



1100 17TH STREET, NW, 2ND FLOOR
WASHINGTON, DC 20036
(202) 783-5550
(202) 783-1583 FAX
WWW.NACCHO.ORG

NATIONAL
ASSOCIATION OF
COUNTY & CITY
HEALTH OFFICIALS

Statement of
Frances B. Phillips, RN, MHA
Health Officer
Anne Arundel County Department of Health
Annapolis, Maryland

On behalf of the
National Association of County and City Health Officials

Before the Subcommittee on Prevention of Nuclear and Biological Attack and
the Subcommittee on Emergency Preparedness, Science, and Technology

Committee on Homeland Security

United States House of Representatives

Protecting the Homeland: Fighting Pandemic Flu from the Front Lines

February 8, 2006

It is my pleasure, Chairman Linder, Chairman Reichert, and distinguished Members, to address you today concerning the vital role of local health departments and their community partners in homeland security on the front lines in pandemic influenza planning and response.

The combined efforts of local health departments and our colleagues in first response will determine the initial, and in many ways, the ultimate impact of an influenza pandemic in the United States. In my presentation, I will describe how local health departments are planning our response to a worldwide influenza outbreak, with an emphasis on how the success of those plans relies on the crucial linkages that have been built between local public health departments and a range of community partners.

For nearly 13 years I have directed a large local health department serving a population of about 500,000, including residents of our historic state capital, Annapolis. Anne Arundel County is also home to many national landmarks such as the U.S. Naval Academy, Fort Meade Army Base, the National Security Agency and other federal installations and the Chesapeake Bay Bridge. In terms of pandemic flu, the landmark about which I am most concerned is the Baltimore Washington Thurgood Marshall International Airport. Collectively, these landmarks have resulted in a relatively high “vulnerability index” of security threats to the county.

Heightened awareness of the potential vulnerabilities is something all the response entities in our jurisdiction share. For years, we have been engaged with our police, fire and rescue, emergency management and other counterparts in planning and exercising for local emergencies. As in the rest of the country, this type of cooperative work intensified after September 11, 2001, building on the mutual understanding that we all have our part to play in any unfolding emergency.

In 2004, I had the unique and rewarding opportunity to serve as Acting Fire Chief for an interim period in my county. In making this decision, the County Executive reflected on the number of instances in which both fire and health departments had jointly addressed local emergencies, and how a common commitment to protecting the safety of county residents was central to the appointment. So often we hear about the differences that exist among the emergency disciplines—but this core mission that we share is key.

I found more that was common to public health during my tenure with this large metropolitan fire department than was different. There were areas where each agency could—and did—benefit from an exchange of expertise. For example, learning from public health’s proficiency in prevention and outreach to diverse communities, including those with special needs, was a gain for the fire department. Likewise, the fire department’s expertise in incident management and chain of command accountability has

proven to be of great utility within the health department in a range of emergency situations.

My department, with a staff of about 850, has experienced a wide array of emergencies, just in recent years. We have had direct experience mobilizing emergency operations in the face of the 9/11 attacks and subsequent anthrax attacks of 2001, severe weather situations, tuberculosis and hepatitis outbreaks and the SARS emergency of 2003. We have also faced more moderate, but nonetheless challenging events, such as the West Nile Virus outbreak and the national flu vaccine shortage of 2005. And of course, on a daily basis we are confronted with localized but urgent public health issues such as well water contamination, respiratory outbreaks in nursing homes and meningitis cases among school children. All of these experiences are vital to building a workforce prepared to respond in the face of a prospect as daunting as pandemic influenza. My remarks today are based on lessons learned from these real world events.

Pandemic Influenza Preparedness Must be Integrated into All-Hazards Preparedness

Local emergency preparedness is based on an ‘all-hazards’ approach. This approach requires communities to assure the essential capabilities necessary to respond to a wide range of emergencies: intentional or naturally occurring infectious disease outbreaks; chemical, explosive or radiologic accident or attack; weather-related disaster; or other emergency.

Since 2001, with the elevated awareness of the country’s vulnerability to intentional attacks with biological agents, there has developed a better understanding of public health’s unique role in protecting the homeland in this kind of scenario. Whether the communicable disease threat is a novel influenza virus, smallpox, anthrax, West Nile Virus, SARS, or other emerging pathogen capable of causing widespread illness and death, there are a core of universal public health response capabilities for which local health departments across the country are planning, training and exercising.

However, those health departments do not and cannot stand alone. All planning and response must be integrated with other local entities, most notably public safety first responders, but also state, federal and non-governmental partners. Fundamental to such integration is a shared command and management framework. With its strong foundation in the Incident Command System, the broader National Incident Management System (NIMS) developed under Homeland Security Presidential Directive 5 provides this common underpinning for all public health and public safety preparedness. Over time, adoption of NIMS will continue to facilitate the integration of language, mental models and even certain cultural aspects of public safety by public health professionals.

