TAKING MEASURE OF COUNTERMEASURES, PART 3: PROTECTING THE PROTECTORS

HEARING

BEFORE THE

SUBCOMMITTEE ON EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICATIONS

OF THE

COMMITTEE ON HOMELAND SECURITY HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

APRIL 17, 2012

Serial No. 112–82

Printed for the use of the Committee on Homeland Security

Available via the World Wide Web: http://www.gpo.gov/fdsys/

U.S. GOVERNMENT PRINTING OFFICE

77–377 PDF WASHINGTON : 2013

For sale by the Superintendent of Documents, U.S. Government Printing Office
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FOR THE RECORD

APPENDIX

TAKING MEASURE OF COUNTERMEASURES, PART 3: PROTECTING THE PROTECTORS

Tuesday, April 17, 2012

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON EMERGENCY PREPAREDNESS,
RESPONSE, AND COMMUNICATIONS,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC.

The subcommittee met, pursuant to call, at 2:03 p.m., in Room 311, Cannon House Office Building, Hon. Gus M. Bilirakis [Chairman of the subcommittee] presiding.

Present: Representatives Bilirakis, Turner, and Richardson.

Mr. BILIRAKIS. The Subcommittee on Emergency Preparedness, Response, and Communications will come to order.

The subcommittee is meeting today to receive testimony on efforts to ensure the protection of emergency response providers in the event of a chemical, biological, radiological, or nuclear attack.

I now recognize myself for an opening statement.

This hearing is the third in a series held by the subcommittee on the vital issue of medical countermeasures. The subcommittee has received testimony on challenges in the research, development, and acquisition of medical countermeasures and all plans and strategies to distribute and dispense diagnostics, medications, and other life-saving equipment.

Today we continue this discussion with a focus on how we protect those who protect the public in the event of a chemical, biological, radiological, or nuclear attack or emergency.

As noted by the WMD commission, the threat of WMD terrorism remains. The better we prepare, the more we reduce the risk. I know everyone agrees. Medical countermeasures are but one component that allows us to do so, and yet they are such a critical piece of this that they deserve special attention as far as I am concerned. It is a critical piece of the puzzle.

As we learned at our last hearing, there are a number of dispensing methods under consideration. We have two distinguished panels of witnesses here today to help us further assess these plans and strategies at the Federal, State, and local levels and to discuss how best to protect emergency response providers and their families through mechanisms such as voluntary pre-event vaccination and the predeployment of med kits.

The provision of such assets to targeted populations is not without precedent. The United States Postal Service has a program well underway in several cities to deliver medical supplies to the public in the event of a biological emergency. As a condition of par-

ticipation, the Postal Service required that the letter carriers themselves and their families be provided with antibiotic med kits in advance in order to ensure their own protection. Kits and a program were then developed with the FDA backing, of course, to achieve this.

Yet the law enforcement members that will escort the letter carriers from home to home do not yet have the same option. The assistant secretary for preparedness and response at HHS is working with the FDA to rectify this, and I look forward to hearing from Mr. Gabriel on the progress toward this important issue.

Another priority that we have heard from the first responder community is its desire for access to anthrax vaccine. Given the millions of doses in the National stockpile that annually expire and are then discarded, it would seem entirely reasonable to make these supplies available to first responders prior to their expiration. That would benefit, of course, the responders who respond frequently to white powder incidents that may some day turn out to be the real thing, and it would certainly work for those of us who do not want to see Federal resources wasted.

I look forward to hearing from Dr. Polk and from our second panel how the pilot is proceeding and what needs to happen to make it successful. I also think that we should look beyond the anthrax threat and have a frank discussion about what other measures, if any, should be taken with regard to other biological, chemical, and radiological threats. It is in all of our interests to ensure that our protectors are protected and that their families are protected and that they are able to come to work and do their jobs when duty calls. That will keep us all safer and more secure.

Our previous hearings in this series have highlighted the challenges we face in developing countermeasures and getting them to the people who need them. First and foremost in our minds should be our first responders, and I look forward to discussing this with all of you today, how we can make this endeavor a success.

Before I recognize our Ranking Member, I ask unanimous consent to enter a statement from the National Sheriffs' Association into the record. Without objection, so ordered.

[The information follows:]

STATEMENT OF THE NATIONAL SHERIFFS' ASSOCIATION

APRIL 11, 2012

Dear Chairman Bilirakis and Ranking Member Richardson: I would like to thank you for allowing the National Sheriffs' Association (NSA) to submit a statement for the record for the House Subcommittee on Emergency Preparedness, Response, and Communications Hearing on "Taking Measure of Countermeasures (Part 3): Protecting the Protectors," held on April 17, 2012.

The National Sheriffs' Association (NSA) is one of the largest associations of law enforcement professionals in the United States, representing more than 3,000 elected sheriffs across the Nation, and a total membership of more than 20,000. NSA is a non-profit organization dedicated to raising the level of professionalism among sheriffs, their deputies, and others in the field of criminal justice and public safety.

The NSA and its members are pleased that your committee continues to place a priority on protecting emergency services personnel. By protecting the protectors, we believe the Nation is and will remain more resilient in the face of natural catastrophes or intentional attacks on our communities. Further, we note that, in the case of a bioterrorism incident such as a wide-area anthrax attack, the responders' household members will need protection as well. Research shows the inclusion of the protection of family members as a key component in the willingness of responders

to report for duty in biological incidents. As responders put their lives on the line for their community, they deserve to have peace of mind from knowing that protective antibiotics are immediately available to their household members as well as themselves.

Since the May 12, 2011 hearing of your subcommittee, we can report or cite little progress toward the goal of an adequately protected workforce. The priorities highlighted in the testimony provided by Chief Tan on behalf of the Emergency Services Coalition for Medical Preparedness (NSA is a founding member) remains unaddressed, and is as germane today as 11 months ago.

Emergency services personnel will be among the first exposed in an event, and will have the greatest need for timely access to appropriate medical countermeasures. The time is right to provide emergency services personnel caches of prepositioned personal and institutional medical countermeasures. The existing processes developed since 2004 to distribute med kits to postal workers could be extended to include the protection of our fire service, law enforcement, emergency medical services, public works, and other components of our emergency services sector critical infrastructure.

We augment this statement only to make explicit that the prepositioned med kits in the homes and workplaces of postal workers participating in the National Postal Model cover their entire households. Thus, knowing that their household members already have protective antibiotics in hand if they should be needed, the postal workers are poised to deliver medical countermeasures to every residence in targeted areas in 1 day as soon as supplies arrive from the Strategic National Stockpile.

On March 27 this year, your subcommittee convened to hear the budget request from the DHS Office of Health Affairs (OHA). Assistant Secretary Garza described the OHA's Medical Countermeasures (MCM) Initiative. This initiative provides 100% of DHS personnel with immediate access to life-saving antibiotic medications in the event of a biological attack to ensure front-line operations can perform their duty to save American lives. Their proposed budget request was to extend this initiative to cover an additional 350 field locations.

On April 2, 2012 the Food and Drug Administration (FDA) held an advisory panel on the issue of defining a pathway for FDA approval of med kits. No first responder agencies were invited to testify, despite our continued interest in this issue and well-known policy position. In contrast, numerous public health and medical associations were invited to provide testimony, despite having no stated policy position on these issues.

The emergency preparedness system in this country is essentially local, with mutual aid support from State and Federal authorities. To leave our local emergency services personnel and their families unprotected is to invite additional difficulties in responding to large-scale biological events. In light of the proposed DHS initiatives, it creates a disparity of the "haves" and "have-nots." As you know, DHS will not be the first responders to communities in need. The true responders will be the sheriffs and their deputies in communities across the country that the National Sheriffs' Association is proud to represent. We fully support what Dr. Garza advocates for DHS and desire to have those same protections given to local responders, including the deputies and their families. These individuals will be the first on the scene, the first in danger, and the first to make the decision to leave their families and stand in harm's way. They must be minimally provided the same opportunity for protection as DHS employees.

We support the November 2011 Institute of Medicine (IOM) report that recommends against issuing med kits to all U.S. households in favor of an approach of issuing med kits to specific populations, where there is sufficient education, control, and programmatic oversight. The emergency services agencies and personnel are that specific population; we are entrusted by our citizenry to carry guns, work with hazardous materials in life-threatening situations, and enter areas unsure of the potential for harm. We are sworn to uphold the law and if necessary give our lives performing that duty, but currently cannot be entrusted to have a supply of potentially life-saving antibiotics on hand for ourselves and our other household members to permit us to respond when we will be most needed.

The NSA urges you to support the creation of a commercial med kit to be used by the first responder community and their households and continue to support the provision of a voluntary anthrax immunization program for all emergency services personnel.

Thank you for your consideration of this matter.

Mr. BILIRAKIS. I now recognize the Ranking Member, Ms. Richardson from California, for any statement that she may want to make.

Thank you.

Ms. RICHARDSON. Good afternoon.

I first want to start off by thanking our witnesses for being here today and for your service on behalf of this country, especially our first responders in our second panel.

We thank you as well.

I am particularly encouraged with Mr. Gabriel, with his background of being a first responder. I think the administration did a great job of getting good people in the right positions. So we look forward to working with you.

Traditionally, when we think of first responders, we tend to think of public safety, police, and fire. They are always the ones that are there. But today we are expanding that definition and I think getting a sense of the other individuals who support our first responders on a regular basis.

Since 2004, the United States Postal Service has worked with the Department of Homeland Security and the Department of Health and Human Services to develop a system to augment the point of distribution network to facilitate a rapid distribution of countermeasures after a biological attack.

In 2005, the Centers for Disease Control recognized that if a major biological event were to overwhelm local response, invoking our letter carriers in the process would be critical to saving lives. The critical role the United States Postal Service can play in distributing medical countermeasures was recognized by President Obama in Executive Order 13527, which directed the Federal Government to develop a National U.S. Postal Service medical countermeasures dispensing model to respond to a large-scale biological attack. Today the resulting National postal model is in operation in St. Paul-Minneapolis, and we look forward to hearing about your success as well as the new program to be launched in Louisville, Kentucky.

The program's success can be attributed to the patriotism of postal workers and the careful planning on behalf of HHS, DHS, and the Postal Service and many other Federal, State, and local partners who have worked together to ensure that the postal employees who participated in this program and their families have access to prepositioned medical countermeasures.

Now when we look at this issue in these very tough fiscal times, I find it ironic that we are having a discussion about including other folks in our first responder model, particularly our letter carriers and postal workers, when we are just over on the Senate side having a discussion about whether we are going to maintain 6 days a week service and keep postal offices open. So it seems kind of ironic, here we are talking about giving more responsibility and utilizing a resource that we know is needed, yet in the same vein, we are talking about cutting it and could very well eliminate our ability to use this program.

Therefore, I urge in the testimony a real frank discussion about the potential impacts of this program and whether, if some of the proposed changes are brought to fruition, do we really think that

they would be met in light of some of the potential cuts that are being proposed? I question if, in fact, that can happen.

Further, some of my concerns are, is that there has been a delay in issuing the guidance, and we look forward to getting some feedback on when that can be expected.

Then finally, with this committee, I am hoping that we will in fact bring to markup H.R. 2356, which was pulled, the WMD Prevention and Preparedness Act of 2011, which would have a great impact on medical countermeasures for first responders.

With that, I thank all of you, both panels, Nos. 1 and 2, for your willingness to testify and the information that you will share with us to make better decisions on behalf of the American public.

With that, Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. Thank you.

Other Members of the subcommittee are reminded that opening statements may be submitted for the record.

[The statements of Ranking Member Thompson and Mr. Turner follow:]

STATEMENT OF RANKING MEMBER BENNIE G. THOMPSON

APRIL 17, 2012

Good afternoon. I want to thank Chairman Bilirakis for holding this hearing.

Adequately trained and equipped first responders are the foundation of our response plans.

We cannot afford to miss opportunities to provide first responders the tools they need to protect the public.

For 26 years, I served as a volunteer firefighter.

When we were called to action, we responded.

When first responders across this country are called to action, they know that inaction or delay can cost lives. They have to act.

DHS needs to adopt a first responder mindset.

In 2008, the Homeland Security Council directed DHS to develop guidance on the appropriate measures for first responders to take following an anthrax attack.

Draft guidance was released in 2009. The final guidance has yet to be issued.

Earlier this year, the full committee was scheduled to mark up H.R. 2356, the "WMD Prevention and Preparedness Act of 2011."

That legislation, introduced by a former Member of this committee, Congressman Pascrell, would have directed the Department of Health and Human Services to make surplus vaccines and countermeasures with a short shelf-life available to first responders.

The same legislation would have reauthorized the Metropolitan Medical Response System, which permits local governments to use grant funding to buy countermeasures to protect first responders and their families.

Unfortunately, the Majority cancelled mark-up of this vital legislation.

I hope that today's hearing can be used to gain additional information on the importance of this legislation and help this committee move toward full committee consideration of H.R. 2356.

I look forward to hearing from the witnesses and I yield back the balance of my time.

