2001. The Council brings together representatives of GNYHA members, other provider groups, and local, State, and Federal public health, emergency management, and law enforcement agencies for the purposes of promoting collaboration and communication across the region and providing a more integrated response to any future attacks or events. Through this collaborative planning process, the Council is also facilitating readiness through the sharing of expertise, experiences, templates, and other information.

Guiding Principles of Preparedness—As the Council has moved forward, it has subscribed to the following principles:

- **High-Risk Area**—The New York City region is a high-risk area for emergencies in general and terrorist attacks in particular. Therefore, providers must anticipate the possibility that an event could occur at any time.
- **Strong Three-Way Partnership**—Preparedness in the health care sector requires a strong, continuous three-way partnership among providers, health/public health agencies, and emergency management and public security agencies.
- **All-Hazards Approach**—Provider preparedness should be undertaken using an all-hazards approach.
- **Incident Command Systems**—Providers should implement an incident command system in order to have a common framework for communicating internally and externally during disasters.
- **Enhancing Communications**—Providers must develop effective mechanisms for communicating. This involves knowing in advance of a disaster with whom, how, and for what purposes to communicate during disasters. It also means developing effective and redundant means of communicating during disasters.
- **Understanding Each Others' Systems**—We must ensure that we understand each other's systems, roles, and responsibilities.
- **Planning and Drilling Together Regularly**—In order to further the foregoing goals, it is essential that we plan and drill together regularly.
- **Training and Education**—Knowledge is the key to ensuring the rapid identification, treatment, and containment of all types of terrorist agents and naturally occurring events.

The following summarizes how we have moved to implement the foregoing principles.

• **Operating Within a High-Risk Area**—In recognition of the high-risk area in which we are located, GNYHA and its members appreciate that an event could occur at any time and at any place and that we must enhance our preparedness with all due speed and deliberation. As a result, since the Council was established in November 2001, *it has met almost weekly through either full Council meetings, workgroup meetings, or membership briefings on topics identified through the Council.* The Council has also become the framework for communicating rapidly and effectively regarding emergencies, alerts, and protocols.

• **Development of Strong Three-Way Partnership**—We have undertaken extraordinary efforts to work collaboratively and in a coordinated manner with the public health, emergency management, and public security agencies who will need our services and whose services we will need. Our preparedness and any future responses will be superior for that effort.

From a local standpoint, we work closely with New York City's Office of Emergency Management, Department of Health and Mental Hygiene (NYCDOHMH), Fire Department, and Police Department. Because we prepare as a region, we have established similar working relationships with the public health and emergency management agencies in the counties surrounding New York City.

On the State level, we have excellent relationships with the New York State Department of Health (NYSDOH), Office of Public Security, and Emergency Management Office, and have incorporated New Jersey's Department of Health and Senior Services and emergency management agencies in our process as well.

On the Federal level, we are fortunate to have not only strong relationships with key Federal agencies, but truly extraordinary individuals assigned to work with us. That is the case with respect to both the Department of Health and Human Services and the Department of Homeland Security, through its Federal Emergency Management Agency (FEMA), both of which support and enhance our activities on a regular basis. Indeed, our communications with and support from both agencies are models for public-private partnerships.

• **Developing an All-Hazards Framework and Implementing Incident Command Systems**—GNYHA and its members have placed a strong emphasis on developing and implementing an all-hazards response framework on the theory that one can never anticipate precisely how or when an event might occur and indeed

an event might present with multiple features. We therefore believe that planning under an all-hazards approach will make us better able to respond to multiple variations of possible attacks and natural events.

As a result, GNYHA and its members have devoted extensive efforts toward implementing strong incident command systems, which can be activated in response to a variety of emergencies. Using the incident command approach also permits hospitals to employ a common response framework with similar roles and responsibilities across organizations. Most hospital incident command systems are modeled after the Hospital Emergency Incident Command System or HEICS, and thus, GNYHA has offered numerous training sessions on implementing HEICS. Special sessions have been offered for individuals working on the evening, night, and weekend shifts in order to ensure the availability of staff familiar with incident command principles during all hours of operation. Many of these training modules are available on the Emergency Preparedness Resource Center located on GNYHA's Web site at www.gnyha.org/eprc so that members can download and use them in their own institutions.

- **Enhancing and Ensuring Effective Communications**—We have placed an extraordinary emphasis on communications because the ability to communicate with one's partners during an emergency is key to an effective and rapid response. We have tackled this issue from two perspectives. First, we have focused on the issue of ensuring that we know with whom, how, and for what purposes to communicate during a disaster. Second, we have focused on ensuring that we have rapid, effective, and redundant means to communicate during a disaster. The following outlines some of the specific systems and mechanisms put in place to address this critical component of preparedness:
  - **GNYHA Emergency Contact Directory**—To improve communications during an emergency, GNYHA has developed a directory of key contact information regarding local, State, and Federal agencies. GNYHA has also created a member directory that contains extensive contact information about members' emergency operations centers, chairs of disaster committees, and other key contacts in the event of emergencies. The directory also contains basic information about each members' capabilities—for example, trauma center designation, decontamination capabilities, and the number of negative pressure isolation rooms. Members are encouraged to update their information regularly, and revised directories are made available quarterly or as needed. The directory proved to be invaluable during the August 2003 Blackout when communication systems were disrupted throughout the region.
  - **Health Emergency Response Data System**—NYSDOH, working collaboratively with the Council, has developed an emergency data collection system called the Health Emergency Response Data System or HERDS. The system, which is an internet-based system located on a secure area of NYSDOH's Health Provider Network, is designed to be activated during an emergency to collect information that may be needed to assess and respond to the emergency and to enhance and protect surge capacity. Although the system is located on NYSDOH's Health Provider Network, local public health and emergency management agencies also have access to the system so that they can better respond to any emergencies affecting their region. The categories of data that can be collected include the following:
    - Bed, staffing, and supply needs and availability;
    - Event-related data, including the number of patients seen and waiting to be seen, admissions, unidentified patients, and mortalities; and
    - Information required to establish a patient locator system, if needed.

NYSDOH also uses the system to collect weekly bed availability data from hospitals, to survey them on such information as vaccine supplies and negative pressure isolation rooms, and to communicate regarding preparations for events such as possible weather emergencies. We have also held a number of drills designed to test both the system itself and the ability of hospitals to use it successfully. Workarounds in anticipation of possible disruptions in the system have also been established.

  - **Ensuring Rapid Communications**—GNYHA provides extensive information to its members through immediate distribution via e-mail of health and security-related alerts, advisories, and directives. To ensure broad distribution of the alerts, GNYHA sends the materials to many different types of individuals in each member institution such as chairs of disaster committees, infection control directors, directors of emergency departments, and directors of security.

- **Assessing Communications Risks and Minimizing Disruptions**—GNYHA has prepared a matrix of communication options that describes each option's functionality and limitations. In addition, GNYHA has prepared a checklist of considerations regarding possible disruptions to communication systems in order to assist members plan for and thus avoid or work around possible disruptions to their systems. Finally, the Council has discussed how to undertake effective risk assessments to identify vulnerabilities and solutions for avoiding disruptions.

