Senate Health, Education, Labor and Pensions (HELP) Committee Hearing:

"A Nation Prepared: Strengthening Medical and Public Health Preparedness and Response"

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Testimony of

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Chairman Harkin, Ranking Member Enzi, and distinguished Committee members, it is my special privilege to appear before you today to discuss an issue of great importance to our nation, public health and medical preparedness and response. The thoughts I will be sharing with you today, while my own, are also embraced by my many state and local public health colleagues across the country that devote considerable time, attention, and resources preparing to most effectively manage the consequences of an array of emerging and evolving threats, such as disease outbreaks and disasters, in order to prevent or reduce illness, injury, and death. In the few minutes I have for opening remarks, I would like to talk about how far we have come and what more we must do to maintain our state of readiness.

We sit here today just four months away from the 10th anniversary of the attacks of September 11th, which were followed just one month later by the anthrax attacks. These two acts of terrorism were seminal events that made it very evident to all Americans of the dangers we can expect to face in the future and the need to rapidly escalate our bioterrorism preparedness efforts that began in earnest just two years earlier in 1999.

By everyone's account, there is no question that tremendous progress has been made over the last 10 years. We are so much better prepared now than we were on that memorable sunny Tuesday morning in mid-September 2001.

In the Centers for Disease Control and Prevention (CDC) September 2010 report where they reviewed the preparedness activities of the states, territories, and the four largest U.S. cities, CDC concluded that "much progress has been made to build and strengthen national public health preparedness and response capabilities." This report provides a national snapshot that shows that all states have a reporting capacity system that can receive urgent disease reports at any time of the day, seven days a week; have capabilities to receive, distribute, and dispense Strategic National Stockpile assets; and nearly all states can rapidly respond within 30 minutes to Health Alert Network messages, which provide information to state and local public health practitioners, clinicians, and public health laboratories about urgent health events. We also know that every state has developed and continues to refine its pandemic planning, as required by the Pandemic and All Hazards Preparedness Act (PAHPA).

The Trust for America's Health annual Ready or Not Report in December 2010 acknowledges that "over the past decade, the country has made great strides in preparing for public health

emergencies." This report shows that last year all but one state increased or maintained its Laboratory Response Network capability for chemical threats and 43 states and DC can currently send and receive important electronic health information with health care providers in their jurisdiction.

One more illustration, just last month, in April 2011, the HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) reported that we have advanced the preparedness of hospitals and communities in numerous ways, including through planning for all-hazards, increasing surge capacity, tracking the availability of beds and other resources using electronic systems, and developing communication systems that are interoperable with other response partners. We can now also work with greater speed and improved response time since so often time is of the essence when it comes to information sharing, laboratory detection of biological threats, and getting vaccines and antibiotics to the public who may be in harm's way.

While it is great to see this in writing from respected authorities, for those of us on the job and in the communities doing this work, this progress is very palpable, but yet fragile, a point I will come back to in a few moments.

Our decade-long commitment of investing in and strengthening the nation's public health enterprise has and continues to pay off in so many ways. Congress, and especially this Committee, should be applauded for its work on laws like PAHPA that give states, territories, localities, and tribes the resources and tools needed to get the job done.

Our approach to preparedness follows two main principles: (1) build capacity and capabilities that can effectively address all hazards, both for everyday emergencies, as well as for catastrophic events, and (2) preparedness is not an end point, it's a process that must continually be developed, maintained, refined, and improved. Allow me to elaborate.

While the birth of our modern day preparedness and response efforts was appropriately centered on bioterrorism, we quickly learned that the most effective and efficient way to protect the public was to know all of your vulnerabilities, anticipate those threats, and build systems, programs, and services that are flexible and agile enough to handle anything that may come our way. Building and maintaining capabilities in such areas as: (1) incident management; (2) information sharing and public warning; (3) biosurveillance (epidemiology and laboratory services); (4) countermeasures distribution and dispensing; (5) surge management for mass health care delivery, mass fatalities, and the coordination of volunteers; and (6) community resilience are in so many ways universal in their application to any and all hazards.

Just thinking back over the last year, there is no doubt in my mind that my colleagues – like Don Williamson, the State Health Officer in Alabama, and Jimmy Guidry, the Medical Director and State Health Officer in Louisiana, in their handling of the Gulf Coast Deepwater Horizon Oil Rig Disaster; or Terry Dwelle, the State Health Officer in North Dakota, dealing with the flooding of the Red River; or Loretta Fuddy, the Director of Health in Hawaii, and Mary Selecky, the Secretary of Health in Washington State, as they work hand in glove with their emergency management and environmental protection counterparts on the Japanese Earthquake/Tsunami and nuclear reactor radiation release crisis – they all will tell you that the strength and success of their response can be directly attributed to years of planning and preparedness following an all hazards model. Even as we sit here today, there are multiple states still recovering from the severe weather of late

April/early May that included severe supercell tornado outbreaks and repeated rounds of severe rain that have now resulted in raging flood waters in the Mississippi River valley.