STATEMENT OF HON. ROBERT L. TURNER

APRIL 17, 2012

Chairman Bilirakis, Ranking Member Richardson, and fellow Members. I would like to welcome the witnesses appearing before us this afternoon.

To paraphrase the Roman poet Juvenal, we are gathered here today to ask "Who protects the protectors?" First responders put their lives on the line each day in the service of their fellow citizens. If there is another attack on the U.S. homeland, they will be the first on the scene and the ones most at risk.

We know that the more we prepare, the lower their risk will be. Medical countermeasures are an important element of our overall emergency preparedness—for we cannot ask men and women to stand in harm's way without taking the proper precautions to ensure their safety.

We must also recognize that first responders perform best when they know their families are safe. The pre-staging of medical countermeasures in the homes of first responders for use by all family members will ensure their peace of mind and allow them to turn their attention to the pressing tasks at hand. I am heartened by evidence that supplies can be safely stored in homes without risk of tampering or improper use. Studies demonstrating a 97% compliance rate evidence the dedication and training of these professionals.

Voluntary anthrax immunizations from expiring stockpiles of the Strategic National Stockpile are another innovative use of Government resources. The distribution of vaccines to first responders 6 months before expiration avoids waste and maximizes the number of emergency workers who are pre-immunized.

Finally, it is important to look beyond the anthrax threat to other biological, chemical, and nuclear dangers. It is not enough to develop countermeasures—for we must also ensure their proper and effective distribution. The delivery of emergency medicine via the U.S. Postal Service (the "Postal Model") does show promise. There are, however, questions that must be addressed before we can be entirely satisfied with this solution.

I look forward to hearing from the witnesses today, and yield back the balance of my time.

Mr. BILIRAKIS. I am pleased to welcome now our first panel of witnesses. Our first witness is Dr. J.D. Polk. Dr. Polk is the principal deputy assistant secretary for health affairs and deputy chief medical officer of the Department of Homeland Security, a position he has held since November 2011.

Prior to joining DHS, Dr. Polk served as the deputy chief medical officer and chief of space medicine at NASA's Johnson Space Center. He also served as assistant professor at the Departments of Preventive Medicine and Emergency Medicine at the University of Texas Medical Branch. Dr. Polk received his degree in osteopathic medicine from A.T. Still University in Clarksville, Missouri. He holds a masters of science in space studies with a concentration in human factors from the American Medical Military University and a masters in medical management from Southern California's Marshall School of Business.

Following Dr. Polk, we will receive testimony from Edward Gabriel. Mr. Gabriel is the principal deputy assistant secretary for preparedness and response at the Department of Health and Human Services.

Prior to joining ASPR, Mr. Gabriel served as the director of global crisis management and business continuity for the Walt Disney Company. Mr. Gabriel previously served as a paramedic in the New York City Fire Department's Emergency Medical Service and was assigned to the New York City Office of Emergency Management as a deputy commissioner for planning and preparedness.

Mr. Gabriel earned his bachelor's degree from the College of New Rochelle and his masters in public administration from Rutgers University.

Welcome, sir.

Your entire written statements will be entered into the record. I ask that you each summarize your testimony for 5 minutes.

We will start with Dr. Polk.

Thank you. You are recognized, Doctor.

STATEMENT OF JAMES D. POLK, DO, MMM, PRINCIPAL DEPUTY ASSISTANT SECRETARY, OFFICE OF HEALTH AFFAIRS, DEPARTMENT OF HOMELAND SECURITY

Dr. POLK. Thank you Chairman Bilirakis, Ranking Member Richardson, Congressman Turner, and distinguished Members of the committee. It is an honor to testify before you today and alongside my colleague from ASPR, Mr. Ed Gabriel, on the Department of Homeland Security's efforts regarding medical countermeasures for first responders.

These issues are particularly important to both Mr. Gabriel and myself as we have started out our careers as first responders. This committee is very familiar with the Office of Health Affairs' role and responsibilities. OHA provides health and medical expertise in support of the DHS mission to prepare for, respond to, and recover from all threats. We are the principal medical and health authority for DHS and the legislative coordinator for biodefense within the Department.

Today I will discuss a few medical countermeasures and first responder initiatives currently under way by the Department and in concert with our interagency partners. The unremitting threat of an anthrax attack using biological agents requires that we continue to remain vigilant. A wide-area attack using aerosolized Bacillus anthracis is one of the most serious biological threats facing the United States. A successful anthrax attack could potentially encompass hundreds of square miles, expose hundreds of thousands of individuals, cause illness, death, fear, societal disruption, and significant economic damage.

If untreated, the disease is nearly 100 percent fatal. Those exposed must receive life-saving medical countermeasures as soon as possible following their exposure. There is no indication of a specific credible anthrax attack against the United States at this time. However, due to the risks and consequences associated with such an event, it is a priority of the Federal Government and DHS to ensure the readiness of the Nation's first responders and Federal, State, local, Tribal, and territorial governments to enhance their capacity to respond to a biological attack.

The mission of DHS includes enhancing response capabilities at the State and local levels. Communities stand to benefit if they have prevaccinated responders able to deploy immediately. DHS, in partnership with CDC, is codeveloping a concept for a pilot project that would provide expiring anthrax vaccines to responders, as you mentioned, as they would have an increased chance of exposure reflective to their response function. Responders would decide on an individual basis whether or not to be vaccinated.

Understanding that all events are local, we work directly with State and local public health emergency response, law enforcement, emergency management, and emergency medical services leaders to develop response capabilities for health security threats, including biological threats. For example, OHA together with FEMA conducted a series of anthrax response exercises at each of the 10 FEMA regions designed to help coordinate roles, responsibilities, and critical response actions following a wide-area anthrax attack.

In 2009, OHA requested comments from the public and interested stakeholders on draft guidance developed through an inter-

agency process for appropriate protective measures for responders in the immediate post-attack environment of an aerosolized anthrax attack. Since then both DHS and HHS' Office of the Assistant Secretary of Preparedness and Response have worked diligently together to develop consensus guidance. The guidance will reflect the most current understanding and evidence-based medicine for protective countermeasures after a wide-area anthrax attack.

Finally, all of these efforts combined with our Biowatch and our National Biosurveillance Integration Center, or NBIC, form a contiguous biosurveillance and situational awareness system that serves to enhance the ability of local responders to be alerted to and respond quickly to biological attacks. DHS has developed and will continue to refine integrated multidisciplinary detection and biosurveillance capabilities to provide the Federal Government and State and local partners with the tools necessary to respond to unfolding biological events.

In conclusion, thank you again for the opportunity to testify today. The Department of Homeland Security values the work of the Nation's first responders and will continue to support them in their critical preparedness and response efforts. I look forward to any questions that you may have.

[The statement of Dr. Polk follows:]

PREPARED STATEMENT OF JAMES D. POLK

APRIL 17, 2012

Good afternoon, Chairman Bilirakis, Ranking Member Richardson, and distinguished Members of the subcommittee. It is an honor to testify before you today on the Department of Homeland Security's (DHS) efforts regarding medical countermeasures (MCM) for first responders.

As you are aware, the Office of Health Affairs (OHA) provides health and medical expertise in support of the DHS mission to prepare for, respond to, and recover from all threats and hazards. OHA's responsibilities include: Serving as the principal advisor to the Secretary and the Federal Emergency Management Agency (FEMA) Administrator on medical and public health issues; leading and coordinating biological and chemical defense activities; providing medical and scientific expertise to support DHS preparedness and response efforts; and leading the Department's workforce health and medical oversight activities. OHA also serves as the primary DHS point of contact for State, local, Tribal, and territorial governments on medical and public health issues.

OHA has four strategic goals that coincide with the strategic goals of the Department:

1. Provide expert health and medical advice to DHS leadership;
2. Build National resilience against health incidents;
3. Enhance National and DHS medical first responder capabilities; and
4. Protect the DHS workforce against health threats.

Today I will discuss a number of MCM and first responder initiatives that support our strategic goals.

EXECUTIVE ORDER 13527: ESTABLISHING FEDERAL CAPABILITY FOR THE TIMELY PROVISION OF MEDICAL COUNTERMEASURES FOLLOWING A BIOLOGICAL ATTACK

Executive Order (E.O.) 13527 seeks to mitigate illness and prevent death, sustain critical infrastructure, and complement State, local, Tribal, and territorial government MCM distribution capacity. The threat of an attack using a biological agent is real and requires that we remain vigilant. A wide-area attack using aerosolized Bacillus anthracis, the bacteria that causes anthrax, is one of the most serious mass casualty biological threats facing the United States. A successful anthrax attack could potentially encompass hundreds of square miles, expose hundreds of thousands of people, and cause illness, death, fear, societal disruption, and significant

economic damage. If untreated, the disease is nearly 100 percent fatal; those exposed must receive life-saving MCM as soon as possible following exposure.

In particular, Section 4 of the E.O. directs Federal agencies to establish mechanisms for the provision of MCM to personnel to ensure that the mission-essential functions of the Executive Branch departments and agencies continue to be performed following a biological attack. Due to the nature of the DHS mission, a significant portion of our workforce performs mission-essential functions, and others could be exposed during daily activities. As a result, Secretary Napolitano directed DHS to develop a plan and seek funding for a capacity to provide emergency antibiotics to all DHS employees in an attacked area, not just those who are mission-essential. OHA leads this effort for DHS and we are pleased to say that DHS is among the first Federal agencies to have met this requirement of the Executive Order.

STOCKPILING AND FORWARD-CACHING OF MCM

In the past year, OHA successfully introduced an MCM strategy to mitigate the impact of a biological attack on DHS personnel. As part of this strategy, OHA implemented a plan to purchase and stockpile MCM for all DHS employees, those in DHS care and custody, working animals, and contractor employees with DHS badges. DHS identified regional cache locations for every DHS Component in order to preposition MCM across the country for employees to have immediate access after a biological incident.

In order to make the plan both cost-effective and protect even our most remotely-located employees, OHA worked with the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA) to draft an Emergency Use Authorization (EUA) that would permit, among other things, the stockpiling and distribution of 10-day courses of doxycycline at component caches and dispensing of the medication by non-health care professionals. This EUA was issued by the FDA Commissioner on July 21, 2011. OHA was then able to forward-cache nearly 200,000 courses of MCM to 127 field locations for regional stockpiling, in addition to centrally stockpiling additional MCM that might need to be utilized following an incident. OHA continues to partner with FDA to satisfy regulatory considerations for re-labeling and forward-caching of MCM. In addition, pre-EUA submissions are in place to support a possible EUA for ciprofloxacin, an antibiotic that is also effective for post-exposure prophylaxis of inhalational anthrax.

Until an EUA for ciprofloxacin is issued, DHS is restricted to distributing this countermeasure in the currently approved 60-day courses and through a traditional medical dispensing model utilizing DHS health care providers, including the Department's more than 3,500 Emergency Medical Service Technicians (EMTs). However, provisions in both House and Senate versions of the Pandemic and All-Hazards Preparedness Act (PAHPA) reauthorization bill would, if enacted, facilitate such pre-event and response activities.

In the event of a biological incident, it is important to remember that all affected DHS personnel and their families will also have access to MCM from the Strategic National Stockpile through existing community points of dispensing (PODs).

ADVISING DHS LEADERSHIP ON HEALTH AND MEDICAL ISSUES

Serving as the principal advisor to the Secretary and FEMA Administrator on medical and public health issues has afforded OHA the ability to ensure synergistic efforts in implementing a Department-wide strategy for MCM. OHA provides guidance and comprehensive planning information to DHS components through the Anthrax Operations Plan Department Guidance Statement (DGS) in coordination with the Office of Operations Coordination and Planning, develops and delivers training on dispensing of the MCM, assists operational components in the development of dispensing plans and conducts DHS points of dispensing (POD) exercises. To supplement the DGS, OHA also provides medical guidance for MCM storage, administration, and non-medical PODs, as well as medical treatment for working and service animals exposed to anthrax spores. We are now in the process of sharing lessons learned and coordinating with the Federal interagency to ensure the consistency of plans across the Federal Government, including our partners at the Department of Health and Human Services (HHS), CDC, and the FDA.

Coordinated medical oversight provided by OHA ensures that the Department's MCM program and medical treatment rendered pursuant to the program is uniform and consistent to National standards. Currently, OHA has a medical liaison officer (MLO) responsible for the provision of medical guidance, support, and leadership at FEMA, which has proven to be a very successful model. We are in the process of establishing MLOs with Customs and Border Protection (CBP), the Transportation Security Administration (TSA), and Immigration and Customs Enforcement (ICE) to

support their operational workforces. These Components will benefit from coordinated and centralized medical programmatic direction and guidance from OHA, along with an established protocols system that will support and enhance steady-state and deployment readiness activities. The Department as a whole will be better situated to prepare for and respond to disasters and significant events through the increased depth in medical leadership this structure provides.