Pandemic influenza planning is a section of our county’s Health/Medical Annex--the “ESF (Emergency Support Function) #8 Chapter”—within the county’s all-hazards plan. This is typical and it demonstrates the integration of the influenza response into an all-hazards approach. Although it is located in the Health/Medical Annex, which contains

the core response elements for a disease outbreak, the roles in executing the response span the gamut of other emergency disciplines, as they do for any other targeted scenario within an all hazards plan.

Key Elements of Front Line Pandemic Influenza Preparedness

1. Disease Surveillance

The purpose of a strong surveillance system is to create time in which to intervene and eliminate or mitigate threats. In local public health, practical disease surveillance means a system by which clinicians in private practice or in hospital settings can detect and report a novel flu virus or a suspect case to a public health authority capable of receiving, interpreting and responding to such a report. Ultimately, the country may reach a point where electronic medical records and associated systems will enable automatic reporting of diseases or suspicious symptoms, but such capability will be immensely challenging in this intensely diverse and complex national environment. We cannot wait, nor can we depend solely on technology when so much is at stake. Our greatest strength is in our American workforce—our astute clinicians, our trained healthcare professionals, our alert hospitals—and the effective partnerships that are forged between this community and capable local public health departments. It is important not to underestimate the immediate and important utility of this model of disease surveillance.

Local health departments are the ‘boots on the ground’ elements of our nation’s disease surveillance system. In my department, we receive 4000 communicable disease reports each year from our partner hospitals and physicians. Typically, these reports involve infectious diseases such as tuberculosis, AIDS, or measles. These reports generate over 2100 disease investigations conducted by public health, with our staff conducting patient interviews, performing contact tracing and, where indicated, beginning prophylactic treatment of persons who have been exposed.

One less typical but important example of public health surveillance recently occurred when the flight crew on a commercial aircraft bound for BWI airport reported a sick passenger returning from extensive travel in Asia. Upon arrival, the individual was immediately transported to a nearby hospital for evaluation. Within the hour, nearly two dozen local, state and federal agency personnel, along with representatives of the carrier, had been alerted and a response plan initiated.

2. Community Awareness and Self-Sufficiency

As the BWI incident demonstrates, planning with a broad range of partners meant that when a real situation arose, the right people were there quickly. In the specific case of pandemic influenza, there is a continuing need for not only governmental, but also corporate and community sectors to be informed about pandemic influenza and to understand their potential roles in a response.

At a local level, the health department is regarded as the source for reliable and practical information, specific to the community. For months my department has conducted continual 'customized' education sessions on avian and pandemic influenza to all sectors, beginning with our police, fire, emergency management and public works departments. We have held ongoing briefings with the Naval Academy, Ft. Meade and NSA personnel; our school system, hospitals, and nursing homes. The business sector, faith-based and community-based organizations have all sought our information and guidance on preparing for a major flu outbreak.

My department serves as a key consultant to county government and several large corporations in developing their continuity-of-operations plans to address prolonged and widespread absenteeism. We have a cadre of trained presenters, as well as a very active website, public sector cable television channel and strong media relationships to assist with these broad communications efforts.

We are not alone in conducting such education. Across the country, some innovative partnerships between public health departments and the private sector are emerging. Whether it is educating their employees through distributing information on preventive measures or volunteering to coordinate points of dispensing on corporate campuses, some companies are showing interest in playing a part in the larger response.

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

3. Community Infection Control

Over the past several years, the legal foundation required for public health to adequately protect the public in a catastrophic health emergency has been significantly strengthened in many states. Both state and local health departments have closely examined our respective responsibilities to isolate or quarantine persons; to control private property or otherwise intervene in private activities. All these would be unprecedented actions, requiring enormous pre-planning. In my county, for example, we are developing an inventory of alternative housing suitable for persons requiring respiratory isolation. We are identifying sources for the medical and social supports should large numbers of people be confined at home. These partners will be a major part of the success of any critical effort to minimize the spread of disease.

Our experience with placing a few SARS suspects in home isolation has been instructive. We experienced 100% compliance, but recognize a pandemic circumstance could be radically different. In such situations, we may call on our public safety partners to assist with security. We recognize the importance of making sure they are educated about risks and are knowledgeable about what prophylaxis is available and the need for any personal protective equipment.

4. Mass Distribution of Vaccines and Medications

Timely development of an effective vaccine, in sufficient quantity to immunize the population against a novel virus, is a huge challenge that the Federal government has taken important steps to confront. Local health departments are responsible on the ground for accepting delivery of the Strategic National Stockpile in which such a vaccine or anti-viral medications would be stored. Mindful that we do not now have the ability to manufacture sufficient quantities of such countermeasures, we must still have in place all the planning, staffing and public information systems necessary to promptly distribute them to all priority populations in the county.

