Statement of

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Representing

THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
(ASTHO)

Mr. Chairman and Members of the Committee, I am Dr. Leah Devlin, Director of the North Carolina Division of Public Health and President of the Association of State and Territorial Health Officials (ASTHO). ASTHO represents the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. Our members are the chief health officials of these agencies. It is a pleasure to appear before you today to discuss the critical reauthorization of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107-188).

First, let me begin by thanking you for recognizing the need in 2002 to invest in building our nation's public health infrastructure to deal with terrorism and other public health emergencies and emerging threats. In responding to the events of September 11, 2001 and the subsequent national anthrax crisis, we realized that many public health agencies, a critical piece of our front line of defense, were not fully prepared to deal with such threats. We thank you for creating a program that has strengthened our laboratory, surveillance and epidemiologic capacities, and improved our communications and information technology systems. Critically important attention and funding were also provided for preparedness planning, readiness assessment, and the education and training for public health professionals to respond to bioterrorism and other public health threats and emergencies. Public health agencies are now recognized as key partners with law enforcement, emergency management and health care in preparedness and response.

My remarks will focus on: 1) what state and local health agencies have done to increase their level of preparedness, 2) what challenges remain that must be addressed, and 3) what resources are needed to sustain a high level of public health security.

In North Carolina, our new Hospital Emergency Surveillance System has dramatically improved our ability to rapidly detect bioterrorism attacks, pandemic influenza, and other disease outbreaks. Today, the North Carolina Division of Public Health receives real-time electronic reports from more than 100 hospital emergency rooms so that we can rapidly identify potential disease outbreaks. We now have seven disease investigation strike teams that respond

immediately to suspicious disease reports anywhere in the state. Our three-tiered State Medical Assistance Team (SMAT) system provides medical care during emergencies and augments our hospital capacity. Investments in our public health laboratories have tripled our capacity to test suspicious substances and confirm the presence of select biologic and chemical agents. None of this existed prior to 2002.

Real life emergencies such as Hurricane Isabel in 2003 tested our ability to protect our citizens. During that hurricane, our regional disease investigation strike teams assessed community health needs and helped redirect critical resources such as food and water to the most vulnerable households. Last fall, following Hurricane Katrina, we sent our mobile hospital, ambulatory care clinic, and more than 500 public health and medical professionals from our SMAT to Mississippi to provide care for more than 7,400 patients over seven weeks. An effort of this magnitude would not have been possible prior to 2002.

Since passage of the Public Health Security and Bioterrorism Preparedness and Response Act, state and local health agencies have made real progress in their ability to respond to bioterrorism and other threats and emergencies. No single state, and no community within any state, has reached a full level of preparedness. The Act has made a tremendous difference, but the safety of the American public requires us to do more.

The ability of the public health system to respond adequately to potential terrorist events, emerging infectious diseases, and other public health threats and emergencies depends on a well-trained, diverse, and adequately staffed public health workforce at the federal, state and local levels. Recruiting, training and sustaining the public health workforce is *the* preparedness crisis. Some states are experiencing retirement rates of up to 45 percent over the next five years. The average age of a state public health professional is 47. The current scenario is a rapidly aging workforce that will experience high rates of retirement over the next five years with no clearly identified source of qualified public health professionals to fill the void.

ASTHO urges you, in the strongest way possible, to include the provisions of the Public Health Preparedness Workforce Development Act of 2005 (S. 506) in your reauthorization legislation.

This bill would provide incentives for health professionals to enter the practice of governmental public health, ensure these individuals commit to a designated number of years of service in public health agencies, and help to retain current employees in the field of public health.

We continue to face new challenges each year, from anthrax to smallpox to SARS to pandemic influenza. One of the lessons of Hurricane Katrina is that we cannot focus too narrowly on specific threats. Instead, an all-hazards approach is needed. We must ensure that essential public health resources – personnel, laboratories, surveillance systems, communications, well thought out response plans – are available to address ongoing and new public health threats.

I cannot emphasize enough how important it is that federal bioterrorism funding to state and local health agencies be predictable and sustainable. Recruitment and retention of qualified public health professionals is not possible in an environment where there are concerns about the future of program funding. There are very few examples of one-time preparedness needs. Even expensive laboratory equipment must be replaced every few years and requires costly maintenance contracts and continuous replenishment of reagents. Antibiotics, antidotes and other medical supplies acquired to prepare for mass casualty events must be rotated, replaced or replenished.

Over the past few years, portions of existing preparedness funding for state and local programs have been redirected to support other federal preparedness needs. For example, last year the Centers for Disease Control and Prevention's (CDC) state and local public health preparedness cooperative agreement funds were cut by $95 million to pay for an expansion of the Strategic National Stockpile (SNS). Prior to that, CDC's state and local public health preparedness cooperative agreement funds were redirected to launch the Cities Readiness Initiative (CRI). The Administration's FY2007 budget doubles the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) funding. This new funding would again be redirected from the Health Resources and Services Administration (HRSA) hospital preparedness cooperative agreement.

While SNS, CRI and ESAR-VHP are all important programs for improving our public health and medical response to catastrophic events, funding them by redirecting resources from existing state and local public health preparedness efforts is wrong. Worthy new initiatives and expanded activities should be worthy of their own funding. Funding cuts may result in layoffs of highly skilled public health professionals, reductions in the number of exercises planned and implemented, and delays in upgrading laboratory equipment, surveillance technology and surge capacity. We must ensure that all state and local health agencies sustain and improve existing public health preparedness activities, not cut back on them.