RESPONSE GUIDANCE FOR FIRST RESPONDERS

OHA also provides our State, local, Tribal, and territorial partners with guidance for protection of personnel responding to a wide-area anthrax attack. Through the Federal interagency process, OHA and HHS's Office of the Assistant Secretary for Preparedness and Response (ASPR) co-led the effort to develop consensus guidance regarding appropriate protective measures for first responders in the immediate post-attack environment of an aerosolized anthrax attack. The guidance reflects the most current understanding of the unique environment that would exist after a wide-area anthrax release. The guidance is a prudent step to provide to first responders the best information on protective measures currently available.

PRE-EVENT ANTHRAX VACCINATION FOR RESPONDERS

In July 2009, the CDC Advisory Committee on Immunization Practices (ACIP) stated that by priming the immune system before exposure to Bacillus anthracis spores, pre-event vaccination might provide more protection than antimicrobial drugs alone to persons at risk for occupational exposure. ACIP recommendations state that, "Emergency and other responders are not recommended to receive routine pre-event anthrax vaccination because of the lack of a calculable risk assessment. However, responder units engaged in response activities that might lead to exposure to aerosolized B. anthracis spores may offer their workers voluntary pre-event vaccination. The vaccination program should be carried out under the direction of a comprehensive occupational health and safety program and decisions for pre-event vaccination should be made based on a calculated risk assessment." (Centers for Disease Control and Prevention, 2010)

"Responders" refers to a diverse set of individuals who perform critical services necessary to mitigate the potential impact of a wide-area anthrax attack. These responders may either be in the area identified as the point of initial release and/or are called in from elsewhere to provide follow-on activities in a contaminated area performing critical services. Our National response capability to a wide-area anthrax attack would be enhanced by having pre-vaccinated responders, able to deploy immediately and confident that they have been afforded as much protective status as possible for these activities. Pre-event vaccination of these responders will increase the ability to save lives, maintain social order, and ensure continuity of Government after a wide-area anthrax attack.

The CDC's Strategic National Stockpile (SNS) approached OHA in June 2011 with the idea of working collaboratively to determine a use for anthrax vaccine with a short shelf life rather than disposing of the unused vaccine. Anthrax vaccine is currently stockpiled in the CDC's SNS to support State and local response during a widespread aerosolized anthrax release. Based on DHS threat assessments and the Department's prioritization of efforts for anthrax preparedness, voluntary pre-event vaccination of responders is deemed to be an appropriate step to prepare for this threat.

Therefore DHS and CDC SNS are developing a program for the provision of expiring anthrax vaccine to Federal departments and agencies, as well as State and local jurisdictions for the voluntary pre-event vaccination of responders. Each Federal, State, local, Tribal, or territorial program must meet eligibility requirements, including the existence of a comprehensive occupational health and safety program through which to manage a vaccination program for anthrax vaccine. It is important to note that the Federal Government is not establishing a Federal vaccination program for State and local responders, but rather providing an existing resource to States and localities who will implement the vaccination program within their jurisdictions. No funding or other resources for any administrative programmatic support requirements will be associated or available through DHS or HHS outside of the provision of the physical vaccine. Such a program would distribute anthrax vaccine to responders at greatest risk of exposure and would not impact vaccines needed for Department of Defense (DOD) personnel recommended to receive the vaccine for general use prophylaxis.

As part of the program development process, CDC and OHA formed a Federal interagency working group to discuss key decision points regarding voluntary pre-event anthrax vaccination of responders. This working group convened a series of

meetings to discuss scientific medical data and policy implications among subject matter expert representatives from over twelve different Federal departments. The group developed pre-event anthrax vaccine risk prioritization guidance for use in the event that demand exceeded supply of vaccine. This guidance identifies the categories of responders eligible to receive pre-event anthrax vaccine, contingent on supply and current threat assessment. All categories of responders identified in this guidance are considered at sufficient risk of future exposure to anthrax to warrant voluntary pre-event vaccination, should the supply be sufficient at the time of the request.

The first step to initiate this pre-event anthrax vaccine distribution program is to pilot the program on a small and manageable scale to ensure the methodology supports responsible vaccine use and to help the U.S. Government understand demand for the vaccine. The pilot program will provide data to allow us to make changes to improve program management and to help scale up the program, as needed, to achieve a safe, reliable, functional, and sustainable capability to widely distribute vaccine, within the constraints of existing program capacity. The pilot will include two Federal departments or agencies and two State or local jurisdictions (including Tribal and territorial jurisdictions) interested in working with DHS OHA and CDC SNS to deliver this program to a pilot cohort of responders. Those selected will manage a voluntary anthrax vaccination program for a minimum of 18 months, in order to accommodate the full 5-dose priming series of vaccine to the volunteer recipients.

CONCLUSION

Thank you again for the opportunity to testify today. The Department of Homeland Security values the work of the Nation's first responders and we are always looking for ways to support them in their critical preparedness and response efforts. I look forward to any questions that you may have.

Mr. BILIRAKIS. Thank you, Dr. Polk.

Mr. Gabriel, you are recognized for 5 minutes.

STATEMENT OF EDWARD J. GABRIEL, MPA, EMT/P, CEM, CBCP, PRINCIPAL DEPUTY ASSISTANT SECRETARY, PREPAREDNESS AND RESPONSE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. GABRIEL. Good afternoon Chairman Bilirakis and Ranking Member Richardson and Members of the subcommittee.

I am Edward Gabriel, the principal deputy assistant secretary for preparedness and response at the United States Department of Health and Human Services. Thank you for inviting me here today on behalf of HHS to testify on protecting first responders.

Before I describe HHS efforts to protect first responders, I want to note that before joining ASPR 7 months ago, I spent 30 years as an emergency medical technician, paramedic, and chief with the New York City fire department emergency medical services. I was on ground prior to the collapse of the towers on September 11 as a deputy commissioner of emergency management and personally witnessed the heroism and sacrifices of fellow first responders.

I understand the needs of first responders, and I truly believe that we in the Federal Government are making a difference in our Nation's preparedness and will continue to improve the lives of those who are doing work on the ground every single day.

As good stewards of our limited Federal resources, HHS and our Federal partners are developing tools and strategies with all-hazards adaptability for our first responders. One tool in development is the med kit. The anthrax med kits would contain antibiotic doxycycline along with instructions for appropriate use in home. Med kits would be available in advance of an emergency to particular groups, such as first responders and families. While further

research is needed to ensure med kits can be safely stored and used in private homes, HHS is optimistic about this capability and its implications for our first responders' protection during a public health or medical emergency.

The second tool in the development is the postal model. HHS awarded the National postal model grants in specific cities and jurisdictions throughout the country. These grants fund planning and exercises to incorporate U.S. Postal Service's employee volunteers into community plans to deliver countermeasures after an anthrax bioterrorism attack.

Recently, HHS supported a tabletop exercise in Louisville, Kentucky. Our primary focus of this exercise was to determine the roles of law enforcement and postal workers in the delivery of medical countermeasures under real-life circumstances. HHS is planning another full-scale exercise in Minneapolis on May 5 to examine issues and implications for the delivery of countermeasures to approximately 40,000 households in four zip codes. Since this program began in 2010, we have captured lessons learned from various exercises and have improved future applications and planning guidance.

As we analyze these results, we will coordinate with our partners and incorporate best practices into similar applications. We are also developing a new and improved medical countermeasures and personal protective equipment to protect first responders in their communities. Since Project BioShield was authorized in 2004, HHS has built a robust pipeline of next-generation medical countermeasure products. We have funded over 80 candidate products that, if successful, will have the potential to transition to procurement contracts and inclusion in the Strategic National Stockpile.

I would like to note that funding for Project BioShield expires in 2013. You and your colleagues are working to reauthorize the Pandemic All-Hazards Preparedness Act, which includes the reauthorization of appropriations for Project BioShield through 2018. The reauthorization of PAHPA supports our work and will ensure we continue to have tools necessary to respond.

Lastly, as my colleague from DHS mentioned, I would like to note that we are in the final phases of completing guidance for first responders following an anthrax attack. This is a significant step in protecting first responders, and I look forward to sharing more on this guidance in the near future.

In conclusion, all of our efforts come down to the same goals: Building a resilient Nation and saving lives when emergencies occur. This is true for all of us, whether at the Federal, State, local, or private sector.

Before I came to ASPR, I was a director of global crisis management and business continuity for the Walt Disney company. My work required strong development of protective relationships worldwide with law enforcement, emergency management, intelligence services, as well as my private-sector counterparts. Based on my experiences, I have learned that meeting the needs of first responders before, during, and after an event is critical. I look forwarded to working with you to ensure that our progress continues and we, as a Nation, are truly prepared.

I thank you for the opportunity to testify before you today, and I would be happy to answer any questions you may have.

[The statement of Mr. Gabriel follows:]

PREPARED STATEMENT OF EDWARD J. GABRIEL

APRIL 17, 2012

Good afternoon Chairman Bilirakis, Ranking Member Richardson, and Members of the subcommittee. I am Mr. Edward Gabriel, the principal deputy assistant secretary for preparedness and response (ASPR) at the U.S. Department of Health and Human Services (HHS). Thank you for inviting me here today, on behalf of HHS, to testify on protecting first responders.

Before I begin this afternoon, I want to mention that maintaining and supporting our State and local response capability is of particular personal significance to me. Before joining ASPR 6 months ago, I spent 30 years as a first responder. I began as an emergency medical technician (EMT) then became a paramedic working throughout the city of New York. I rose through the ranks to become a New York City Fire Department Emergency Medical Services system assistant chief and ultimately became the deputy commissioner for planning and preparedness in New York City's Office of Emergency Management. I was on the ground with other first responders prior to the collapse of the towers on September 11, 2001 and personally witnessed the heroism and sacrifices of our first responders. I have spent my career responding to emergencies. I understand the needs of first responders and I truly believe that what we in the Federal Government are doing is making a difference in our Nation's preparedness and will continue to improve the lives of those doing the work on the ground.

This afternoon I'm going to talk to you about the unique role that HHS plays in protecting and supporting the Nation's first responder community and helping them become more resilient after tragedy strikes. Our strategic approach involves creating best practices for getting medical countermeasures to first responders quickly in a range of emergency situations; developing promising new products, tools, and technologies to protect our first responders and giving them the tools needed to be successful; and integrating behavioral health into overall public health and medical preparedness, response, and recovery planning. First responders are defined as a diverse set of individuals (emergency medical services practitioners, firefighters, law enforcement, and HAZMAT personnel, the emergency management community, public health and medical professionals, skilled support personnel, emergency service and critical infrastructure personnel, certain other Government and private sector employees, and individual volunteers assisting in response activities) who are critical to mitigating the potential catastrophic effects of public health emergencies. I'll talk about our new approaches to coordination where Federal, State, local, Tribal, territorial, and private-sector partners comprise the "medical countermeasures enterprise" and come together to collaborate and plan the development and deployment of countermeasures. Our approach throughout this enterprise takes the whole system into account—from early research to deployment—and includes the needs of first responders. I'll also focus on the first responder community not only in the context of medical, fire, and police but also other critical human services and how you and I, our families, and those in our communities might also play critical roles in a first response. I hope to leave you today with a clear picture of our work in this area and our proactive strategies to continue progress. Our Nation's ability to respond to an emergency depends on truly collective approaches and a strong partnership with our State and local partners who have the primary role in those first critical moments when the speed and thoughtfulness of response translates into more lives saved.

Supporting and assisting our Nation's first responders is a top Federal priority; however, we all recognize that the act of first response occurs primarily at the State and local level. Therefore, we focus attention on empowering States and communities to prepare for and respond to emergencies as safely, effectively, and efficiently as possible. As we are all aware, when disasters strike it is the response from the local community during the minutes before and after the event that saves lives. Our communities need to be resilient and be able to respond quickly. Today, State and local communities are more resilient than ever before. Incidents including the tornadoes that touched down in Alabama and Missouri in 2011 and recent flooding in Louisiana demonstrated how State and local communities are able to respond during the initial stages of the public health emergency response with little to no need for Federal assistance. HHS' Hospital Preparedness Program (HPP) and Public

Health Emergency Preparedness (PHEP) cooperative agreement programs support State and local resilience by funding preparedness activities and infrastructure at State and local public health and medical facilities. A Hospital Preparedness Program report entitled "From Hospitals to Healthcare Coalitions: Transforming Health Preparedness and Response in Our Communities," describes the achievements of our State partners in building health care preparedness across the Nation, and illustrates how States have used the capabilities developed and funded through the program in both large and small incidents. One specific accomplishment detailed in this report is that more than 76 percent of hospitals participating in the HPP met 90 percent or more of all program measures for all-hazards preparedness in 2009. These activities promote community resilience and improve health outcomes following emergencies and disasters.

Despite HPP and PHEP investments, the financial realities we are all facing today continue to challenge our public health and medical infrastructure and, ultimately, communities' ability to be resilient. We are already witnessing a decline in the State and local public health workforce as a result of these fiscal constraints.