- **Building in Redundancies**—Although a vulnerability assessment might minimize disruptions in communication systems, GNYHA and its members have sought to build in as many redundancies in communication systems as possible. This is evidenced by the multiple ways that members can be reached as set forth in GNYHA's emergency contact directory mentioned above. In addition, GNYHA members have established and rely on the following systems:
  - **800 Megahertz Radios**—GNYHA worked with New York City OEM to establish a health care channel on the city's 800 Megahertz radio system. This channel permits New York City health care facilities to communicate among each other and with OEM during emergencies. The city conducts roll calls on this system on a daily basis. This system was used extensively during the 2003 Blackout to communicate member needs for generators, fuel, and other supplies.
  - **Two-way Emergency Response Radios**—GNYHA has also developed a two-way radio emergency response network to enable GNYHA to communicate with its members both inside and outside of New York City.
- **GNYHA Web Site**—GNYHA provides extensive information on the issue of preparedness through its Emergency Preparedness Resource Center located on its Web site at www.gnyha.org/eprc. This information is updated regularly and is made available on the public area of GNYHA's Web site so that the public and providers can have access to the information day and night. In order to address the concerns of the community, the Web site includes a section with materials on preparing for and responding to disasters from a community perspective.
- **Syndromic Surveillance**—GNYHA has supported the efforts of NYCDOHMH as it has built its impressive syndromic surveillance system, which is designed to identify clusters of suspicious symptoms, such as gastrointestinal or respiratory problems, that might signal a bioterrorism event or other serious public health problem. Currently, NYCDOHMH collects daily emergency department logs from area hospitals, emergency medical services call data, certain employee absenteeism rates, and local pharmacy purchases, all toward the goal of identifying and containing possible infectious disease outbreaks or other events as quickly as possible. Should a cluster be identified, NYCDOHMH would investigate and notify area emergency departments and infection control directors accordingly.

- **Understanding Each Other's Roles, Resources, and Responsibilities: Planning and Drilling Together Regularly**—Understanding each other's roles, resources, and responsibilities is essential to a well-coordinated response to an emergency, and thus, GNYHA and its members have worked hard to understand precisely what each hospital's and agency's capabilities, planned responses, and resources might be under a variety of scenarios. This is accomplished in great part through our collaborative planning process and the undertaking of many drills and exercises, all designed to assess the strengths and weaknesses of the response system and then to of course address any identified gaps. Some of the more notable examples of these efforts are the following:
  - **Preparing for Bioterrorism**—Since its inception, the Council has focused its discussions on a number of bioterrorism agents, spending a significant amount of time on identifying, treating, and containing smallpox in particular. In August 2002, however, a small hospital in Brooklyn experienced a "smallpox scare," which raised useful questions regarding various elements of responding to such a situation. As a result, NYCDOHMH and NYSDOH, working collaboratively with the Council, developed extensive guidelines for managing a suspect smallpox case. While the guidelines focus on smallpox, many aspects of the guidelines apply equally to managing other infectious diseases as well. The guidelines are available on GNYHA's Web site at www.gnyha.org/eprc.
  - **SARS Planning and Response**—The work that has been done to prepare for a possible bioterrorism attack proved to be helpful to the health care system's ability to respond quickly to the threat of Severe Acute Res-

piratory Syndrome or SARS in 2003. The Centers for Disease Control and Prevention (CDC) immediately transmitted health alerts to State and local health departments, which in turn immediately distributed the alerts to providers. In order to ensure broad distribution of the alerts within its members, GNYHA distributed them to its many e-mail lists. GNYHA also held briefings on SARS, which were given by NYSDOH and NYCDOHMH; held meetings of its Council to discuss the development of SARS guidelines and surge capacity plans; and created a SARS page on its Web site.

- **Development of Threat Alert Guidelines**—To assist members work within and respond to changes in the Federal color-coded threat alert levels, GNYHA worked with its Council, NYSDOH, and NYCDOHMH to develop Threat Alert Guidelines for health care providers. The Guidelines provide a checklist of measures providers should take by alert level. Each level is divided into a number of categories of measures, which include such issues as overall emergency planning, communications, security, staffing, and supplies. The Guidelines are distributed each time a planned event or possible anticipated emergency arises.
- **2003 Blackout Response**—The 2003 Blackout tested us all and demonstrated the gaps that we still needed to address. But it also highlighted what worked well: our emphasis on redundant communications paid off; our collection of emergency contact information regarding members helped us reach every member; our 800 Megahertz radio system helped address emergency generator and fuel requirements; the HERDS system collected information about available beds in anticipation of the possible evacuation of a facility; and most importantly, our strong three-way partnership with the health and emergency management agencies proved invaluable. Following the Blackout, GNYHA prepared checklists outlining considerations for preparing for future disruptions in power and communications and held a debriefing session attended by members as well as local, State, and Federal agencies.
- **Undertaking Drills and Exercises**—Although we meet and work together regularly, we find that drills and exercises are an excellent way to test our systems and to identify gaps. We thus have placed a heavy emphasis on conducting table-top exercises, communication drills, and other exercises. We have picked up the pace of these drills and exercises as we unroll more components of our systems and have more to test.

- **Training and Education**—The Council has placed heavy emphasis on training and education. Thus, GNYHA has offered over 65 briefings and training sessions to its members and key agencies since September 11. The topics have included programs on various biological, chemical, and radiological events; preparing for and responding to power outages and other disruptions; undertaking evacuations; implementing incident command systems; communication systems; and facility security. Recognizing that training is a continual process, we often revisit issues already presented. Upcoming programs include:
  - Briefing on *blast injuries* that will be given by the CDC's National Center for Injury Prevention and Control on August 4.
  - Briefing on *utilizing volunteers during emergencies*, which is tentatively scheduled for August 9.
  - Briefing on *Republican National Convention planning*, which is scheduled for August 17 and which will be presented by multiple local, State, and Federal agencies.

IV. PREPARING FOR THE REPUBLICAN NATIONAL CONVENTION

The foregoing outlines our preparedness for both naturally occurring events as well as possible terrorist attacks, which we assume can occur at any time and at any place in the New York City region. However, it also provides detailed information about the planning and preparedness that has already taken place and upon which we build to prepare for major planned events, such as the upcoming Republican National Convention.

The health care sector's preparations for the RNC have followed the same collaborative process outlined above. GNYHA, on behalf of its members, has been involved in the preparations being undertaken by the local, State, and Federal Governments, including participation in the table-top exercise held by the Secret Service and the New York Police Department in April 2004; participation in numerous meetings held by NYCDOHMH regarding its preparations; and coordination with New York City OEM. GNYHA also held an initial briefing for providers on June 18 that permitted local, State, and Federal agencies, including the Secret Service, FEMA, and

HHS to address their preparations. Another similar briefing is scheduled for August 17.

At the initial RNC provider briefing, NYSDOH and NYCDOHMH reviewed guidelines that outline what actions the two agencies are taking as well as actions providers should take in order to ensure the preparedness of the health care system for the RNC. The following outlines the guidelines provided:

• **Activation of New York City's Emergency Operations Center and Multi-Agency Command Center:** Both New York City's Emergency Operations Center and a Multi-Agency Command Center that will be established by the New York Police Department will be fully activated round-the-clock before, during, and after the RNC. GNYHA, NYSDOH, NYCDOHMH, and other health-related agencies will be staffing one or both of these locations in order to provide assistance and to coordinate any needed responses by the health care system. In addition, key agencies as well as GNYHA will establish their own command centers and/or operations plans for the period of the RNC.

• **Review and Activation of Hospital Disaster Plans**—Although NYSDOH has taken the position that it will not request hospitals to activate their disaster plans unless an incident occurs, both NYSDOH and NYCDOHMH advise hospitals to review their disaster plans and to ensure that staff understands the hospital's incident command system and their own individual roles and responsibilities.