And in my state of Tennessee, we live in the New Madrid Seismic Zone, which includes the states of Tennessee, Kentucky, Missouri, Arkansas, and Illinois. The planning assumptions for a catastrophic earthquake of a magnitude 7 or greater in this area could impact 50% of Tennessee's population. Such an earthquake would overload response capabilities and cripple local and state government. Tennessee projections include: 33,000 injuries, 3,000 fatalities and 7,000 seriously injured; 342,000 in need of shelter; 2.1 million without food, water, or ice; 107,000 structures totally destroyed; 265,000 structures with major damage; 1,000 damaged bridges, 330 collapsed; 608 schools collapsed and unusable; 54 hospitals damaged; and 50% of all emergency vehicles destroyed. Up to seven other states may experience similar levels of loss of life, damage and destruction.

We have been engaged in a wide array of public health emergency responses including multiple white powder incidents (ongoing since 2002), sheltering of hurricane evacuees from partner states (2005/2008), TVA coal fly ash spill (2008), ice storm (2009), and the H1N1 influenza pandemic (2009). More recently, the response activities associated with the severe flooding in both May of 2010 and 2011 included shelter staffing and support, vaccinations, water sampling, community assessments, vector control, prescription assistance, the use of emergency response information systems, and the creation of public information messages and fact sheets that were posted to the state's Web site and disseminated to the public and response partners. Of note, our previous work in 2010 was leveraged during our 2011 flood response allowing us to be ready, agile, and fully engaged. As a result of planning, exercising, frequent communications, and improvements in community health, Tennesseans responded to assist their neighbors and their communities. The results of these efforts represented a visual picture of the successes of the preparedness interventions. The successful public health response and recovery was made possible by preparedness funding.

Regarding my second point about preparedness being a process, not an end point, the main thought here is that plans cannot remain static, they must be periodically and rigorously reviewed and revised based on experience, lessons learned, and evolving information; sophisticated laboratory and field equipment must be properly maintained and serviced; the public health workforce must remain sharp and skilled requiring ongoing training; and our plans and people must go through regular drills and exercises to reinforce our strengths and identify gaps and weaknesses where we need to improve on a continuous basis. This takes not only ongoing commitment, but resources.

Before I share with you my final thoughts, one additional point I want to make is the critical importance and value of partner collaboration, information sharing and situational awareness, and community resilience. In Tennessee, community partners from healthcare, business, media, state and local governmental agencies and bordering states have all been at the table to contribute to planning and response efforts. One example includes the partnership with retail pharmacies and their ability to participate in both the H1N1 vaccination campaign and antiviral medication distribution to the under-insured. These partners equate to public health force multipliers and can have a significant impact on prevention of disease. These relationships will continue to be fostered to ensure all-hazards response capabilities exist. This is especially valuable as we continually strive to improve our medical countermeasures distribution and administration operations.

With the assistance of preparedness funding, the Tennessee Emergency Medical, Awareness, Response, and Resources (TEMARR) suite of information systems has been developed. TEMARR integrates numerous systems, technologies, programs, and leadership from across the state to respond to emergencies. Collectively, the TEMARR systems provide a broad picture of situational awareness and are used to more effectively manage and monitor Tennessee Department of Health (TDH) responses to disasters using national and international data exchange standards. We now have the capacity to better understand the disaster itself, alert key response agencies, identify and contact pre-credentialed first responders, allocate resource needs in terms of people and equipment, apply all required resources to the disaster, quickly triage and track all persons impacted, and transport them to the correct healthcare facility. Using ASPR funds, the state established eight Regional Medical Communication Centers as a joint venture between hospitals and TDH. Prior to the centers, limited interoperable communications existed among EMS agencies, emergency management, hospitals, and public health across the state to support a medical response.

The above information systems could not have been developed without preparedness funding and will quickly disappear without sustained funding. By developing and delivering the TEMARR systems to the state we eliminated the need for multiple agencies to construct or procure like capabilities. The use of statewide solutions, that meet the needs of system users, provides for the sustainability of information technology infrastructure. The innovative use of interoperability standards supported by the U.S. Department of Homeland Security Office of Interoperability and Compatibility has promoted data exchange and collaboration at the federal, state, and local level. Other critically needed efforts beyond pure requirements and standards development are to continue collaboration with the HHS Office of the National Coordinator (ONC) for Health Information Technology and ASPR, and to merge, integrate or support the transparent movement of message traffic across health information exchanges.

To ensure comprehensive community resilience and preparedness, Tennessee has adopted an all-hazard planning approach. This approach must include prevention strategies that are innovative and aggressively outreach to multiple population groups. Some of these initiatives include the annually high rates of childhood immunizations, collaborations with mental health providers for disaster response, child care center preparedness planning, vulnerable population outreach and information sharing, ongoing dialogue with professional associations, and proactive training and exercises.