As good stewards of Federal resources, we must focus on developing tools and strategies for all-hazards which can be implemented in a range of emergencies. If a chemical, biological, radiological, nuclear (CBRN), or emerging infectious disease incident were to occur, we might have a few minutes or hours, not days, to dispense medical countermeasures to treat first responders and their communities, depending on the nature, scope, and size of the event. We will need first responders on the ground as soon as possible to treat the health impacts of the event and maintain the safety and security of their communities. In the aftermath of an event we will rely on multiple modalities to protect first responders, including pre- and post-event treatments. This treatment strategy is central to many of our preparedness plans including those for anthrax, smallpox, influenza, and other agents. For bacterial threats, antibiotics offer one of the best courses of action as vaccines can take days, weeks, or months to be effective unless provided to responders before-hand. For example, the CDC's Advisory Committee on Immunization Practices recommends a three-dose anthrax vaccination regimen, as a post-exposure prophylaxis, for responders following an event, in addition to antibiotics. While the first vaccine dose would be administered as soon as possible post-exposure, the second and third doses would be administered 2 and 4 weeks later. The vaccine is not immediately effective and is not fully protective until after that third dose. Antibiotics are an important part of treatment strategies to bridge time gaps by maximizing protection from vaccines post-exposure.

To provide a quick and effective response, first responders will need to receive the most effective treatments quickly. I am pleased to say that Federal partners are working better together to ensure that we have the best tools available to treat and respond effectively to public health and medical emergencies. Federal partners are collaborating via the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE)—the overarching interagency convening body for medical countermeasure development, stockpile, and use. ASPR leads the PHEMCE, which brings together three primary HHS agencies—the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA)—along with four key interagency partners—Department of Homeland Security (DHS), Department of Defense (DoD), Department of Veterans Affairs (VA), and Department of Agriculture (USDA). Working together full-time, as an enterprise, we are coordinating, exchanging information, and learning from each other daily to optimize preparedness and response for public health emergencies. The PHEMCE is bringing together partners not only to identify and support the development of a number of novel medical countermeasures to protect first responders but to also identify and plan for the use and distribution of acquired products.

Today, HHS and other Federal partners are working to develop new tools with potential all-hazards adaptability to support and protect first responders. While HHS does not lead first responder activities, we do have a critical and unique role in advancing promising approaches in response at the National level which can then translate into local use. One such approach in the development and pre-approval phases is the anthrax "med kit." The anthrax med kits contain the antibiotic doxycycline along with instructions for appropriate use in the home. Upon approval, med kits would be available in advance of an emergency to particular groups such as first responders and their families. These med kits could be purchased directly, either by the first responders themselves or their employers. While further research is needed to ensure med kits can be safely stored in private homes without misuse, we are optimistic about this capability and its implications for first responder protection during a public health or medical emergency.

As you know, we have already seen success in the use of the med kit concept through pilot testing the National U.S. Postal Service (USPS) medical countermeasures dispensing program. Supporting implementation of actions described in Executive Order 13527, *Medical Countermeasures Following a Biological Attack,* HHS has invested $10 million since 2010 to support National Postal Model grants awarded to specific cities and jurisdictions throughout the country. The grants fund planning and exercises to incorporate USPS employee volunteers into community plans to deliver medical countermeasures after an anthrax bioterrorism attack. Under this model, volunteer USPS letter carriers receive pre-event antibiotics via a Home Antibiotic kit that they store in their homes; these are for themselves and household members. If a public health or medical emergency requiring medical countermeasures occurred, letter carriers and their household members would be instructed to begin taking their antibiotics. This would allow these USPS volunteers to perform their mission, as outlined in the National Postal Model, to deliver antibiotics as prescribed by their specific postal plans. Law enforcement officers accompany the letter carries as they deliver the antibiotics to homes in predetermined ZIP codes. Since this program began, we have learned lessons from the various exercises and have improved future applications and planning guidance. Recently, HHS held a table-top exercise in Louisville, KY. A primary focus was determining the roles of law enforcement and postal workers in delivery of medical countermeasures under "real-life" circumstances. HHS is planning another full-scale exercise in Minneapolis on May 5 to examine issues and implications for the delivery of countermeasures to approximately 40,000 households in four zip codes. As we analyze results, we will coordinate with our partners and incorporate best practices into similar applications.

As we work with our partner agencies to develop all-hazards tools to support first responders, we must also develop policy documents to guide efforts to protect first responders and their communities from an anthrax attack and other emergencies. These interagency guidance documents will provide clarity and improve coordination to ensure that the needs of all responders are met before, during, and after an emergency. It is critical that strategies are developed before an event to ensure that the tools available for all responders are used to their maximum capacity.

In addition to developing the policies themselves, there will be implementation challenges, including monitoring recipients of pre-event vaccinations, and in the aftermath of an event, the immediate availability of adequate vaccine and the availability of resources to support vaccination in the midst of an on-going event will need to be addressed. These challenges span the regulatory authorities and resources of several Federal agencies and departments, as well as those of our State and local partners. HHS is actively engaging with interagency partners to address these challenges and establish policies for the distribution of medical countermeasures to first responders, not just for anthrax, but for all potential hazards and threats. As such, the resulting guidance documents will be considered "living documents" in the sense that they will be refined as the evidence base is strengthened for determining exposure risk and the efficacy of protective measures and feedback is received from stakeholders. Even as we update existing guidance and disseminate new guidance, we will look forward to continuing dialogue with our stakeholders and partners in the first responder community.

We've done considerable work in developing novel approaches to get medical countermeasures to first responders quickly and coordinate at all levels of government to ensure that our first line of defense is protected in an emergency. However, we are also looking forward and developing new and better medical countermeasures to both protect first responders and the communities they live in, as well as improving their tool kit to treat those affected. In August 2010, HHS Secretary Sebelius released the Public Health Emergency Medical Countermeasures Enterprise Review: Transforming the Enterprise to Meet Long-Range National Needs (MCM Review). The MCM Review examined the steps involved and made recommendations regarding the research, development, and regulatory approval of medications, vaccines, and medical equipment and supplies for a public health emergency. In implementing recommendations of the MCM Review, HHS has already made progress in improving the entire medical countermeasure pipeline—from early stage research and development to distribution.

As I mentioned earlier in my testimony, the PHEMCE is bringing together partners to identify and to support the development and deployment of a number of novel medical countermeasures to protect first responders. My office works closely with HHS partners including NIH, CDC, and FDA to develop, procure, and stockpile medical countermeasures for CBRN threats as well as emerging infectious diseases, including pandemic influenza. We are now more prepared for a broad range of threats and emerging infectious diseases than at any point in our Nation's history.

We have a robust pipeline of next-generation products—we have gone from having very few products in the medical countermeasure pipeline over the last decade to funding over 80 candidate products that, if successful, have the potential to transition to procurement contracts and inclusion in the SNS. These products include: An entirely new class of antibiotics; anthrax vaccine and antitoxins; a new smallpox vaccine and antivirals; radiological and nuclear countermeasures including candidates to treat the various phases of acute radiation syndrome; pandemic influenza countermeasures; and chemical antidotes. In many cases, these products represent the future for enhanced protection of first responders.

Since Project BioShield—the primary tool HHS uses to procure novel CBRN medical countermeasures for the SNS—was authorized in 2004, HHS has strengthened internal and external contracting mechanisms, and research and development pathways, and has incorporated lessons learned from past challenges. As my colleague at DHS will detail, there is much discussion about the pre-event vaccination of first responders against threats such as anthrax. However, the current vaccine regimen is burdensome as it requires five vaccinations over 18 months and annual boosters to produce immunity. We all agree that all responders have to be adequately protected, and if a decision is made to make anthrax vaccine available to them, it would help to have vaccines that require fewer immunizations. As part of its efforts to develop vaccines to protect the entire civilian population, HHS is currently investing in more than 20 programs for next generation anthrax vaccines, four of which have transitioned from early to advanced research and development. The programs have the potential to provide protective immunity with 3 doses of vaccine or less, are easier to administer, and have a decreased life-cycle cost due to lack of the cold chain requirement.

Funding for Project BioShield expires in 2013 and work to reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA) is on-going. The proposed legislation includes the reauthorization of appropriations for Project BioShield through 2018. Investing in development of medical countermeasures, novel approaches to response operations, and our public health infrastructure is critical in ensuring that adequate medical countermeasures are available for dispensing as soon as possible following the start of a public health incident. The reauthorization of PAHPA will support our work and will ensure we continue to have the tools necessary to respond.

As part of our strategic approach to encouraging innovation in medical countermeasure development, we are also developing new tools for all responders and a number of these efforts are already showing results. HHS is developing a next generation portable ventilator that will be lighter and less expensive, making it easier and quicker to administer critical treatments. In 2007, HHS convened a blue ribbon panel of experts to review the state of ventilators in the market against the requirements for use in all-hazards preparedness. In September 2010, an advanced research and development contract was awarded to Newport Medical in California for design and development of a next-generation portable ventilator that is at a highly-affordable price point and that could be used with minimal training on a broad range of patients from neonates to adults. A prototype was developed by July 2011 and is currently being evaluated. The initial results are promising and the program is on schedule to file for market approval in September 2013.

As we develop medical countermeasures to respond to public health and medical emergencies we must not ignore the needs of first responders and their communities after an event. Community-based responders are the first to arrive on the scene when an incident occurs and they remain in the community through recovery. A major event such as an aerosolized anthrax attack will require response and recovery activities long after the initial threat has passed. First responders will play a key role in these locally-led recovery efforts toward the restoration of public health and medical services. First responders are the backbone of our public health and safety infrastructure; by supporting them, we ensure that the human infrastructure remains intact throughout the response and recovery phases, and ready for the next emergency. Recovery is a part of preparedness, and the National Disaster Recovery Framework, released in September 2011, provides guidance to all levels of government, the private and nonprofit sectors, and individuals and families on activities they can undertake both pre- and post-disaster to plan for a successful recovery. HHS leads the Health and Social Services Recovery Support Function under that framework, and ASPR has established a Recovery Coordination Office to carry out those responsibilities and also leverage opportunities to incorporate recovery into on-going preparedness efforts. We have also supported innovation and continuous improvement in our efforts to support first responders and others during the recovery phase. Based on lessons learned in Hurricanes Katrina and Rita, HHS recognized the need for enhanced coordination of disaster-related health care, mental

health and human services needs at all phases of response. Today HHS' Administration for Children and Families, in partnership with FEMA, administers the Federal Disaster Case Management Program, which provides disaster survivors with a single point of contact for accessing resources and services to address disaster-caused needs, and for developing and completing a personalized Disaster Recovery Plan. While they are not first responders in the traditional sense, our disaster case managers are on the ground in the aftermath of a disaster providing support to their fellow responders and impacted individuals.

In addition to supporting officially designated and trained first responders, we are also leveraging the internet to supplement the first response. In particular, under the America Competes Act, we are issuing a "challenge" for development of a web-based application able to automatically deliver a list of the top-five trending illnesses from a specified geographic region in a 24-hour period. Under the envisioned program, data would then be sent directly to State and local health practitioners to use in a variety of ways, including building a baseline of trend data, engaging the public on trending health topics, serving as an indicator of potential health issues emerging in the population, and cross-referencing other data sources. The more we know and the earlier we understand emerging health trends, the better prepared we all are—including first responders—in providing treatment to affected individuals and limiting the impact of the event.

In conclusion, all of our investments and efforts come down to the same goals—building a resilient Nation and saving lives when emergencies occur. This is true for all of us, whether in the Federal, State, local, Tribal, territorial, or private sector. Before coming to ASPR, I was the director of global crisis management and business continuity for the Walt Disney Company. In this position I was responsible for the development and implementation of global policy, planning, and training to manage crises for The Walt Disney Company. I was also responsible for East and West Coast Medical and Emergency Medical Operations as well as the Walt Disney Studio's Fire Department. My work with Disney required development of strong and productive relationships with law enforcement, emergency management and intelligence services counterparts, as well as private sector counterparts world-wide. Based on my experiences, meeting the needs of our first responders before, during, and after an event is critical. We have made great strides toward building a robust enterprise to develop medical countermeasures and to quickly get them to people who need them. We are incorporating the clinical community into National preparedness systems and are preparing clinicians to treat patients affected by emergencies. We are collaborating with State and local partners to develop, exercise, and improve their response capabilities. All of our efforts will ensure the next public health or medical emergency is responded to in the best, most effective way possible. I look forward to working with you to ensure that this progress and our strategies for the future continue to prepare the Nation and save lives.

Thank you for the opportunity to testify before you today. I am happy to answer any questions you may have at this time.

Mr. BILIRAKIS. Thank you for your testimony. I appreciate it very much.

I will recognize myself for 5 minutes for questions.

This question is for Dr. Polk and Mr. Gabriel. On October 2009, DHS published draft guidance for protecting the health of first responders immediately following a wide-area anthrax attack. We know that the first responder community is waiting for this guidance, and of course, our Ranking Member brought this up in her opening statement. Of course, the guidance has since become a joint effort between DHS and HHS. So my question, of course, is for both of you. Please tell me where this guidance is and why is it now more than 30 months since a draft was received and we still don't have the final guidance published that our first responders can use to prepare for any type of an event? If you can both address that, I would appreciate it. Thank you.

Dr. POLK. Sure. Thank you, Mr. Chairman.