• **Review of Threat Alert Guidelines**—NYSDOH and NYCDOHMH request hospitals to review the Threat Alert Guidelines developed by GNYHA, NYSDOH, and NYCDOHMH as guidance for their internal planning with a specific focus on the activities that should be undertaken for Level Orange.

• **Activation of HERDS**—NYSDOH will activate its Health Emergency Response Data System prior to the RNC. NYSDOH will request hospitals to input daily bed availability by type of bed, emergency department activity, and the roster of their contact persons for each shift throughout the RNC. NYSDOH will be ready to request and provide more information should the need arise. Hospitals are also advised to make certain that several people familiar with data entry into the system are on duty during all shifts.

• **Availability of Staff**—Key administrative staff are advised to be available on-site at the hospital during the RNC. In addition, most key departments in hospitals have limited vacation and other time off. Hospitals are also advised to review staffing and to ensure their ability to call in extra staff if needed. In order to ensure the availability of staff, hospitals are advised to recommend to their employees that they have their own family emergency preparedness plans in place so that they will feel comfortable reporting to and staying at work during an emergency.

• **Communications**—The guidelines advise hospitals how NYSDOH and NYCDOHMH plan to communicate with them during the RNC and, in particular, in the event of an emergency; that hospitals should ensure that they constantly monitor those means; and that each hospital should provide each agency with accurate contact information for the hospital. In general, communications will take place using the 800 Megahertz radios, HERDS, the Health Alert Network, e-mail and facsimile, and regular conference calls. Hospitals are also advised to review the checklist for preparing for disruptions in communications that GNYHA prepared as a result of the 2003 Blackout. Finally, hospitals are advised to post key agency contact information in their emergency departments and other areas throughout the hospital. NYSDOH will be advising health departments in counties outside of New York City to maintain daily contact with hospitals in their counties during the RNC.

• **Planning for Disruptions in Power**—Hospitals are advised to review the checklist for preparing for disruptions in power that GNYHA prepared as a result of the 2003 Blackout. In particular, hospitals are advised to test their generators, ensure a sufficient supply of fuel for the generators, and have emergency contact information for their fuel vendors.

• **Emergency Department Preparedness**—NYSDOH and NYCDOHMH have provided specific guidelines for emergency department readiness that include anticipated types of cases and symptoms (including their relative likelihood), recommended supplies, and data that should be collected by emergency department staff. Emergency department triage and medical staff are being advised to obtain information on whether patients presenting right before, during, and after the RNC with certain symptoms are RNC attendees, demonstrators, or in any way associated with RNC-related events. Unexpected clusters of illness should be reported to NYCDOHMH. Staff are also advised to drill on various protocols that might be utilized should an event occur.

• **General Infection Control Preparedness**—NYSDOH and NYCDOHMH advise hospitals to re-enforce respiratory hygiene measures among clinical and triage staff in emergency departments and other settings. They also advise that fever and

rash as well as fever and respiratory symptom triage protocols should be reinforced to avoid the spread of infectious diseases.

• **Syndromic Surveillance**—NYCDOHMH will of course be monitoring its syndromic surveillance system, which, as indicated previously, collects extensive information from emergency departments, EMS, employee absenteeism data, and pharmacy sales in order to identify particular clusters of suspicious symptoms. For the purposes of the RNC, the system will be monitored with a lower threshold for responding to suspicious symptoms than under normal circumstances. NYCDOHMH advises hospitals participating in the system to be prepared to respond in the event that a "signal" is detected suggesting a potential illness cluster. In that event, NYCDOHMH will notify the infection control and emergency department contacts in the hospitals and more extensive information will be requested. Hospitals may also be requested to undertake more extensive screening, testing, chart reviews, and other activities. NYCDOHMH will also be prepared to visit hospitals to assist in making diagnoses, collect data, and monitor aspects of the event.

• **Final Alerts and Advisories**—NYSDOH and NYCDOHMH plan on sending Health Alerts to providers right before the RNC in order to reinforce the foregoing advice and any new information. GNYHA will in turn distribute the Alerts to its broad list of hospital staff GNYHA will also be reinforcing the multiple ways members can reach GNYHA at OEM, the MACC, and at GNYHA both during and outside regular business hours.

V. THE PRICE OF PREPAREDNESS

Quite clearly, extensive efforts are in place to be prepared for a vast array of events, both planned and unplanned, in the New York City region. The collaborative efforts that have taken place through GNYHA's Emergency Preparedness Coordinating Council are intended to enhance preparedness in the most efficient, efficacious, and expeditious way.

The Cost of Preparedness—However, the price of preparedness is still high. In late 2002, GNYHA undertook a survey of its members' actual and anticipated expenditures associated with their preparedness activities. The survey requested information about their incremental expenditures over and above what they would have spent on preparedness if the World Trade Center attack had not occurred, and excluding any costs incurred in the immediate response to the September 11 attacks. The survey requested cost information broken down into three categories:

• Expenditures undertaken during the period September 11, 2001, through December 31, 2002;

• Expenditures planned for the year 2003; and

• Expenditures that would be undertaken in 2003 if additional funds were available.

Fifty-four hospitals responded representing 51 percent of the institutions and 61 percent of the total operating expenses of the potential sample. The survey indicated that teaching hospitals had invested more heavily in preparedness than non-teaching institutions, a finding that is not surprising given that teaching hospitals are more likely to serve as regional trauma centers and burn centers, possess advanced disease surveillance and analytical laboratory capabilities, and tend to have a broader scope of services than community hospitals in general. In addition, hospitals in New York City not surprisingly spent more on average than did hospitals outside of the city, presumably because New York City hospitals place a higher priority on preparedness and have imposed a more aggressive timetable for implementation due to the higher risk of an attack in New York City.

• **Total Expenditures For Preparedness By Downstate Hospitals**—In order to predict regional and Statewide expenditures for preparedness and based upon the observation that teaching hospitals have made greater investments in these activities, GNYHA extrapolated the survey findings using average expenditures per staffed bed according to hospitals' teaching status to all hospitals in the New York City metropolitan region as well as to all hospitals Statewide. Based on this extrapolation process, GNYHA determined that hospitals in the Downstate region alone:

• Spent $149.7 million on incremental preparedness activities between 9/11/01 and 12/31/02;

• Planned to spend an additional $183.6 million on incremental preparedness activities during 2003; and

• Identified additional needed but unbudgeted preparedness projects with projected costs totaling $788.6 million.

See Figure 1, which depicts the results of the extrapolation process and which appears in the supplement to this testimony.

Average Expenditures For Preparedness Per NYC Hospital—With respect to individual hospital expenditures for preparedness, hospitals in New York City:

• Spent on average nearly $2.5 million per hospital during the period from 9/11/01 to 12/31/02;

• Planned to spend on average an additional $2.9 million per hospital during 2003; and

• Identified additional needed but unbudgeted projects with projected costs totaling on average $12 million per hospital.

See Figure 2, which demonstrates the average expenditures per New York City hospital and which appears in the supplement to this testimony.

Although the costs identified through GNYHA's survey are significant, they do not capture the actual cost to our members in terms of the hours upon hours of administrative, clinical, and other personnel time that have been devoted to and will continue to be devoted to training, development of protocols, and reviews that will be undertaken each time a new threat alert or piece of intelligence is transmitted. In short, the price of preparedness is great and on-going, and there is no indication that providers in the New York City region will be able to stand down in terms of their level of preparedness.