While we've not experienced a pandemic, local health departments have had parallel experiences and exercises that have tested our ability to provide mass vaccine and medication distribution. In our case, in October 2001, we rapidly mobilized mass clinics to distribute ciprofloxacin to U.S. Postal Service or U.S. Senate employees potentially exposed to anthrax while working. During the 2004 seasonal flu vaccine shortage, with delayed shipments causing the public to become extremely anxious to get their flu shots, our department gave over 6800 doses in two days, at a rate of 670 doses an hour.

This effort demonstrated the value of a thoroughly trained and responsive public health workforce. In my department, every staff person, from school nurse to addictions counselor to restaurant inspector, is required to be trained, at a minimum, in basic emergency preparedness using the NIMS model.

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

Federal Leadership

It is a positive step that so many in this country are paying attention to pandemic influenza before we find that threat a reality. We often tend to focus on the last event, but in this case the focus has been on being proactive—a fact which is evidenced by the very existence of this hearing. Your leadership on this issue is appreciated.

However, there doesn't always appear to be the same sort of cooperation and coordination occurring at the Federal level among the various agencies involved in pandemic influenza preparedness as there is even in Anne Arundel County. Leadership questions in the event of a biological attack have been debated by Federal agencies in the press. Should the Department of Homeland Security (DHS) be at the forefront or should the Department of Health and Human Services (HHS) play the leading role? If DHS is in

charge, how will they draw on public health expertise and resources to guide the Federal response?

The same question frequently arises when setting up an incident command at the local level for a biological incident. Is the public health officer the incident commander? The answer is sometimes yes, sometimes no. The answer depends on the health department, it depends on the community and it depends on the event. The decision should be made based on a clear understanding of needs and capabilities. Most often at the local level, the understanding is that if public health is not the incident commander in a public health emergency, whoever does assume that role will rely heavily on the public health officer to provide the guidance and situational awareness necessary for decision-making.

Thus far, the Department of Homeland Security has made progress in understanding and integrating public health in fits and starts. Initial efforts toward fulfilling HSPD-8 showed limited understanding of what public health even was and how it would mount a response in an incident. As I described above, pandemic influenza response will require much more than medical care and hospital beds. To its credit, DHS later reached out to public health practitioners for input on documents like the Universal Task List and the National Preparedness Goal. DHS and HHS appear to have improved their communication somewhat, but there is still much room for improved coordination between these two agencies.

For example, the interdisciplinary cooperation I have described that will be so valuable in the event pandemic influenza arrives in Anne Arundel County appears not to be a high priority in the current Federal approach. Congress has appropriated some much-needed additional funds, \$350 million, for local and state health departments, and new guidance for those efforts is on its way. Yet, little discussion is taking place regarding the non-CDC grantees vital to the success of a pandemic influenza plan. Can DHS grantees use their funds for collaboration on this sort of planning? Should they be required to do so?

Federal agencies need to collaborate at the highest level of government to send coordinated and reinforcing messages to all grantees at state and local levels that multidisciplinary cooperation is a high priority. Through the structure of grant programs and the guidance provided, DHS and HHS can either facilitate local efforts in that regard or hinder them with inconsistent guidance. Both agencies should include local public health practitioners, the ones who will be key responders on the ground, in their consultations. It is not enough for DHS to rely exclusively on HHS for public health input.

Another way that those at the Federal level can help to make our national response to emergencies like pandemic influenza more unified is to remember the professional diversity of their audience when rolling out national programs. Local emergency response agencies are being required to absorb and integrate a continual stream of new initiatives, ranging from NIMS and the National Response Plan to the Target Capabilities and the National Preparedness Goal. Training courses are introduced through FEMA and the Emergency Management Institute. Yet the local audiences grappling with all these

new programs—while continuing their day-to-day workload serving their communities—need to understand just how these programs are relevant to their roles in an emergency. When a federal contractor with a fire service background conducts a basic Incident Command System training for public health workers, the concepts are correct, but the anecdotal examples don't resonate. In terms of public health, there are a wealth of solid examples of departments that have integrated ICS into even their day-to-day operations. Courses that reference those familiar experiences are more likely to have an impact. Unfortunately, such courses are hard to find.

Finally, while much time is spent asking local and state emergency personnel to understand how the national plan is structured, we need to remember that no matter how serious the emergency, the response always begins locally. And in the case of pandemic influenza, the effectiveness of that early response will determine how the emergency unfolds. Standardization is important to the extent that it can be realized, but national plans also must support a response in every corner of this diverse country. A one-size-fits-all approach simply will not be successful.

Whether pandemic influenza or some other disaster afflicts our nation, there is no shortage of dedicated Americans at every level of government working hard on homeland security. Continuing to promote, support, and build local partnerships among public health, health care, public safety, emergency management, and a host of private sector partners will only improve our ability to protect the health and safety of our communities.

Thank you.