In your letter of invitation, you asked if the lines of authority within the federal government are clear during medical and public health emergencies. Yes, the National Response Plan (NRP) correctly assigns coordination of emergency health and medical functions to the U.S. Department of Health and Human Services (HHS) under Emergency Support Function 8. It also makes clear that the U.S. Department of Homeland Security is the overall coordinating agency for issues including and transcending those addressed in ESF-8.

You also asked if HHS should require more state and local accountability and federal oversight for developing medical surge capacity. ASTHO supports the development and implementation of performance measures to assess progress in preparedness. Accountability is essential and best measured against a limited set of performance measures that are evaluated over time and flexible enough to allow states to match their individualized strategic plans to national goals.

In closing, I want to again thank the members of this Committee for your past commitment to improving public health preparedness. While we applaud the accomplishments that this Committee has permitted the public health community to make, we know that so much more can be and must be done to improve our nation's security. We welcome the opportunity to continue to work with you in pursuit of that goal.

Thank you for your attention. I will be pleased to answer any questions you may have.

Major Infrastructure Development in North Carolina Public Health Preparedness and Response since 9/11/2001

STRENGTHENING LOCAL PREPAREDNESS STATEWIDE

- **Established seven Public Health Regional Surveillance Teams**
- **Provided local funding and guidance to 85 local health departments and the Eastern Band of the Cherokee Indians**

PROVIDING STATE LEVEL LEADERSHIP AND EXPERTISE

- **Established a state level Office of Public Health Preparedness and Response**
- **Appointed the Public Health Preparedness and Response Advisory Committee**
- **Created the Public Health Command Center**

CREATING NECESSARY LEGAL AUTHORITIES

- **Sought passage of two new laws** 1) reporting by hospitals of Emergency Department data 2) extended isolation and quarantine authority
- **Sought passage of major legislation** to require reporting of zoonotic diseases from the state veterinarian and improved reporting requirements for suspected bioterrorism events
- **Added smallpox, pandemic flu, west nile virus, and monkeypox to the NC list of required communicable diseases reports**

DEVELOPING AND EXERCISING THE PLANS

- **Developed numerous plans as a part of the NC Emergency Operations Plan**
- **Developed the first FEMA approved mitigation plan for infectious diseases**
- **Routinely conducted state, regional and local field exercises**
- **Established the Avian Influenza & Human Health Task Force**

ASSURING EARLIEST DETECTION: SURVEILLENCE

- **Initiated the development of the North Carolina Public Health Information Network** which includes the **NC-Health Alert Network (NC-HAN)**, the **National Electronic Disease Surveillance System (NEDSS)**, the **NC Hospital Emergency Surveillance System (NCHESS)**, a pre-hospital emergency medical services data system called **PreMIS**, the **Laboratory Information Management System (LIMS),** and the **NC Immunization Registry**
- **Developed the Mobile Data Entry Project** a system for collecting electronic data in the field including geocoding for GIS applications
- **Created the NC Hospital Emergency Surveillance System (NCHESS)**
- **Embedded Public Health Epidemiologists (PHEs) at the 12 largest hospitals in NC**
- **Established NC-DETECT (North Carolina Disease Event Tracking and Epidemiology Collection Tool)**

IMPROVING COMMUNICATIONS

- **Established the North Carolina - Health Alert Network (HAN)**

- **Enhanced the existing NC Medical Communications Network**
- **Participated in the development of statewide telecommunications partnerships with state and local first responders**
- **Established system of communications with the private healthcare providers**

IDENTIFYING THE AGENT EARLY

- **Developed the NC Laboratory Response Network (LRN) in the State Laboratory of Public Health**
- **Created the first statewide registry of biological agents in the nation**
- **Developed the white powder protocol used by all first responders and law enforcement**

GETTING HEALTH INFORMATION ON RISK TO THE PUBLIC

- **Distributed to 1.5 million people an insert into all major newspaper publications**
- **Provided additional staffing and technology support to the Department of Health and Human Services Care Line** to answer citizen inquiries
- **Established new public information officers in the Division and the Department** including bilingual (Spanish) expertise

IMPLEMENTING TRAINING TO MAINTAIN READINESS

- **Partnered with the North Carolina Community College System and the University of North Carolina to develop educational modules that will enhance statewide preparedness and response efforts**
- **Developed the first training program in the country for how law enforcement and public health work together – Forensic Epidemiology**
- **Implemented the NC National Incident Management System (NIMS) Training Program**
- **Implemented numerous preparedness trainings of the public health workforce**
- **Conducted in partnership with UNC School of Public Health a workforce development survey and learning management system**

BUILDING SURGE CAPACITY FOR MASS CARE

- **Partnered with the Office of Emergency Medical Services (OEMS) to plan and implement a statewide Hospital Preparedness Program**
- **Established the 3-tiered State Medical Assistance Teams (SMAT)**
- **Strengthened capabilities at the State Medical Examiners Office**

LEARNING FROM REAL LIFE EXPERIENCES

- **Established and operated shelters in Wake and Mecklenburg counties for hundreds of Hurricane Katrina and Rita evacuees in NC**
- **Investigated and contained one of the eight laboratory confirmed cases of SARS in the country in 2003**
- **Managed the distribution of limited flu vaccine available during the 2004 flu season**