Funding for Preparedness—New York State hospitals have received only relatively small amounts of funding toward their preparedness activities. While GNYHA and its members are appreciative of the bioterrorism funding that has been made available and continues to be made available through the Health Resources and Services Administration (HRSA), the amounts that filter down to individual hospitals do not begin to address the expenditures that are being made by the New York City region's hospitals.

The following details the amounts that have been made available or will be available to hospitals in New York City through the HRSA Bioterrorism program to date:

• FY2002: $40,000 per hospital;

• FY2003: $85,000 per hospital plus $4.2 million *total* for all New York City hospitals for special projects; and

• FY2004: amounts per hospital not yet determined, but total amount available is similar to FY2003.

See Figure 3, which demonstrates the cost of preparedness per New York City hospital juxtaposed with the amount of HRSA funding made available to date. Figure 3 appears in the supplement to this testimony.

The Poor Financial Condition of New York State Hospitals—The need to increase and maintain preparedness and in turn to increase expenditures for this purpose could not come at a worse time. *Hospitals in New York State suffer from the worst financial conditions of hospitals anywhere in the country and have experienced 5 years of bottom-line losses.* This situation is rooted in the following factors:

• New York's previously regulated all-payer rate-setting system, which squeezed any surpluses out of hospitals;

• Declining revenues resulting from private payer negotiations and their practices of delaying and denying payments;

• The mission of caring for the State's three million uninsured residents; and

• The imposition of unprecedented Medicare cuts, beginning with the Federal Balanced Budget Act of 1997, continuing with reductions in payments to teaching hospitals, and now pending are cuts in the New York City area wage index, which, if implemented, will reduce Medicare payments to area hospitals by over $100 million annually.

Clearly, the financial condition facing New York's hospitals impedes their ability to undertake the activities that are essential to both fulfilling their basic mission of providing health care and their new role as the front line of the public health defense and emergency response systems.

Securing the Necessary Resources to Ensure Public Health and Health System Preparedness—It is essential that the New York City region's hospitals obtain the resources they need to continue to enhance and maintain their preparedness for the protection of all of us. We therefore request that Congress authorize additional funding for these purposes. Our hospitals take on additional responsibilities in light of their location in the New York City region due to the region's role as the Nation's financial center, its many national landmarks, and the view of the world that New York City holds a little bit of everything that is good about America. Our hospitals take on these additional responsibilities for the benefit of the country at large, and they in turn deserve to be supported in their efforts.

I thank you for the opportunity to appear before you today and am of course available to answer any questions you may have.

SUPPLEMENTAL TABLES

Figure 1.—Preparedness Expenditures by Time Period Extrapolated to New York City Region and New York State According to Teaching Hospital Status and Expenditures per Staffed Bed

	Total Respondents ($ in millions)	GNYHA Downstate Hospitals ($ in millions)	New York State Hospitals ($ in millions)
Spent—(9/11/01–12/31/02)	90.2	149.7	218.3
Planned Expenditures—(1/1/03–12/31/03)	110.5	183.6	269.3
Needed but Unbudgeted—Projects (1/1/03–12/31/03)	468.6	788.6	1,215.4

Figure 2. Average Preparedness Expenditures Per Hospital by Region

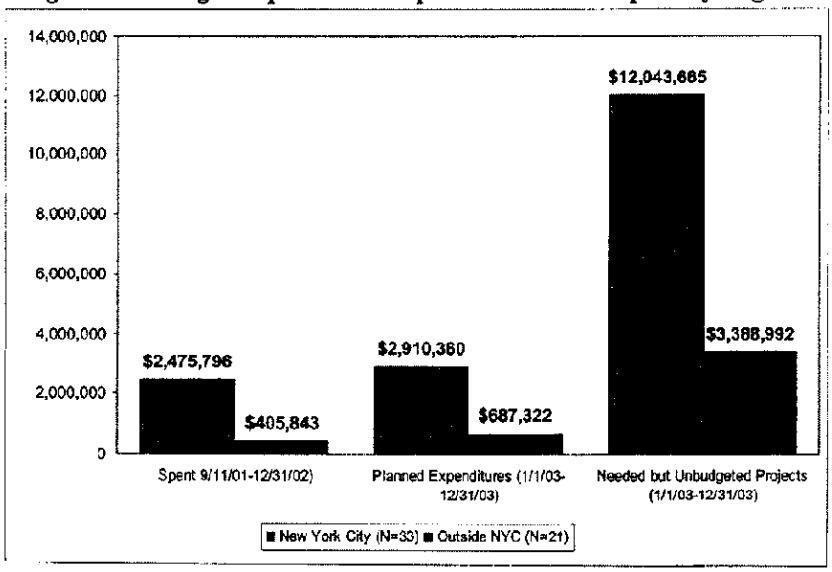


Figure 3.—Cost of and Funding for Preparedness Per NYC Hospital

	Average Expenditures Per Hospital	Funding Made Available Per Hospital
Actual—9/11/01–12/31/02	$2.5 million	0
Actual/Projected—1/1/03–12/31/03	$2.9 million	$75,000 (HRSA FY2002 and expedited portion of FY2003)

Source: GNYHA survey of incremental expenditures for preparedness over and above what each hospital would have spent but for the World Trade Center disaster.

Needed but unbudgeted for 2003: $12 million per hospital.

HRSA funding available during 2004: $50,000 per hospital plus additional funding ($4.2 million total for all NYC hospitals) for special projects

The CHAIRMAN. Thank you, Ms. Waltman.
Dr. Martinez.

RICARDO MARTINEZ, M.D., SUPER BOWL SENIOR MEDICAL ADVISOR, NATIONAL FOOTBALL LEAGUE CHAIRMAN AND CHIEF EXECUTIVE OFFICER, MEDICAL SPORTS GROUP

Dr. MARTINEZ. Mr. Chairman, Thank you for the opportunity to speak to you today on this important issue. I am Dr. Ricardo Martinez, and I am a board-certified emergency physician, but I am also the senior medical consultant for the National Football League on emergency and disaster planning and response, and with me today is Mr. Milt Ahlerich, who is vice president of security for the National Football League.

The NFL places a premium on fan safety and security, and during the professional football season, the league maintains a national communication center to coordinate and integrate as many as 16 large-scale events on any given weekend. Each averages about 65,000 personnel and fans. Now, each event alone represents the population of a small city and the expected challenges and incidents that accompany that.

In the aftermath of September 11th, the Commissioner's office began to identify nationally the best practices in security and created an advisory board of experts in game operations, security, and emergency planning. As a result, they created a best practices program, and that was recommended to all NFL teams through a series of conferences and on-site reviews of each facility by an independent security firm and training seminaries for team security. That program has grown over the years, and it is described in much greater detail in the submitted testimony, but in 2003, the NFL provided staff from each team with in-depth presentations on pregame and game day security practices and techniques, basic emergency procedures, and the trainer course to train local staff in the facilities.

The NFL firmly believes that complacency can erode well thought out plans and therefore it is essential to continue to review, upgrade, and assist the member clubs with these issues. The NFL also subscribes to the belief that security, medical, and operations must be integrated, work in an integrated fashion to maximize their effectiveness and to strengthen and coordinate the response to an emergency. All front line staff are the first link of the chain of survival for managing all kinds of incidents.

The best practices program was, therefore, expanded this year to include training on emergency disaster planning and response, the incident command system, special situations such as biological and hazardous materials, public health threats, and issues such as full and partial evacuation procedures. As we speak here today, this program is being used to train staff around the country and will continue to evolve with experience.