First off, I am happy to report both Ed and I have worked diligently with our counterparts in DHS and HHS on this guidance to get it moving forward, and it was approved by the DRG earlier this

month. My last understanding is that it is going through the signature cycle, getting all of the interagency logos applied to it, and then it will very soon—within the coming weeks—go through the final interagency vetting process and then be released.

So I think it was Dr. Garza in his testimony that said we were rounding third and heading for home, and I think we are almost home.

Mr. BILIRAKIS. Okay. So give me a better estimate. Be more precise as to when you think our first responders will get the guidance.

Dr. POLK. I think that will depend on if we get any comments back from the interagency vetting process. If we have any other comments back from any of the interagency's partners, it may take a little bit longer to vet those. But I would imagine we would have that, quite frankly, by mid-May.

Mr. BILIRAKIS. Why has it taken so long?

Dr. POLK. I think initially, you know—and to be as precise as I can, a lot of it is to make sure that we had the absolute best level of evidence to go into the document. Because there were changes in evolution over the last several years as to what is the best PPE equipment to use, what is the best treatment for anthrax, and also, as we had all of these other different programs come on-line, whether it was vaccination, whether it was pre-event vaccination or post-event vaccination, we wanted to make sure that this document was contiguous with other programs that were coming out, that we did not cause confusion or actually add to a problem with our first responders by having one document that said one thing and a second document that said another that was a follow-on document for public health. So we wanted to make sure that we vested a lot of time to get this right the first time.

It is still going to be released as a draft so we can get public comment when the folks see it because we are under no guise that we have anticipated all the issues that may confront the first responders. But we wanted to make sure that we had it right because these folks, quite frankly, are going to be rushing into an anthrax event in a hot zone, and this is not something where we wanted to leave a lot of guesswork.

Mr. BILIRAKIS. Okay. Thank you.

Mr. Gabriel.

Mr. GABRIEL. Well, I have seen the overall document since getting to ASPR back in November and September, and I have taken a look at it. I know our offices have been working closely within our partners at the HHS side, the Centers for Disease Control, as well as all of our other partners to make sure that the guidance was clear enough to meet the needs of somebody who is on the ground.

The issue with anything like this is it can't be perfect. When you try to look at guidance like this, you want to keep it as general for the people that are really in the field to understand and use appropriately. Sometimes when you look at document development like this, you get a lot of technical sort of concepts put into something that needs to be operationalized at the field level. I have seen that from my experiences over the last.

So we took a good hard shot over the last few months fixing those gaps and making sure that it meets the needs of responders more clearly so that when they look at and give us their input again on this, they are able to say, hey, this will work in the field. I think that is important. So I think that we are just a handful of days away from getting this out. Again, I can't speak for the process above me. But I think the first responder community will be generally happy with it, when it gets their visibility on it.

Mr. BILIRAKIS. Thank you.

Dr. Polk, you discussed in your testimony that your office is working on guidelines for the use of expiring doses of anthrax vaccine in the National Stockpile for provisions on a voluntary basis. You mentioned, of course, to first responders. We know that such a program is of course a priority. It also sounds like good Government. We are going to save money. It is a better alternative to throwing away millions of perfectly good vaccines. I am sure you will agree. In fact, legislation under consideration by this committee has asked for that very thing.

I would like to hear more about the pilot and to understand your principles for implementation, even though the program guidance is not yet ready. I would also like to hear how this program will differ from the unsuccessful smallpox vaccination effort for health care workers undertaken by the Federal Government a few years before. So if you could respond, I would appreciate it.

Dr. POLK. Yeah. Thank you, Mr. Chairman and thanks for the opportunity to talk about this novel program.

Obviously, DHS has worked hand-in-glove with our HHS CDC partners on this. As you mentioned, the Strategic National Stockpile has vaccine that expires every year, sometimes to the tune of about 2 million doses, $48 million per year, that we have to recycle, throw out when it expires and recycle. The goal of this pilot program is to take this vaccine approximately 6 months before it expires and make it available to the State and local governments as a prevaccination or pre-event vaccination program for their folks. Again, I have to stress it is a pilot, meaning that the goals of a pilot are to discover where are the gaps, where are the lessons learned before we distribute this more widely or make this a more wide program. I believe we have worked diligently with CDC on the nuances of how to get the logistics of the vaccine from the stockpile to the State and locals. I believe what they are looking at right now is the legal departments from each are looking at, where do we have the authorization to spend appropriated funds, under what section, whether it is through FEMA or whether it is through CDC, et cetera, to get the vaccine there, essentially pay for postage, to make sure that we can get the vaccine there to the State and locals?

Mr. BILIRAKIS. Which States are you proposing to participate in the pilot project?

Dr. POLK. Well, I believe the States are going to, you know, have an application process to apply and to essentially allow the States to volunteer. The criteria are going to be fairly short and succinct. They need to have an occupational surveillance program so that they can monitor any vaccine reactions, et cetera. They need to have a good distribution program. They need to make this vol-

untary. Those are the basic guidelines that the States are going to have to use. But we obviously want to make sure that if they are going to give this vaccine that they have good follow-up for anyone who has a vaccine reaction, that they can answer questions, that they can educate the folks who are going to get the vaccine properly. So those are the criteria that the States would use initially. So they are not going to be very rigid. So hopefully we will get a fair amount of folks that are willing to engage in the program.

Mr. BILIRAKIS. Thank you.

I recognize you for 5 minutes, Ranking Member Richardson.

Ms. RICHARDSON. You mean 8 minutes and 18 seconds.

Dr. Polk, can you tell me how much has been spent on the anthrax vaccine and what is the expected shelf life?

Dr. POLK. Well, I can't tell you offhand. The Strategic National Stockpile is owned by CDC. So I would have to defer to my colleagues in HHS exactly as to what the cost is that they spend on that vaccine or what the expected shelf life is. But typically, FDA has medications for a 1-year shelf life for the most part. Although certain medications can be extended based on the type of medication or what buffer are in those medications to extend their shelf life. But I would have to defer to my colleagues.

Ms. RICHARDSON. Mr. Gabriel, do you know the answer to that?

Mr. GABRIEL. Well, if the answer is on this card, I do. I have just been told that we spent $2 billion. It has got a 4-year shelf life.

Ms. RICHARDSON. Mr. Polk, did I understand you correctly that hopefully the guidance would be out by mid-May in draft form?

Dr. POLK. I would hope so. That is assuming that with all of the vetting that we have done on this document, which we have done a great deal, that I imagine that we have resolved a lot of the interagency questions that have come about before. So, hopefully, it will slide fairly quickly through that vetting process.

Ms. RICHARDSON. In the second panel, we are going to be able to ask the question of the letter carriers, what they feel the impact might be if, in fact, they are experiencing cutbacks as has been proposed, which I certainly do not support. But have you had an opportunity to think about—either of you gentlemen—if the Postal Service is not able to serve in support of this program, what your other options would be?

Mr. GABRIEL. Well, I will start first, and then J.D. will take it from there.

From a postal model perspective, I was actually out in Louisville talking to the postal workers directly on this. They want to volunteer and participate. But they are a piece of an overall process that involves management, that has come out of our all-hazards preparedness programs and our BioShield programs, including points of dispensing, both closed and open points of dispensing models. The postal model itself, we are looking at med kits.

So if you look at an overall approach, if the postal model system begins to show and continues to show that it is effective, clearly, as we move forward, that has to be in our arsenal for protecting first responders and civilians.

Ms. RICHARDSON. No, my question was if it is not available to you.

Mr. GABRIEL. We will have to use different models as we already are.

Ms. RICHARDSON. Is there anything else sufficient to the level——

Mr. GABRIEL. Yeah. I think our points of dispensing models are good. I think the CDC, working with our DHS partners, have tested those models across large municipalities where real good work has been done for a number of years.

Ms. RICHARDSON. Is there any—and I apologize for cutting you off. But we were called for votes here. I was teasing the Chairman about extending my time.

Mr. BILIRAKIS. We are going to try to go another round, too, if we possibly can.

Ms. RICHARDSON. My question is: Is there any other means—I realize the CDC has its process. But I don't know of any other means that could do the actual residence-to-residence distribution and have that kind of process in place. Is there anything else that compares to that?

Mr. GABRIEL. Resident-to-resident model, hand-delivered, no, it doesn't exist now. However, the med kit, home med kit process certainly has some implications relative to that. But we are not there yet.

J.D., want to answer?

Dr. POLK. Yes. At least from a DHS perspective, I don't think there is a one-size-fits-all that is going to work in any particular community. I think whether it is pods, home med kits, postal model, what may work in a rural area may not work in an inner city. I think as many models that we can use to help augment or distribute, to shorten the time for medication to exposure certainly is going to be supported by DHS.

Ms. RICHARDSON. Okay. Do either of you have any idea of when the public health emergency medical countermeasures enterprise plan will be released? That is in reference to October of last year. GAO reported that between 2007 and 2010, HHS invested $4.3 billion into countermeasures development, both the acquisition and research and development. HHS and DHS updated risk assessments and inventoried the Strategic National Stockpile that HHS has not updated the countermeasure investment priorities set forth in the Public Health Emergency Medical Countermeasures Enterprise Plan of 2007. HHS has confirmed to GAO that it would release an updated priorities plan in the spring of this year.

Mr. GABRIEL. Let me take that one, councilman—excuse me—Congresswoman. It is that New Yorker in me testifying in front of the New York City Council versus the Congress.

So two things about that. Just a little bit about the overall approach we are doing with this, and then I will give you a specific answer. We have tried to build this plan by making sure that whatever we put in this overall program has an end-to-end approach, so that it is useful on the side for responders and it has the scientific input. To give you the quick answer to that, we are expecting release of that by this summer.

Ms. RICHARDSON. Thank you.

I yield back.

Mr. BILIRAKIS. Thank you. We are going to try to go another round. I am going to go ahead and ask one more question, and I am going to give the Ranking Member an opportunity as well. Then we are going to have to break for votes. We have three votes pending, and then we will come right back. We will dismiss the first panel now, after we finish our questions, and then we will start with the second panel as soon as we finish for votes. Okay.

Mr. Gabriel, your agency met with FDA just a couple of weeks ago to get the FDA's initial thoughts on an approval process for a first responder antibiotic med kit. There appears to still be some concerns in the public health and regulatory community over misuse of antibiotics. In your opinion, do you think the first responders, as well-educated members of the medical and law enforcement communities would be likely to handle the medication appropriately? Can you site any scientific studies that demonstrate that this might not be the case? What does your data from the current postal plan suggest?

Mr. GABRIEL. Well, thank you for that question. There was a meeting at the FDA, and there was a discussion about this. I think both the first responder community as well as the scientific and medical community talked to this advisory panel to the FDA. There are two sides to this particular discussion. But from a perspective—we are excited on our side and are looking at the med kits as a potential option here from the HHS ASPR side. The FDA has looked at it and will come to us, get back to us with more formal regulations or recommendations from them directly. So to answer on what the outcome is going to be, I don't know.

However, as a first responder, we are dedicated people. We are trusted to do a lot of different things in a lot of different environments. Most of the studies and materials I have seen on this show that in the past studies that we have run these kinds of things, the people are dependable to handle these things appropriately.

However, in the end, the overall recommendation comes through the FDA, and that is what we are going to wait for. But first responders every day are going into your houses, taking care of people with heart conditions, cutting you out of buildings and doing the things that they put their lives on the line to do every day. They are dependable people.

Mr. BILIRAKIS. I definitely agree with you.

Okay, I will recognize the Ranking Member for at least one question.

Ms. RICHARDSON. You mentioned—well, we talked a little bit about well it has taken almost 3 years now to get the guidance. So as we get ready to look at appropriations, you may want to advise the folks that you work with that it really puts this project in great vulnerability if we haven't received the guidance if we want further funding. Since it is coming up to expire for 2013, what would be the case that either of you would make of why we absolutely need to continue the program? I am referring to the BioShield.

Mr. GABRIEL. BioShield funds a number of different programs that we really do need the money for. The whole point of the dispensing process came through that. We use that funding every single day for a number of different projects in treating and preparing emergency response people to be ready during disaster. BioShield

is a terrific program. Overall, there will be gaps in our ability to move forward on product development that are already in the pipeline if the funding doesn't come through. I mean, there is a lot more detail there. But the answer to the question as straightforward as I can, we want to make sure it is a continuum of the good work that is done so far on the projects and developments of countermeasures with over 80 of them in the pipeline.

In addition to that, we also have used it for the development and acquisition of incentives to industry to make sure that the industry has a clear path forward and is willing to commit to us as a Government to continue to work on these projects.

Ms. RICHARDSON. Okay. If you could supply to the committee, if the Chairman does not object, the details of why you think it is so critical to continue and what are the benefits. Then if you could also clarify how much of the funds are actually being spent on expiring products, such as anthrax, oxidants, and a smallpox vaccine.

Mr. BILIRAKIS. I do not object. So ordered.

Okay. Well, thank you very much. I want to thank you for your service. Thank you for your testimony today. Without objection, what we will do is we will dismiss the first panel, and then we are going to recess, and we will be returning following votes. Thank you very much for your patience.

[Recess.]