As we look toward the future, with your permission, I would like to respectfully share with you three recommendations for your consideration:

First is the need to reauthorize PAHPA. The Pandemic and All Hazards Preparedness Act is a well designed and effective law that served us well. That being said, over the five years of it being in existence and in working with and using PAHPA, a short list of potential revisions and additions have been identified that would make a reauthorized PAHPA even stronger and more effective. I know your staff have been in contact with ASTHO leadership and discussed our suggestions for consideration.

Next, even during these very difficult fiscal times when hard budget decisions have to be made, adequate funding through the CDC Public Health Emergency Preparedness (PHEP) and ASPR Hospital Preparedness Program (HPP) cooperative agreements to states must be maintained. We cannot let our progress erode. Tennessee base preparedness funding has decreased by 37% from 2004 to 2011.

The nation's state and local public health system is already seriously frayed due to the adverse impact of the recession on state and local governments. Budget cuts at all levels of government are jeopardizing the significant gains that state, territorial, and local health departments made in prevention and preparedness programs during the past decade. From 2008-2010, more than 44,000 jobs were lost in state and local health departments, reducing staff such as public health physicians and nurses, laboratory specialists, and epidemiologists. These job losses represent 14 percent of the state health workforce and 20 percent of the local health workforce. Recent reports from both the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) on the impact of budget cuts on the health of Americans indicate that, since 2008, state and local health agencies have been forced to reduce critical public health programs, such as immunizations, HIV/AIDS prevention and treatment activities, and all-hazards preparedness and response efforts.

My last point is that of community resilience. One of the best ways to help a community become more resilient is to improve their overall health through prevention. A healthier community and a healthier individual will fare far better in an emergency than a community or individual that is coping with underlying preventable health conditions, such as obesity, heart disease, or diabetes. Ensuring that adequate resources and attention is paid to addressing America's major health problems and common risk factors will have a major impact on the overall preparedness and response capacity of public health, and all other, emergency responders. These can be addressed through other Public Health Service Act programs authorized by this Committee, such as the Prevention and Public Health Fund, Community Transformation Grants, and the Preventive Health and Health Services Block Grant, just to name a few.

No state or community is ever completely prepared to address the health and medical consequences of a major disaster, terrorist event, or pandemic. However, since 2001, states have significantly improved and demonstrated their ability to prevent, respond to, recover from, and reduce the effects of a full range of threats and hazards. Through planning, training, education, drills, exercises, and building partnerships, state public health agencies have improved disease surveillance and laboratory testing, patient care surge capacity, decontamination capacity, and availability and deployment of pharmaceutical and other medical supplies. If you recall the reports I cited earlier that demonstrated progress, they also identify more that needs to be done, which requires our collective attention. ***Protecting the public from threats is a matter of national security, and protecting the public's health is no exception.***

Thank you for this opportunity and I would gladly address any of your questions.

Susan R. Cooper, MSN, RN

Susan R. Cooper, MSN, RN, made Tennessee history on January 20, 2007 when she became the first nurse to serve as commissioner of the Tennessee Department of Health.

Commissioner Cooper is a master's prepared registered nurse. She earned both her bachelor and master of nursing degrees from Vanderbilt University School of Nursing.

Cooper was raised in Tennessee and considers it a great honor to have been asked by Governor Bill Haslam to continue serving as commissioner of health. Her priorities are to protect, promote and improve the health of all Tennesseans. She considers this the most important work she will face in her career.

"Now is the time that I can perhaps influence the citizens of this state in a positive manner," said Cooper. "I hope to leave a footprint on the health status of this state."

Cooper first came to state government in 2005 charged with developing Tennessee's Health Care Safety Net program for citizens facing disenrollment from TennCare. Cooper later assumed leadership of Project Diabetes, a program created to address the threat of Type 2 diabetes facing Tennesseans. In addition, she helped facilitate the creation of the GetFitTN initiative. The statewide public awareness program is aimed at addressing the rising epidemic of Type 2 diabetes and risk factors that lead to diabetes, like obesity. The program involves educating adults and children about how they can make modest lifestyle changes to delay or prevent the onset of Type 2 diabetes.

Before joining state government, Cooper was a faculty member and assistant dean of practice at Vanderbilt University's School of Nursing, overseeing the nurse-managed clinics and operations led by the school. She also served as co-director of the Health Systems Management program at Vanderbilt University School of Nursing.

Cooper has an extensive background in health policy, health care regulation and evidence-based practice. She helped create the Center for Advanced Practice Nursing and Allied Health at Vanderbilt University Medical Center, covering the regulatory needs and credentialing for hundreds of non-physician providers at Vanderbilt.

Cooper currently resides in Franklin, Tennessee. She enjoys spending time with her three grown children and four grandchildren.