Now, the Super Bowl provides an opportunity to put these principles into practice in a new city each year. The Super Bowl has a huge impact on the local community where it is played. While challenging, it also offers the potential to increase the local emergency preparedness capacity to both routine emergencies of everyday day life and to the new emerging threats. The planning process

can provide a forum for improved communications, strengthening relationships, helping overcome organizational and political barriers, and for fostering of innovative partnerships. The NFL works in partnership with all levels of government, civic, and private organizations to share its expertise and to create an environment that fosters team work and integration.

Starting up to a year in advance, the NFL ensures that venue management, security, emergency medical services, local hospitals, police, fire, and emergency management, public health, civic organizations, businesses leaders, and the political community come together early, early in the planning discussion. These groups are also brought together with architectural and transportation planners, an issue you raised, to prepare emergency access routes, staging, triage and treatment areas, decontamination zones, signage and other needed infrastructure. We love fire for decontamination because they have hoses and water, and we love them.

Planning and cooperation are not enough. The NFL encourages broad-based drills and training exercises, and we integrate emergency response information through staff handbooks, orientation programs, and information tags they hang around their neck. For game day operations, we have an integrated command post that facilitates information sharing and coordination across a host of agencies and disciplines.

Now, does all of this make a difference? Well, we called some of the recent Super Bowl host cities after September 11th, and here are some of the comments they made: A new recognition of health care as a first responder, a stronger relationship between public safety and the health community, a more coordinated detection of and response to hazardous and biological materials, better cooperation between hospitals for surveillance and data collection, new models for responding to major emergencies, new training programs at local medical centers, and the transfer of lessons learned at this city level to statewide planning.

For the last 2 years, the Super Bowl has shown patrons of a stadium an evacuation video, an idea that was started by the San Francisco 49ers. The Commissioner's office is now producing a localized version that would be provided to each team for use at their own facilities.

The NFL recognizes that our success lies in the strength of the public-private partnerships and wishes to thank the many Federal, State, and local partners who each day dedicate time, energy, hard work, and resources to strengthen America's capabilities. Thank you for the opportunity to present a brief overview of some of the NFL's activities, and I am happy to answer your questions.

Thank you.

[The prepared statement of Dr. Martinez follows:]

PREPARED STATEMENT OF RICARDO MARTINEZ, M.D.

Mr. Chairman, and Members of the Committee, thank you for the opportunity to speak to you today on this very important issue. I am Dr. Ricardo Martinez, a board-certified emergency physician and a senior medical consultant to the National Football League on emergency and disaster planning and response. I have attached to my statement a brief CV that more fully describes my background and prior public service. I am joined today by Mr. Milt Ahlerich, Vice-President of Security for the National Football League.

The National Football League places a premium on fan safety and security. During the professional football season, the National Football League maintains a national communications center to coordinate and integrate the various events that take place around the country on game days. On any given weekend, as many as 16 large-scale events may take place, involving an average of 65,000 fans and personnel. In many ways, each event alone represents the population of a small city and the expected challenges and incidents that accompany such a population.

In the aftermath of September 11th, the Commissioner's office, under the direction of Mr. Ahlerich and his staff, began to identify the best security practices in stadiums from around the country and created an advisory board of professionals with expertise in facilities and game operations, security, and emergency planning. As a result, the NFL created a Best Practices program that was recommended to all NFL Teams through a series of conferences around the country. The NFL followed up with onsite reviews of each facility by an independent security firm that observed and reported the level of compliance with the NFL's Best Practices and made recommendations to improve. In the summer of 2002, the NFL held a training seminar for team security officials on the best practices and offered advice on steps clubs could take to enhance security without unduly inconveniencing fans.

In 2003, the NFL conducted a training program for up to five people from each team, and provided them with in-depth presentations on pre-game and game day security, venue inspections, vehicle inspection, access and credentialing, proper screening procedures and techniques, basic emergency procedures and much more. In addition, "train-the-trainer" courses were provided so that local facility staff could be trained on the basics of this important information. The NFL firmly believes that complacency can erode well thought-out plans and procedures and therefore it is essential to continue to review, upgrade and assist the NFL member clubs in maintaining their high levels of compliance with the Best Practices.

The NFL subscribes to the firm belief that security, medical and venue operations must work in an integrated fashion to maximize the effectiveness of event operations and to strengthen and coordinate the response to an emergency. More important perhaps is the recognition that front line staff, be it ushers, parking attendants or concessioners, are the first contact point in the "chain of survival" for medical emergencies and for managing security and operations incidents.

Therefore, this year the Commissioner's office updated and expanded the Best Practices program to include information on emergency medical and disaster planning and response. Subject matter included in-depth discussion of the planning, prevention, response and recovery phases of emergencies and disasters; an overview of the Incident Command System used for disaster response; special situations such as biological, hazardous material and other public health threats; and issues such as full and partial evacuation principles.

Again this year, the NFL sponsored a training program for senior staff from each NFL team and their associated facilities, which program was conducted at three locations across the United States. In addition to the presentations, the NFL created a separate training program module for teams and facilities that can be modified and used for the training of their front line staff in the local facility. This program teaches staff how to recognize an emergency, what to do in an emergency; how to contact help and what information to report; what to do until help arrives; how to protect themselves and others, how to recognize and respond to special situations such as hazardous materials; their role in a Multiple Casualty Incident, and how to evacuate calmly and safely. This current version of the Best Practices program is being used to train staff around the country as we speak here today.

Like any search for best practices, the information continues to evolve as people gain experience in this new environment. What is important is that we all continue to look for ways in which we can all improve our readiness and response to both the expected emergencies of everyday life and to the new threats that are emerging. That is why Congressional hearings like that of today are so important. We listen, and we learn.

Perhaps no single event provides the National Football League an opportunity to put these principles into practice than the Super Bowl. Each year, the NFL brings together a large cadre of experts from both inside and outside the NFL and oversees and manages the Super Bowl and its associated events. It is hard and demanding work. Having been the senior medical advisor since 1988, I can attest to the enormous changes in complexity and magnitude over time. After September 11, this complexity increased even more dramatically, both in intensity and in scope. The unthinkable is no longer unthinkable.

As you know, by its nature, the Super Bowl has a huge impact on the local community where the game is played. This can be very challenging, but it also offers the opportunity to increase the emergency preparedness and capacity of the commu-

nity. Because of the terrific support of the local community and surrounding areas for this event, Super Bowl planning can provide a forum for improved communications, strengthened relationships, and can help overcome organizational and political barriers, and foster innovative and creative partnerships. Cooperation among all agencies, resources and organizations that could potentially prevent or respond to a major incident is vital. Preparations and planning include incidents resulting from causes as diverse as crowd overload, to major trauma, a hazardous exposure, or a major incident.

The NFL works in partnership with agencies at all levels of government, as well as private organizations, to share its expertise and to create an environment that fosters teamwork and integration. Starting up to a year in advance, the NFL ensures that venue management, security, emergency medical services, local hospitals, police, fire, local emergency management, public health, civic organizations such as the Red Cross, business leaders and the local political community come together early in the discussions of emergency and disaster planning and response. Such an effort provides a better understanding of the complexity, and the reality of responding to and managing the consequences of possible incidents, and focuses attention on the practical aspects of how a community would actually respond to a given incident. Since 9/11, we do not ask "what if"; rather, we ask "when if" and then work with others to hammer out a solution.