Mr. BILIRAKIS. Well thank you very much for your patience. I really appreciate it.

I want to welcome our second panel. Our first witness is Chief Al Gillespie. Chief Gillespie is the president and chairman of the board of the International Association of Fire Chiefs and serves as the fire chief of the City of North Las Vegas, Nevada. Chief Gillespie holds a bachelors of science in fire administration and has completed a fellowship at Harvard's Kennedy School of Government.

Next, we will receive testimony from Mr. Bruce Lockwood. Mr. Lockwood serves as deputy director of emergency management for the town of New Hartford, Connecticut. Mr. Lockwood is also second vice president of the U.S. Council of the International Association of Emergency Managers and previously served as president of the IAEM Region 1. Mr. Lockwood served on the National Commission on Children in Disasters, where he chaired the Subcommittee on Evacuation, Transportation, and Housing, and served as a member of the Subcommittee on Pediatric Medical Care.

Following Mr. Lockwood, we will receive testimony from Sheriff Chris Nocco. Sheriff Nocco is the sheriff of Pasco County, Florida, which happens to be in my Congressional district, a position he has held since May 2011. Prior to his appointment by Governor Scott, Sheriff Nocco served as a major and supervisor of the Pasco County Sheriff's Office Joint Operations Bureau. Sheriff Nocco has also served as a chief of staff of the Florida highway patrol and as the deputy chief of staff to the then-speaker of the Florida House and now U.S. Senator Marco Rubio.

Sheriff Nocco has also served as a member of the Philadelphia public school police, the Broward County Sheriff's Office and the Fairfax County, Virginia Police Department. During his service in

Fairfax, Sheriff Nocco responded to the September 11 attacks and the anthrax attacks.

Sheriff Nocco received his bachelor's degree in criminal justice and his masters of public administration from the University of Delaware.

Finally, we will receive testimony from Mr. Manuel Peralta. Mr. Peralta is the director of safety and health for the National Association of Letter Carriers, a position to which he was elected in July 2010. Prior to pursuing this position, Mr. Peralta held a number of positions within the National Association of Letter Carriers.

Welcome.

We welcome all of you. We look forward to your testimony. Your entire written statements will appear in the record. I ask you to summarize your testimony for 5 minutes, and I will first recognize Chief Gillespie.

Thank you very much and you are recognized, sir.

STATEMENT OF CHIEF AL H. GILLESPIE, EFO, CFO, MIFIREE, NORTH LAS VEGAS FIRE DEPARTMENT, AND PRESIDENT AND CHAIRMAN OF THE BOARD, INTERNATIONAL ASSOCIATION OF FIRE CHIEFS

Chief GILLESPIE. Good afternoon, Chairman Bilirakis, Ranking Member Richardson, and Members of the committee. I am Al Gillespie of the North Las Vegas fire department and president and chairman of the Board of the International Association of Fire Chiefs. The IAFC is a member of the Emergency Services Coalition For Medical Preparedness.

Thank you for the opportunity to represent fire and EMS responders today.

My testimony is based upon my experiences as fire chief in several places, including North Las Vegas. As one of our Nation's most attractive destinations, we are a high target for a terrorism attack. My department has a Homeland Security and Special Operations Division. On 9/11 and the days that followed, first responders served our Nation with little concern for their personal health. We have learned many lessons from the terrorist attacks that day and from the anthrax attacks later that year.

With Congress' leadership, we have raised preparedness and training in many areas, but there is more work to do. As chief, I know my personnel will respond. If you ask me if they would respond to a fire or a medical emergency, a pandemic or a biological attack, my answer is yes.

However, numerous studies on the abilities and willingness of emergency services personnel to respond to pandemics have uncovered some concerns. The Journal of Occupation and Environmental Medicine published a study where only 49 percent of the participants answered that they would be both able and willing to respond to a biological incident. Another study published by the Disaster Management and Response revealed that only 38 percent of responders stated they would respond if their immediate families were not protected. However, 91 percent reported they would stay on duty if their families and themselves were fully protected and vaccinated.

Mr. Chairman, the fire and emergency services will do all we can to protect our communities. We need Congress to do all it can to protect our first responders and address a major gap in preparedness for a pandemic or biological bioterrorist attack. We should not wait for an attack to validate the surveys and provide absolute proof.

Congress should add language during the conference committee for the Pandemic and All Hazards Preparedness Reauthorization Act that focuses on protecting first responders. Otherwise, a major gap in our National preparedness system will remain. The IAFC believes Congress should authorize the Department of Homeland Security and the Department of Health and Human Services to establish and test a voluntary anthrax immunization program for emergency first providers. In addition, Congress should direct these Federal departments to deploy prepositioned antibiotic kits into the homes of emergency service providers to protect first responders and their families. Extending these protections to first responders and their families will improve preparedness and prevent the responders from infecting their families.

I would like to reiterate that any anthrax immunization program should be voluntary. The Strategic National Stockpile prepositioned regionally includes an anthrax vaccine for deployment after attack. However, if there is an attack, immediate emergency response will be provided by local personnel who are not necessarily immunized. The current plan calls for the delivery of countermeasures to States within 12 hours of an emergency declaration.

The Federal policy should be changed to set up a pilot program that rotates nonexpired potent and safe vaccines from the SNS to voluntary emergency responders' immunization programs. This would improve preparedness and better utilize Federal resources and tax dollars. Additionally, this effort could provide real-world practice for distributing countermeasures after an attack. As DHS and HHS design the program, they can create record-keeping guidelines that ensure that first responders who volunteer for the program receive the proper and full vaccinations. We have learned that DHS and HHS are developing pilot programs, as you have heard, to make vaccines in the SNS available as Federal excess property and are interested in receiving more information about this program.

In addition, the prepositioned home med-kit program should be extended to emergency responders for their families. The brave postal workers who volunteer to distribute the antibiotics under the National postal model are provided prepositioned home med kits covering the individuals and their families. The CDC conducted a pilot study on the household's ability to maintain the kit. The study found that of 4,000 households, 97 percent returned their med kits intact. I firmly believe the emergency response community can be trusted to follow instructions and maintain med kits in their homes. Prepositioned med kits into the homes of emergency personnel will address unacceptable response time gaps and family concerns. DHS and HHS should develop storage and use instructions for the kits.

In conclusion, the fire and emergency response is primarily a local responsibility. Our ability to fulfill our mission requires prop-

er preparation. Congress must address this current weakness and enhance emergency response providers' willingness and ability to safely respond and save lives during a biological emergency. On behalf of America's fire and emergency service leaders, thank you for holding this hearing and the opportunity to address the subcommittee. I look forward to answering your questions.

[The statement of Chief Gillespie follows:]

PREPARED STATEMENT OF CHIEF AL H. GILLESPIE

APRIL 17, 2012

Good afternoon, Chairman Bilirakis, Ranking Member Richardson, and Members of the committee. I am Chief Al Gillespie, of the North Las Vegas Fire Department located in North Las Vegas, Nevada and the president and chairman of the board of the International Association of Fire Chiefs. The International Association of Fire Chiefs represents the leadership of over 1.2 million firefighters and emergency responders. IAFC members are the world's leading experts in firefighting, emergency medical services, terrorism response, hazardous materials spills, natural disasters, search and rescue, and public safety policy. As far back as 1873, the IAFC has provided a forum for its members to exchange ideas, develop professionally, and uncover the latest services available to first responders. The IAFC is also a member of the Emergency Services Coalition for Medical Preparedness. I thank the committee for your continued interest in our Nation's medical countermeasures and for the opportunity to represent fire and EMS responders during today's hearing.

My testimony is based upon my experiences as a fire chief. As one of our Nation's most attractive tourist destinations, we in the Las Vegas area are a high target for a potential terrorist attack. In response, our department has stood up a Homeland Security & Special Operations Division composed of emergency management, tactical medics, urban search and rescue (USAR), technical rescue, and haz-mat rescue teams.

Our entire department is staffed by over 200 uniformed and civilian employees who provide a great service to our community. Day in and day out, I count on each one of these proud and well-trained men and women to fulfill our diverse missions. As their chief, I know that they will respond rapidly and professionally when called upon for natural and man-made disasters.

Throughout the fire and emergency services as we remembered the 10th anniversary of 9/11, we marked the sacrifice our men and women made that day for our Nation. In the days that followed, the first responders continued to serve our Nation with little concern for their personal health. We have learned many lessons from the terrorist attacks that day and from the anthrax attacks later that year. With Congress' leadership and support, we have raised preparedness and training in many areas, but there is more work that can be done.

As I've said, as a chief, I know my personnel will respond. If you asked me if they would respond to a fire, the answer is "yes." If you asked me if they would respond to a medical emergency, the answer is "yes." If you asked me if they would respond to a pandemic or a bio-attack, my answer is "yes."

However, in recent years, numerous published studies have uncovered interesting questions and concerns held by responders. For instance, the Journal of Occupational & Environmental Medicine published a study by Columbia University examining the factors associated with the ability and willingness of essential workers to report to duty during a pandemic. The study surveyed 1,103 workers from six essential workgroups in Nassau County, New York and found that although a substantial proportion of participants reported that they would be able (80%); much less would be willing (65%) to report for duty. In fact, only 49% of the participants answered that they would be both able and willing.

Other studies report similar trends. A study published in a 2007 issue of Disaster Management & Response surveyed paramedics to examine their concerns about responding to a pandemic. In this study, 80% of respondents reported they would not stay on duty without protective equipment or proper vaccination. If provided protective equipment, but not a vaccine, this rate decreased to 61% of respondents reported they would not stay on duty. This study also revealed that 91% of the respondents reported they would remain on duty if they were fully protected. While that response rate is a good sign, it dramatically falls to a projected response rate of only 38% if the respondent fears that their immediate family is not protected.

Mr. Chairman, the fire and emergency services will do everything we can to protect our communities, but we need Congress to do all it can to protect first responders and address a major gap in preparedness for a pandemic or a bioterrorist attack in the United States. Currently, we only have surveys that suggest a lack of response, but we should not wait for an attack to provide absolute proof. Your committee has a strong legislative record of addressing gaps in preparedness from supporting legislation to allocate the D-Block to public safety to authorizing grants and other programs for local governments to increase preparedness capabilities. Although the Pandemic and All-Hazards Preparedness Reauthorization Act has passed both the House and the Senate, I am concerned that unless Congress adds language during the conference committee that focuses on protecting first responders, a major gap will continue to exist.

As such, the IAFC believes Congress should task the Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS) to test and create a voluntary anthrax immunization program. In addition, Congress should request these Federal agencies deploy pre-positioned antibiotic kits into the homes of emergency services providers to protect first responders and their families. The DHS and the HHS should work together to boost the immunization levels of all emergency services providers on a voluntary basis and protect responders and their families. Extending these protections to first responders and their families (those who live in the responder's home) will improve preparedness and prevent the responder from infecting their families during times of great National need.

VOLUNTARY ANTHRAX IMMUNIZATION PROGRAM

First, I would like to reiterate that any anthrax immunization program should be voluntary. We have heard great debate that an anthrax attack is a low-risk threat, due in part to the existence of a vaccine. This vaccine is a major tool in the Strategic National Stockpile (SNS), maintained by the Centers for Disease Control and Prevention (CDC), U.S. Department of Defense (DoD) and other Federal agencies, including HHS and DHS. The SNS's cache of antibiotics, chemical antidotes, antitoxins, life-supporting medications, IV administration, airway maintenance supplies, and medical or surgical items is pre-positioned regionally throughout the country and ready to be deployed after an attack. However, if there is an attack, immediate emergency response will be expected by the public. Under current models, this response will be provided by local jurisdictions whose personnel are not necessarily immunized. This will result in a major lag in response, putting public safety and public health at great risk. The current plan calls for vaccines and medicines to be delivered to any State in the United States within 12 hours of Federal and State/local declarations. Each State then utilizes their plan to receive and distribute vaccines and other medicines, which will result in a lengthier time lapse before local emergency services and first response are deployed.

Over time, drugs and vaccines in the SNS expire. While a Shelf-Life Extension Program (SLEP) has been developed for select Federal stockpiles, other vaccines and drugs are appropriately rotated out of the SNS and destroyed. Changing Federal policy to set up a pilot program that rotates non-expired, potent, and safe vaccines and drugs from the SNS to voluntary emergency responder immunization programs would greatly improve preparedness levels and better utilize Federal resources and tax dollars. Additionally, such an effort to rotate and release vaccines to State and local jurisdictions could provide real-world practice for the Federal plan to rapidly push out the SNS cache after an attack.

The DHS and the HHS should work together to develop and test a voluntary anthrax vaccination pilot program, which ultimately could address a gap in preparedness and improve emergency response time to a bio-attack. As these departments design the program, they can create record-keeping guidelines to assist chiefs ensure their personnel who volunteer for the program receive the proper and full vaccinations. In addition, utilizing the SNS could lower the costs of standing up such an operation while increasing preparedness levels around the Nation.

We have learned that DHS and HHS are developing pilot programs to make vaccines in the SNS available as "Federal excess property," and are interested in receiving more information about this type of program.