Our physicians spend a great deal of time working with their counterparts in the State and local medical communities, as well as government officials, to facilitate the coordination and teamwork required for the Super Bowl. In addition, such emergency and disaster planning requires intimate cooperation between these groups and Federal agencies such as the Department of Homeland Security, the Centers for Disease Control and Prevention, the EPA, and the Department of Energy. Of particular note is that these groups are also brought together with architectural and transportation planners to plan and prepare ingress and egress paths, emergency access routes, staging areas, triage and treatment areas, decontamination areas, blow out gates, signage, and other needed infrastructure.

Planning and cooperation are not enough. Therefore, the NFL encourages broad-based drills and training, incorporating as many providers and resources as possible. In addition, specific medical plans are written for the Super Bowl venue and the associated events, with orientation and training programs offered for a myriad of supervisors and front line staff. Emergency medical and disaster response information is integrated into staff handbooks, as well as on lanyard hang tags that many staff wear around their necks for ready reference.

For game day operations, an integrated operations command post facilitates information sharing and coordination across a host of agencies and disciplines. In the weeks prior to the event, scenario practices and table top exercises provide an opportunity for teamwork and problem-solving, as well as for improvement of existing response services.

Does all of this make a difference? Comments and feedback from recent Super Bowl cities are encouraging. Let me share a few with you from Houston by Dr. Richard Bradley of Houston Fire EMS and the University of Texas Health Science Center. He notes that as a result of Super Bowl's planning process, there is:

- a closer working relationship between health professionals and law enforcement and Federal agencies, and better understanding of each others needs and resources;
- stronger organizational and political links exist between EMS and public health;
- much better cooperation between hospitals for surveillance and data collection;
- a new secure system to facilitate hospital data collection and hospital bed status; and
- development of new models for responding to major emergencies.

Dr. Bradley notes that the benefits are still paying off and that the planning for Super Bowl was instrumental in Houston's preparations for the recent MLB All-Star game.

Dr. James Aiken of LSU School of Medicine shared his insights as well. Super Bowl planning helped local agencies and organizations to look critically at a number of issues and to develop new city-wide disaster planning. He notes that, since Super Bowl XXXVI, there is:

- stronger relationships between public safety and the health community;
- a new recognition of health care as a first responder;
- development of new training programs at the local medical centers
- improved coordination of detection and response for hazardous materials; and
- transfer of lessons learned to a state-wide disaster planning process.

He, too, noted that this new city-wide planning has been useful for other events such as Sugar Bowl and the Final Four.

The work involved, as well as the lessons learned, could be the basis of entire day of discussion, but more importantly, the National Football League strives to continue to improve each city it visits through Super Bowl and each city it touches through its teams. As we all learn and move forward, the NFL will continue to look for, and update, its Best Practices program.

One last comment does deserve mention. Two years ago, the NFL did exactly that, in noting that the San Francisco 49ers had created an evacuation video for Candlestick Park. Recognizing the opportunity to provide additional guidance and help to its patrons, the Super Bowl has now incorporated the showing of an evacuation video several times prior to the event. I have a copy of this video, made by NFL Films, for you here today. The Commissioner's office is currently producing a localized version of the San Francisco video that will be provided to each League team for use at its facility.

The NFL recognizes that our success lies in the strength of public-private partnerships and wishes to thank our many Federal, State, and local partners who, each day, dedicate time, energy, hard work and resources to strengthen America's safety net. Thank you again for the opportunity to present a brief overview of some of the National Football League's activities to improve the Nation's preparedness and capabilities and I am happy to answer your questions.

The CHAIRMAN. Thank you, Doctor.

Just picking up there, why would these cities find that your evacuation and planning was unique? Shouldn't they have already had in place this type of an approach?

Dr. MARTINEZ. Well, I have to tell you I think the experience of my colleagues here is probably the same, but the fact is such a high profile event actually helps you overcome some of the organizational barriers that exist. I mean, when we go into cities, the biggest things we see are that we are able to change and improve the linkages between the front end, the emergency response from fire and police, and then kind of to the back end, the EMS and public health. We tend to, and this is my physician hat on, we tend to talk to ourselves a lot and communicate with ourselves, but truly working it through, it takes a big impetus to do that; and the second area is that it is funny. The public safety side is often municipal-based. The hospital side is actually market competition, and trying to bring those worlds together is something we are able to do.

The CHAIRMAN. Well, I wonder how we replicate that, encouraging communities to do that, without having to have a Super Bowl in every town. We should be looking and trying to think about that.

The other witnesses are involved in the actual preparation that would involve Federal funds and Federal participation. I would like to know independent of the HRSA funding stream, which we all recognize is incomplete and probably misallocated, can you give us your top two or three things that you think need to be improved relative to your relationship with the Federal Government or generally? Starting with you chief, since you are right in the middle of the Federal Government.

Mr. SELLITTO. Well, I think we are lucky in the District of Columbia that we do not have many layers of government above such as my colleagues in Maryland and Virginia do. We are receiving our funding in a timely fashion. That is one obstacle we have overcome. We do not have to go through the county and State levels. I think we are lucky there.

One of the things that I am concerned with is pre-distribution of medications. It is an issue that some jurisdictions have accomplished already, I believe Montgomery County to our north. Here in the District, we were ready to distribute medications to the first

responders. My concern is always if there is a biological outbreak today, who will come to work tomorrow. Okay. They are supposed to pre-deploy some medications that will cover the employees and their families. In the District here, there was a legal obstacle to doing that, and it is going to require some legislation. I do not know how many other communities across the country will fall into the same scenario as they try to do things like this, but again, I think that is a major issue that has to be looked at maybe at a higher level.

We talked a lot about surge capacity. We increased our capabilities here to transport from the scene to the hospitals, but I think we see where the numbers at the hospitals still cannot support 7,300 patients that was brought up or something like that.

You mentioned transportation. We are looking at—in fact, we had an exercise about a month ago where we looked at possible use of Marc, VRE, along with Metro to take the patients out of the city to those outlying hospitals. Of course, that can only happen if the rail system is not compromised as a result of some type of attack. Those are some of the other things we are looking at, getting beyond the highways I guess we could say.

We have some issues—and, again, this is talking about the regional aspects. We are working on regional response protocols at different subcommittee levels through the Council of Governments. Unfortunately, we can agree to a protocol change at committee level, but when we go beyond the borders, although let us say Alexandria City agrees to the protocol, they still have to run backwards to their county and State to make sure it is not a conflict with any other protocol. We are finding those regional operations guidelines and stuff, development of them, to be a little handicapped because the local jurisdictions in some cases do not have the power to adopt them, so it has to go all the way up to their States to allow them to operate under a different protocol.

One of the things we did using the dirty bomb scenario was looked at radiation response protocols and found out that every jurisdiction in the area had differing guidelines and none of them matched. Now, that is one thing that we worked. It took about 6 months to work through it, and we did come up with a new protocol that is adopted in the region so that if there was an event, everyone would be playing off the same sheet of music, and one by one, we have to go through all the different scenarios and come up with those guidelines.

Again, it is a little harder in this area, because as soon as we are talking with mutual aid partners, it is crossing State lines, whereas I think maybe in New York it might be a little easier because they are all at least in one State.

Another thing is the standards to which we are measured, and I think it was alluded to earlier there are no set standards in some areas that we can measure our readiness. I know Homeland Security is working on development of some new scenarios with task lists that will, I think, really be good guidance into the question are we prepared, and we will be able to answer it based on those new standards that are forthcoming.

The CHAIRMAN. Thank you, Chief.

Doctor.

Dr. THIBAULT. Thank you. I would answer at kind of three different levels. The first is direct support for emergency preparedness, the recognition that hospitals need direct support to take on these added roles and to bring to a level of excellence and that those funds be distributed in a flexible way, because the needs of one hospital will be different from that of another in terms of where are the deficiencies and that we avoid expending money and energy with mandated standards and programs that do not necessarily serve our goals. The availability of money directly to hospitals, recognizing their first responder role, flexibility in those, and at least a partnership in deciding what rules and mandates would either accompany them or be associated with them.

The second level is a recognition that the ability of our hospitals to respond to even an ordinary emergency, to say nothing about a sustained or unprecedented emergency, is really dependant upon the capacity, the flexibility and the capacity of the system as a whole. How well health care is funded has a direct effect on what our capacity is going to be. Right now, most of our urban hospitals are functioning at 90 percent or greater capacity. Their ability to have the flexible for surge capacity, their ability to even maintain a stable bottom line is dependant upon the total pot of resources available for health care. There is a direct relationship between the ability of our health care system to respond to an emergency and the general health of our health care system, and we cannot disassociate the two.

The third level is research, and I am very encouraged by the passage of the Bio Shield, but I think we cannot underestimate the importance of the pursuit of new knowledge so that we are ready to respond to new emerging infections, whether they be used for bioterrorism or whether they be naturally occurring. The support of fundamental research and then the application of that research in better treatments, better detection methods is going to benefit society as a whole and is going to be directly—is going to directly support our ability to respond to bioterrorism.

We are very pleased in New England that we have a regional center to study biological agents, and one of the high security bio containment laboratories will be placed in Boston. I think continued support for fundamental research and the application of that research to the health of the public is also going to be important in keeping us in the highest state of preparedness.

The CHAIRMAN. Thank you, Doctor.

Ms. Waltman, do you have any thoughts on that question?

Ms. WALTMAN. We have the same issue in New York City, obviously, as in other urban areas with respect to the financial health of hospitals. We happen, just factually, to have experienced 5 years of bottom line losses. In the last 2 years, we have actually closed seven hospitals, and we have closed 10 percent of the city's hospitals because of financial problems, and while in the long run, we may end up as a system being perhaps financially stronger for that, it really does minimize our surge capacity as we close more and more hospitals.

Surge capacity is more than just beds. It is staffing and it is supplies and it is other kinds of equipment, but what we do see is trying to be more efficient and struggling with the financial cir-

cumstances facing hospitals. At the same time, there is a greater expectation of us in terms of our preparedness with respect to a variety of different kinds of terrorist attacks.

Also, another concern that we have is we can perhaps judge what our own surge capacity is, but I kind of call this protecting our surge capacity, and it gets back to this collaborative approach. There are many things we can do to evaluate how many patients we can take, but if transportation routes are cut off or certain other things occur, schools close down and other barriers that get put in play because of other agencies who might be taking certain actions, really does impact the surge capacity of hospitals. If our workforce cannot come to work, they are scared to go to work, it really does affect our own surge capacity, and what we are doing is constantly engaging in drills and walking through scenarios and trying to understand better what all the other players do should certain events occur so we can better judge and evaluate and put in place mechanisms to work around the barriers that are placed there.

I will also say that I think that there are still ways, notwithstanding a lot of the collaboration that goes on, to coordinate the funding that is given out with respect to preparedness within the Federal Government, the State and localities, because there are still different kinds of grants going in different directions, people working on very well-intended projects, but I do think that there needs to be more coordination with respect to those different types of programs because of the seriousness of the issues that they focus on.

The CHAIRMAN. Well, I thank the panel. Unfortunately, I have another event I have to go to, another meeting, but I very much appreciate your testimony. It is extremely useful, and, more importantly, we appreciate the fact that you are on the front lines and that you are out there trying to make this work whether the Federal Government is helping you or not. Hopefully, it is. Hopefully, we are all getting better at this, but we have a long way to go and we all recognize that.

So keep us posted on your thoughts and ideas.

Thank you.

ADDITIONAL MATERIAL

QUESTIONS OF SENATOR GREGG FOR SECRETARY TOMMY THOMPSON

REGIONAL COORDINATION

Question 1. Under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, the Department is directed, in awarding hospital preparedness grants, to prioritize applications from entities that focus on regional coordination. GAO studies and reports from the field describe a serious lack of regional coordination in multi-jurisdictional metropolitan areas such as Washington, DC, Boston, New York City, Philadelphia and others. Will you be reviewing State plans to identify inadequate regional coordination? How does the Department plan to correct these deficiencies in regional planning in the coming grant year?

HOSPITAL PERFORMANCE

Question 2. Since, under the same Act, the Department is awarding these grants on a formula rather than a competitive basis, what recourse do you have to insist on certain performance measures being achieved by grantees in States and localities? Do you have the authority to condition funding on performance?

FUNDING FLOW

Question 3. We understand that delays getting funding through State and local intermediaries have stymied the ability of hospitals to make sufficient plans and procurements intended by the HRSA hospital grants. Particularly in high-threat areas, do you have the authority to provide funding directly to hospitals? If so, do you plan to do so in order to generate the preparedness levels needed to respond to a mass casualty event?

FUNDING DISTRIBUTION

Question 4. We understand that the funding streams for hospitals are often being distributed in small portions to every hospital in a State rather than through a strategic, tiered approach where a few hospitals have maximum capacity and others develop varying capacities below the maximum. The current practice leads to key hospitals not getting enough of the funds to buy real capacity and instead are using the money for small-ticket items like protective gear and pharmaceutical caches. Will you change HRSA protocols allowing approval of plans that give small amounts of money to every hospital without a more strategic approach to State-wide or region-wide surge capacity development?

SURGE CAPACITY

Question 5. HRSA requires hospitals to define surge capacity as that capacity available above and beyond daily operations. Hospitals are not allowed to count toward your benchmark the real-life approach of discharging non-critical patients, canceling elective surgeries and outpatient clinics to free up providers and space. Under your definition, how many grantees have achieved this excess capacity? Do you think that requiring hospitals to build beds and other capacity that sit unused until an emergency is the best use of the HRSA dollars? Would you consider a change in your surge capacity definitions?

EVALUATION AND ACCOUNTABILITY

Question 6. As the CDC and HRSA grants enter their 4th year and fourth billion dollars of funding, when can the HELP Committee expect to see the Department develop a comprehensive, quantitative evaluation for Congress on the achievement of the CDC and HRSA benchmarks in every State?

STRATEGIC NATIONAL STOCKPILE

Question 7. Would you describe what medical countermeasures are available as part of the Strategic National Stockpile in the event of a radiological or chemical attack? What additional countermeasures, if any, is the Department considering securing with regard to these two threats?

QUESTION OF SENATOR KENNEDY FOR SECRETARY TOMMY THOMPSON

A Massachusetts biotechnology company received the first FDA approval of a rapid test to detect exposure to anthrax. The test was developed with a $1 million collaborative contract between CDC and Immunetics of Boston and is a good example of the possibilities of such public/private partnerships.

CDC sought to develop the new test for inclusion in the Bioterrorism Laboratory Response Network and for effective widespread use in the event of another anthrax attack. CDC says the test is "quicker and easier to interpret than previous" tests and can be used by any laboratory without specialized equipment or training.