PRE-POSITIONED ANTIBIOTIC KITS IN THE HOMES OF EMERGENCY RESPONDERS

Not all bioterrorist attacks can be treated with a vaccine, which the SNS cache and other Federal programs take into account. The National Postal Model (NPM) utilizes postal workers who volunteer to dispense antibiotics after a bioterrorist attack to reduce surge at dispensing points. The brave postal workers who volunteer to serve their Nation in such a capacity are provided Household Antibiotic Kits

(HAKs) or med kits. These kits are pre-positioned in their homes and provide coverage for the individual and their family. This type of program should be extended to pre-position med kits into the homes of the emergency responders and further mirror the postal model to include the emergency responder's family.

The United States Postal Service (USPS) along with HHS, local, and State public health and law enforcement partners tested the operational capability to distribute medical countermeasures through the National Postal Model with three Cities Readiness Initiative (CRI) proof-of-concept drills (in Seattle, Boston, and Philadelphia) and a comprehensive pilot in Minneapolis/St. Paul. The CDC also conducted a Home Med-Kit Evaluation Pilot Study in St. Louis to examine the household's ability to maintain the kit as directed and preserved for emergency use. This study found that of 4,000 households, including first responders, corporation employees, and community health clinic staff, 97% of participants returned their med kit intact at the end of the study. While this is just one study, I firmly believe that the emergency services community can be trusted to follow instructions and maintain med kits in their home. To do so, instructions for the kits will have to be developed that address best practices for storage, as we know that the bathroom medicine cabinet is one of the worst places to store medications due to temperature and humidity issues.

Pre-positioning med kits into the homes of emergency responders will address a time gap in preparedness. During an attack, if first responders are waiting for the release of medical countermeasures from the SNS to the State and then through public health agencies to responders, they have indicated through multiple studies less inclination to report for duty. For a response to disasters or attacks, this lag time may create an unacceptable situation, and pre-positioned med kits for emergency responders and their families are warranted.

Emergency response is primarily a local responsibility. First responders throughout our Nation are rightfully assumed to be able and willing to respond to emergencies including disasters and attacks. However, we do not send firefighters to a call without the proper equipment and training. Our ability to fulfill our missions requires proper preparation. Congress must address the current gaps to enhance emergency service providers' willingness and ability to safely respond and save lives during a biological emergency.

On behalf of America's fire and EMS leaders, I would like to thank you for holding this hearing and the opportunity to address this subcommittee. I look forward to answering any questions that you may have.

Mr. BILIRAKIS. Thank you, chief, for your valuable testimony.

Now I will recognize Mr. Lockwood for 5 minutes.

You are recognized, sir.

STATEMENT OF BRUCE LOCKWOOD, DEPUTY DIRECTOR, EMERGENCY MANAGEMENT, NEW HARTFORD, CONNECTICUT, AND SECOND VICE PRESIDENT, USA COUNCIL, INTERNATIONAL ASSOCIATION OF EMERGENCY MANAGERS

Mr. LOCKWOOD. Thank you. Chairman Bilirakis, Ranking Member Richardson, and Members of the subcommittee, thank you for giving me the opportunity to discuss the issue of protections afforded by medical countermeasures and their distribution from the perspective of the emergency services sector. I am Bruce Lockwood, deputy director of emergency management for the town of New Hartford, Connecticut, representing the Emergency Services Coalition on medical preparedness. I am the second vice president, IAEM USA, International Association of Emergency Managers, which has more than 5,000 members worldwide and is a nonprofit educational organization dedicated to promoting the principles of emergency management and representing those professionals whose goals are saving lives, protecting property and the environment during emergencies and disasters.

On behalf of the coalition, I thank you for the time devoted to this topic. These are important hearings in developing and promoting policies that prepare the Nation and ensure our resilience. As James Glassman recently noted, bioterrorism remains a current

concern and that, compared with other defense expenditures, this one on a cost-benefits calculation, looks awfully cheap. Budgets are constrained. But to cut back on the only truly effective method of fighting bioterrorism may be worse than foolish; it could be lethal.

Since Lawrence E. Tan, chief of emergency medical services, New Castle County, Delaware, representing the coalition provided testimony in front of this subcommittee on May 2011, there has been insufficient progress at protecting the protectors at the local level. This lack of progress means citizens cannot be guaranteed the continuity of provision of emergency services in all areas of the country during a large-scale biological event. I believe there are some simple, immediate, and commercially sound methods to start providing protections that would substantially increase our resilience. I urge you to express your support for a voluntary anthrax immunization program for emergency services and first responders.

To complement this immunization program, I urge you to support the immediate development of med kits for all emergency services personnel and their households. I believe these are primary, necessary first steps in ensuring the continuity of emergency services during large-scale anthrax events. These steps will mitigate the additional demands on emergency services during the event and ensure responders can stay on the job without fear their families are unprotected. During bioterrorism incidents, protective antibiotics should be available immediately to the household members of the responders as well as for the responders themselves. The critical task established by DHS is that communities develop processes to ensure that first responders, public health response, critical infrastructure personnel, and their families receive prophylaxis prior to the opening of a community pod.

The simplest and most effective manner to achieve this critical task is by combining immunization with prepositioning med kits in the homes and workplaces of emergency servicers. The coalition supports the Institute of Medicine's 2011 report that rejects the idea of distributing antibiotics to the general community in favor of targeted population-specific distribution. Emergency services are that specific population with specific needs and specific circumstances. There is strong consistent evidence that we cannot assume emergency services providers are confident in their ability to serve in large-scale events, notably biological events. In no professional category can emergency providers be guaranteed to report for duty; in cases where they might infect their family members, less than half would report.

I want to draw your attention to an area of acute concern, the protection of children. From 2008 to 2011, I served on the Congressionally-chartered National Commission on Children in Disasters. The commission report states: Congress, HHS, DHS, and FEMA should ensure availability of and access to pediatric medical countermeasures at the Federal, State, and local level. To ensure this happens, stockpiles must specifically be developed for children. Further, the children emergency services need specific measures to ensure their safety while their protectors are deployed in defense of the community. The DHS Office of Health Affairs has provided the coalition a background briefing on a pilot anthrax immunization program.

I support the intent of the program, to protect emergency services personnel. This use of expiring vaccine could have the material benefit of the preparedness of the Nation. We must emphasize the protection of the protectors is paramount, not the expediency of this stockpile management. The vaccine was acquired many years ago. Lack of policy on its use is thankfully now being addressed. The Office of Health Affairs in its budget hearing before this committee on March 27 requested an expansion of their countermeasures program for all DHS employees. I believe this program has been formed by careful analysis that DHS employees are subject to disproportionate threat and require special protection.

These same employees and their families work alongside and are dependent upon local emergency services personnel. The same protection should be afforded to all emergency services personnel. Having one leg of the three-legged response system protected is no protection at all. The Federal Government and others have gathered the evidence to show that the antibiotic med kits can safely be administered and antibiotic resistance is not a scientific concern. For more than 4 years, med kits have been provided on a voluntary basis to the U.S. Post Office employees and their families. More than 97 percent of these kits were returned for renewal unopened. Emergency services personnel routinely handle equipment and materials that are more lethal and have more profound consequences than the antibiotics that would be included in these med kits. Some responders carry guns; other administer medications to critically ill patients outside of a hospital, and yet others work with hazardous materials and life-threatening situations.

Entrusted with these powers and responsibilities, there is no basis for assuming med kits would be widely abused in the homes of emergency services. The coalition supports the development and the distribution of FDA-approved antibiotic countermeasures to protect from anthrax all emergency services personnel and their families.

Private companies are interested in developing these med kits, potentially bringing efficiency to the distribution administration of a program that could cover all Federal workers.

The prospect of having a protected Federal workforce operating alongside an unprotected local emergency services personnel is something we should endeavor to avoid. Perceptions that there are different classes of responders would undermine preparedness. The current methods of medical countermeasures have not proven capable of meeting our National goals, including the protection of emergency services sector. New supplementary approaches are required to ensure those on the front line of the response community and their families are protected. Pre-event voluntary immunization and the development with commercial partners of med kits are part of the next generation stockpile effort. The prospect of critical infrastructure failure is real and would be compounded by a lack of National strategy to protect first responders. The protection of protectors and their families has been overlooked and must be addressed. I look forward to answering your questions.

[The statement of Mr. Lockwood follows:]

PREPARED STATEMENT OF BRUCE LOCKWOOD

APRIL 17, 2012

Chairman Bilirakis, Ranking Member Richardson, and Members of the subcommittee, thank you for giving me this opportunity to discuss the issue of the protections afforded by medical countermeasures and their distribution from the perspective of the emergency services sector. I am Bruce Lockwood, Deputy Director, Emergency Management, Town of New Hartford, CT, here representing the Emergency Services Coalition on Medical Preparedness. I am the 2nd Vice President of the U.S. Council of the International Association of Emergency Managers (IAEM), which has more than 5,000 members world-wide. It is a non-profit educational organization dedicated to promoting the "Principles of Emergency Management" and representing those professionals whose goals are saving lives and protecting property and the environment during emergencies and disasters.

On behalf of the Coalition I thank you for the time devoted to this topic because these are important hearings in developing and promoting policies that prepare the Nation and ensure our resilience. As James Glassman recently noted, bioterrorism remains a current concern, and that "compared with other defense expenditures, this one—on a cost-benefit calculation—looks awfully cheap . . . budgets are constrained, but to cut back on the only truly effective method of fighting bioterror may be worse than foolish. It could be lethal."

Since last May when Lawrence E. Tan (Chief of Emergency Medical Services, New Castle County, Delaware) representing the Coalition provided testimony in front of this subcommittee there has been insufficient progress in protecting the protectors at the local level. This lack of progress means citizens cannot be guaranteed continuity of emergency services in all areas of the country during a large-scale biological event. I believe there are some simple, immediate, and commercially-sound methods to start providing protections that would substantially increase our resilience.

I urge you to express your support for a voluntary anthrax immunization program for emergency services and first responders. To complement this immunization program I urge your support of the immediate development of a med kit for all emergency services personnel and their households. Public Health research has shown that the availability of medical countermeasures for responders and their families may increase their willingness to report for duty. I believe these are primary, necessary first steps in ensuring the continuity of emergency services during a large-scale anthrax event.

These steps will mitigate additional demands on emergency services during an event, and ensure responders can stay on-the-job without fear their families are unprotected. During bioterrorism incidents, protective antibiotics should be available immediately for the household members of responders as well as for responders themselves. The critical task established by DHS is that communities "develop processes to ensure that first responders, public health response, critical infrastructure personnel, and their families receive prophylaxis prior to POD opening." The simplest and most effective manner to achieve this critical task is by combining immunization with pre-positioning med kits in the homes and workplaces of emergency services.

The Coalition supports the Institute of Medicine 2011 report that rejects the idea of distributing antibiotics to the general community in favor of targeted, population-specific distribution. Emergency services are that specific population, with specific needs and specific circumstances.

There is strong and consistent evidence that we cannot assume emergency services providers are confident in their ability to serve in a number of large-scale events, most notably a biological event. In no professional category can emergency providers be guaranteed to report for duty; in cases where they might infect family members less than half might report.

I want to draw your attention to an area of acute concern: The protection of children. From 2008 until 2011 I served on the Congressionally-chartered National Commission on Children and Disasters. The Commission report states: "Congress, HHS, and DHS/FEMA should ensure availability of and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats." To ensure this happens stockpiles must specifically be developed for children. Further, the children of emergency services providers need specific measures to ensure their safety while their protectors are deployed in defense of the community.

The DHS Office of Health Affairs has provided the Coalition a background briefing on a pilot anthrax immunization program. I support the intent of the program

to protect emergency services personnel. This use of expiring vaccine could have the material benefit for the preparedness of the Nation, but we must emphasize that the protection of the protectors is paramount, not the expediency of stockpile management. The vaccine was acquired many years ago; a lack of policy on its use is thankfully now being addressed.

I hope that the voluntary anthrax immunization program goals and outcomes will be developed with local emergency services personnel, and that the true cost of administering the program is part of future administration budget requests. Additionally, I hope this new policy direction of support for pre-event vaccination spurs HHS and the vaccine development community to further research and development efforts that will produce a simpler "next generation" vaccine that does not require five doses for full protection.

The Office of Health Affairs in its budget hearing before this committee on March 27 requested an expansion of their countermeasure program for all DHS employees. I believe this program is informed by the careful analysis that DHS employees are subject to disproportionate threats and require special protections. As our Nation's emergency response system is primarily local, the key component of our system is left unprotected by a DHS-only focus. The same protections should be afforded all emergency services personnel, State, local, and Tribal. Having one leg (the Federal) of the three-legged stool (Federal, State, and local) response system protected, is no protection at all.