Unfortunately, CDC has not clarified whether it intends to purchase this test for the national stockpile. As a result of the current uncertainty, State health agencies have said they don't know whether to buy the test. Given CDC's support for this new method of detecting anthrax, it is surprising that the most recent bioterrorism guidelines do not mention the test's availability.

Please clarify whether CDC or any other agency in the Department intends to purchase this new test for the national stockpile, and, if so, what the timeline for that purchase will be, and whether CDC plans any revision in the current bioterrorism response guidelines to reflect the availability of the new test.

QUESTIONS OF SENATOR MURRAY FOR SECRETARY TOMMY THOMPSON

I would like to ask some questions regarding bioterrorism preparedness and response—questions I asked Dr. Gerberding almost exactly 1 year ago today. Unfortunately, I wasn't provided with many answers at last year's hearing and have not received any written answers since that time—so I'm hoping you can help me with some answers today.

While the President signed an important piece of legislation yesterday, Project Bioshield provides many needed tools without training. I am concerned that we haven't built the "surge capacity" for public health and the health care communities to adequately provide mass health care during a major event.

As we all know, the first line of defense in a biological attack or outbreak will be our health care providers. Yet, prior to the September 11th attacks, fewer than 5 percent of ER doctors were trained in responding to this kind of public health threat.

Due to the demands of public health, it is unlikely that a significant number of public health officials and employees within public health departments have taken advantage of training opportunities. So, it is unlikely that our ER doctors are any more prepared than they were 3 years ago.

Unfortunately, the response to a biological attack must be rapid and any delay could mean thousands of lives lost. Mobilization of a highly skilled response team may not be feasible or possible. And it may take too long.

Question 1. What has the Administration done to encourage greater training of primary care providers or ER doctors in treating a biological outbreak?

Question 2. If a biological attack were to occur—how have we prepared public health authorities to rapidly detect a possible biological attack?

We need to continue building the infrastructure for providing better communication between public health and the health care community at the Federal, State and local levels. And, in the event of a biological attack, our State and local public health agencies and hospitals will need the laboratory capacity and connectability to adequately respond to a mass event.

Question 3. What has the Administration done to enhance this communication and increase our laboratories' capacity to deal with a large-scale attack?

As you know, Washington State's Secretary of Health, Mary Selecky is at the forefront of preparing for biological incidents. She began working on these issues prior to September 11th and is known throughout the country as a leader in preparing public health agencies and facilities to respond to wide-spread attacks. I have worked with her extensively on this issue and both of us are well aware that biological threats are not bound by borders.

As the SARS epidemic spread from Asia to Toronto, there were tremendous concerns about how the health care system in neighboring New York would respond if the disease spread across the border. On the other side of the country in my home State of Washington, we shared the same concerns, as did our neighbors in British Columbia.

While the SARS outbreak wasn't an act of bio-terrorism, it was a clear reminder that any attack using biologics such as smallpox would not recognize State or national borders. Our neighbors to the North or South could likely be affected. In addi-

tion, we may have to turn to those neighbors for help in responding to a massive domestic attack.

I believe it is essential for border communities in Washington to work with health care providers in Canada in order to be fully prepared for a bio-terrorist attack.

Question 4. Would you please provide the committee with the Administration's progress in reaching bilateral agreements with Canada and Mexico in the event of a bioterrorism attack?

Question 5. What efforts are currently in place to coordinate a bioterrorist preparedness plan between our State agencies, Federal agencies and Canada or Mexico?

Question 6. Are there public health models that we can emulate to build a regional agreement with International partners?

Question 7. We need to ensure that the first priority is providing immediate care to those threatened—are there mechanisms for providing care without the limitation of national borders?

We know there are treatments and vaccinations available for protecting individuals in the event of a bio-terrorist attack. And, despite the signing of Project Bioshield, our capacity to manufacture those treatments is still limited.

And, there are real concerns about safety and side effects of current vaccinations. Today we face new and emerging threats and the proposed changes in research, drug approval and vaccine safety are concerning. For example, stockpiling Cipro will do little to protect children or pregnant women from an anthrax attack since this drug has not been approved for use by children or pregnant women.

Question 8. If we expedite FDA approval, what guarantee are we providing vulnerable populations like pregnant women, children and the elderly?

I am aware that the NIH is working on a next-generation smallpox vaccine.

Question 9. Are additional vaccines or antibiotic treatments being considered for more vulnerable populations that are safe and effective in responding to a biological terrorist attack?

Mr. Secretary, it is clear we have made some progress but there are still too many questions left unanswered.

The bottom line is that uninterrupted planning and sustained education efforts will allow us to create and maintain a ready response capacity.

That is going to take a significant amount of funding—and I hope you agree that any decrease in resources will decrease our ability to respond—and will undermine what we have accomplished to date.

QUESTIONS OF SENATOR CLINTON FOR SECRETARY TOMMY THOMPSON

As you know, I have written to you and Secretary Ridge over the last several months concerning the long-term mental health counseling needs of the FDNY and NYPD personnel who continue to deal with the aftermath of September 11.

I am very concerned about moving forward into fiscal year 2005 and beyond. The FDNY Counseling Services Unit and the New York City Police Department informs me that continued counseling services are needed beyond the end of this year totaling approximately $8–10 million. The latest extension of Project Liberty will only allow FDNY to take on new cases until September 30 and then will need to phase-out in December.

Congress appropriated $8.8 billion in the aftermath of the September 11 attacks for FEMA to use in response and recovery including services for FDNY and NYPD. It is my understanding from the Appropriations Committee that funds remain available within the Disaster Relief Fund that could be allocated for future needs of the FDNY and NYPD. I believe FEMA and HHS need to provide funding beginning October 1 and continuing so that no firefighter or police officer is turned away if they are seeking help.

Question 1. Will HHS continue working with us to make sure we are providing our fire, police, and emergency services personnel with the counseling services they need?

Question 2. Can I get your assurance that HHS, in conjunction with FEMA, will provide New York with additional funding and whatever technical advice needed, for those on the front lines of our city's defense?

While I recognize that the most recent round of CDC funding for local health department preparedness included the "City Readiness Initiative" to try and address the issue of threat in the distribution of funding, NYC remained only 29th per capita in funding for 2004.

Question 3. As you begin to think about the 2005 round of grants, what are you doing to further address questions of threat and risk?

Question 4. What about the HRSA hospital preparedness funding? What are you doing with regard to considering threat for those grants?

QUESTIONS OF SENATOR CLINTON FOR ANDY MITCHELL

As you know, the language in the fiscal year 2004 Homeland Security Appropriations law was silent on how the Department could allocate funds to States after a small-state minimum of .75 percent is applied, which I understand the Department treats as a base.

The Congressional Research Service has confirmed that it was well within the Department's discretion for the Department to have allocated State Homeland Security Grant funds based upon factors such as threat and risk. I've met with Secretary Ridge about this issue and written to him about it a number of times and I believe that he agrees that these funds should be allocated based on threat and risk, as every homeland security expert I've heard from has said should be done.

Question 1. Why then did the Department choose to allocate fiscal year 2004 State Homeland Security Grant funds based on population alone?

Question 2. If the fiscal year 2005 Homeland Security Appropriations bill again gives Secretary Ridge the discretion to allocate State Homeland Security Grant funds based on threat and risk, will the Department continue to allocate funds based on population or will it allocate funds based on threat and risk?

[Whereupon, at 1:00 p.m., the committee was adjourned.]

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