The Federal Government and other private programs have gathered the evidence to show these antibiotic med kits can be safely administered, and that antibiotic resistance is not a scientific concern. For more than 4 years antibiotic med kits have been provided to volunteers in the U.S. Post Office employees and their families. More than 97% of these kits were returned for renewal unopened. Emergency services personnel routinely handle equipment and materials that are more lethal and have more profound consequences than the antibiotics that would be included in the med kits. Some responders carry guns; others administer medications to critically ill patients outside of the hospital, yet others work with hazardous materials in life-threatening situations on a daily basis. Entrusted with these powers and responsibilities, there is no basis for assuming med kits will be widely abused in the homes of emergency services personnel.

In a country where it is estimated that there are more than 50 million inappropriate antibiotic prescriptions issued for viral infections the prospect of resistance is a public health concern. Pre-positioning med kits with first responders is a microscopic component of overall antibiotic use, representing less than one-hundredth of 1 percent. Trained personnel in command structures with clinical oversight can be trusted, as has been demonstrated daily as well as in times of great stress.

The Coalition supports the development and distribution of FDA-approved antibiotic countermeasures to protect from anthrax to all emergency services personnel and their families, as a critical protective measure against anthrax and other agents. Private companies are interested in developing these med kits; potentially bringing efficiency to the distribution and administration of a program that could cover Federal workers (DHS, USPS) and the entire National emergency services sector. The prospect of having a protected Federal workforce operating alongside unprotected local emergency services personnel is something we must avoid, because perceptions that there are different classes of responder could undermine overall preparedness.

The current methods of distributing medical countermeasures have not proven capable of meeting our National goals, including the protection of the emergency services sector. New supplementary approaches are required to ensure that those on the front lines of the response community and their families are protected.

Pre-event voluntary immunization and the development with commercial developers of a med kit are part of a next generation protection and National stockpile effort. The specter of critical infrastructure failure is real, and would be compounded by a lack of a National strategy to protect first responders. The protection of the protectors and their families has been overlooked, and must be addressed.

Mr. BILIRAKIS. Thank you for your testimony. I appreciate it. Now I will recognize Sheriff Nocco for 5 minutes.

STATEMENT OF SHERIFF CHRIS NOCCO, PASCO COUNTY SHERIFF'S OFFICE

Sheriff NOCCO. Thank you.

Chairman Bilirakis, Ranking Member Richardson, committee Members, thank you for your time.

On behalf of the Pasco Sheriff's Office and the citizens of Pasco, Florida, I would like to thank Chairman Bilirakis for the invitation to testify today on the needs and countermeasures for first responders to a CBRNE attack. Although some may not believe that this is a clear and present threat to our community, those of us who are on the front lines of law enforcement truly understand the gravity of the risk. Pasco County encompasses 745 square miles and has an estimated population of 480,000. This does not include our seasonal residents. Pasco is in the heart of the Tampa Bay region in proximity to the city of Tampa and the coastline along the Gulf of Mexico. What I am about to describe is not unfamiliar to many mid- and large-sized agencies but describes the Pasco Sheriff's offices.

The consequences of a CBRNE emergency will stretch our response and recovery capabilities. No matter the nature of the severity of a CBRNE event, it will be the local first responders who will provide the initial operational response and oversee crisis management. The Pasco Sheriff's office is primary provider of law enforcement services to 89 percent of the county and provides specialized services and mutual aid to the four incorporated citizens. We are the first responders at the forefront of this issue. The State of Florida established regional teams to respond to CBRNE incidents. When these teams are selected our Sheriff's Office was not designated as part of a regional team. If a large-scale CBRNE incident was to occur in Pasco County, we would be forced to rely upon regional State and Federal specialists for their response components to assist with disaster management, investigation, and to provide a sufficient level of emergency response. Special advice and resources would also be required as part of the recovery management phase, including the provision of long-term health monitoring, psychological support, building and environmental decontamination, re-establishing public confidence, and supporting a return to normality.

Understanding that your time is limited and with the opportunity to speak with you today, I would like to take a few moments to explain the concerns of the Pasco Sheriff's Office. These recommendations and thoughts are intended to convey the perspective not only of law enforcement executive but those of front-line deputies. Caches of prepositioned personnel and institutional medical countermeasures should be afforded to law enforcement first responders similar to the process developed for postal employees. Law enforcement agencies will be in the forefront of operations in a biological disaster, and it is critical that our personnel are available and safe to perform their duties.

When initiating a program to distribute the anthrax vaccine for first responders in case of a biological attack, please allow local law enforcement agencies along with other emergency services a voice in making the decision as to who will be defined as a first responder. There are many components of our sheriff's office that will

be in need of this vaccine besides our sworn deputies. This would include our communications section and medical staff in our jail, just to name a few.

There are other services in our local government that would fully support our operations. If they do not enter a hot zone to support us because they are not properly vaccinated, our capabilities would suffer tremendously. Local law enforcement agencies deserve a seat at the decision table when defining the term first responder because we are the immediate boots on the ground in any situation. As we are discussing countermeasures, we need to mention CBRNE protective suits. Although every law enforcement officer should have a protective suit but does not at this time, we should immediately ensure our special operation units have them. SWAT and SERT teams across the country should be the first provided with protective suits and equipment to respond to a CBRNE attack. We often think a CBRNE attack will be a large-scale disaster affecting a large metropolitan area. One of the main goals of a terrorist is to maximize fear in a society. What greater fear and easier access can be achieved with minimal resources required than for a terrorist to attack a school, church, synagogue, or mall with a CBRNE component in their operation, such as a dirty bomb. In such an incident, this would probably include an active shooter and hostage situation. What greater sense of hopelessness could we have than if our specialty teams respond very quickly as they usually will, stood on the perimeter and not be able to advance in a situation because we are not properly prepared to go into an active situation that requires protective suits.

Although this hearing is focused on countermeasures, I would be negligent in my duties to you, the deputies I stand with, and the citizens we serve if I did not raise the issue of the most critical piece of emergency response that is still missing today, interoperable communication. The best plans for the worst disasters are useless if we cannot communicate with each other. Today, 10 years removed from the events of 9/11, we are a country that still has not addressed the greatest failures, and that is the ability for all first responders to seamlessly communicate with each other on a secure frequency.

In my humble opinion, this should remain our first priority for funding, for it is the catalyst for success and the response to any incident. The Tampa Bay region is in need of a fully interoperable communications system. As Federal dollars are distributed for homeland security issues, I would encourage you to make interoperable communication a top priority.

I thank you for your time. I look forward to your questions, and may God bless all our first responders.

[The statement of Chief Nocco follows:]

PREPARED STATEMENT OF CHRIS NOCCO

APRIL 16, 2012

Chairman Bilirakis, Representative Richardson, and Members of the committee: On behalf of the Pasco Sheriff's Office and the citizens of Pasco County, Florida, I would like to thank Chairman Bilirakis for the invitation to testify today on the needs and countermeasures for first responders to a chemical, biological, radiological, nuclear, or explosive (CBRNE) attack. Although some may not believe that

this is a clear or present threat for our community, those of us who are on the front lines of law enforcement truly understand the gravity of the risk.

Pasco County encompasses 745 square miles and has an estimated population of 480,000; this does not include our seasonal residents. Pasco is in the heart of the Tampa Bay Region in proximity to the city of Tampa and a coastline along the Gulf of Mexico. We are a diverse community whose No. 1 economic engine is agriculture. In the near term, we anticipate significant growth in areas of finance, education, technology, and the health care industry.

The consequences of CBRNE emergencies will stretch our response and recovery capabilities. No matter the nature or severity of a CBRNE event, it will be the local first responders who will provide the initial operational response and oversee crisis management. The Pasco Sheriffs Office is the primary provider of law enforcement services to 89% of the county and provides specialized services and mutual aid to the four incorporated cities—we are the first responders and at the forefront of this issue.

The State of Florida established regional teams to respond to CBRNE incidents. When these teams were selected, our Sheriff's Office was not designated as part of a regional team. If a large-scale CBRNE incident was to occur in Pasco County we would be forced to rely upon regional, State, and Federal specialist response components to assist with disaster management, investigation, and to provide a sufficient level of emergency response. Specialist advice and resources would also be required as part of the recovery management phase, including the provision of long-term health monitoring, psychological support, building and environmental decontamination, re-establishing public confidence and supporting a return to normality.

Understanding that your time is limited and with this opportunity to speak with you today, I would like to take a few moments to explain the concerns of the Pasco Sheriffs Office. These recommendations and thoughts are intended to convey the perspective not only of a law enforcement executive, but those of a front-line deputy.

- Caches of pre-positioned personal and institutional medical countermeasures should be afforded to law enforcement first responders similar to the process developed for postal employees. Law enforcement agencies will be in the forefront of operations in a biological disaster and it is critical that our personnel are available and safe to perform their duties.
- When initiating a program to distribute the anthrax vaccine for first responders in case of a biological attack, please allow local law enforcement agencies, along with other emergency services, a voice in making the decision as to who will be defined as a "first responder". There are many components to our Sheriff's Office that will be in need of this vaccine beyond our sworn deputies. This would include our communications section and the medical staff in our jail to name a few. There are other services in our local county government that would fully support our operations and if they do not enter a "hot" zone to support us because they are not properly vaccinated, our capabilities would suffer tremendously. Local law enforcement agencies deserve a seat at the decision table when defining the term "first responder" because we are the immediate boots on the ground in any situation.
- As we are discussing countermeasures, we need to mention CBRN protective suits. Although every law enforcement officer should have a protective suit, but does not at this time, we should immediately ensure that our special operation units have them. SWAT (Special Weapons and Tactics Team) and SERT (Special Emergency Response Team) teams across the country should be the first provided with protective suits and equipment to respond to a CBRNE attack. We often think a CBRNE attack will be a large-scale disaster affecting a large metropolitan area. One of the main goals of a terrorist is to maximize fear in a society. What greater fear and easier access can be achieved with minimal resources required than for a terrorist to attack a school, church, synagogue, or mall with a CBRNE component in their operation, such as a dirty bomb? In such an incident, this would probably include an active shooter/hostage situation. What greater sense of hopelessness could we have than if our specialty teams, who can arrive on the scene quickly, stood on the perimeter not able to advance into the situation because we are not properly prepared to go into an active situation that requires protective suits?

Although this hearing is focused on countermeasures, I would be negligent in my duties to you, the deputies I stand with, and the citizens we serve if I did not raise the issue of the most critical piece of emergency response that is still missing today: Interoperable communication. The best plans for the worst disasters are useless if we cannot communicate with each other. Today, 10 years removed from the events of 9/11, we, as a country, have not fully addressed one of our greatest failures and that is the ability of all first responders to seamlessly communicate with each other

on a secure frequency. In my humble opinion, this should remain our first priority for funding, for it is the catalyst for success in the response to any incident. The Tampa Bay Region is in need of a fully interoperable communication system. As Federal dollars are distributed for homeland security issues, I would encourage you to make interoperable communication the top priority.

Thank you for your time and your consideration of these concerns. May God continue to bless the men and women of the Pasco Sheriffs Office and all first responders throughout America.

Mr. BILIRAKIS. Thank you. Thank you very much.

Now I will recognize Mr. Peralta for 5 minutes.

STATEMENT OF MANUEL L. PERALTA JR., DIRECTOR OF SAFETY AND HEALTH, NATIONAL ASSOCIATION OF LETTER CARRIERS

Mr. PERALTA. Good morning, Chairman Bilirakis, Ranking Member Richardson, and the Members of the subcommittee.

My name is Manuel Peralta, and I am the director of safety and health at the National Association of Letter Carriers. It is an honor to provide information about how letter carriers are bolstering our National security by participating on a voluntary basis in a program to distribute medicines to Americans in the event of a biological attack. I will be brief because you are busy and because we have mail to deliver. Six days a week, letter carriers deliver mail to more than 150 million homes and businesses throughout this country, and today is no exception.

In December 2003, just 2 years after the worst terrorist attack in American history, President George W. Bush asked the United States Postal Service to consider delivering antibiotics to residents of large metropolitan areas following the release of a biological agent. President Bush and his homeland security advisors knew that no other entity had a network capable of carrying out such a mission. He knew further that letter carriers who are regularly named by the American people as the most trusted Federal employees, who are ideally suited for such a complex task.

On February 18, 2004, the Secretaries of Health and Human Services and Homeland Security, along with the Postmasters General signed a memorandum of agreement to establish policies and procedures. The result is the City Readiness Initiatives Postal Plan, a Federal program led by HHS and designed to help major cities respond to a large-scale public health emergency and avert mass casualties by dispensing antibiotics to the population within 48 hours. President Obama confirmed the value and the bipartisan nature of this postal initiative through his Executive Order of December 2009. This order enacts recommendations inspired by the September 11 commission. Both Presidents responsible for protecting the American people knew that no one goes to every address in America 6 days a week, and no one knows the neighborhoods, like letter carriers.

To date, six communities have become involved: Seattle, Minneapolis, Louisville, Philadelphia, Boston, and San Diego County with the cities of Vista and San Marcos. Each program involves intensive planning and the participation of various Federal agencies. But one constant is the role of letter carriers. We look upon this not as a chore but as another form of service. The Nation's letter carriers, who I am privileged to serve as an elected officer of the

NALC take seriously our role embedded in the Constitution of providing universal mail service to every corner of this country, binding this vast land together and unifying individual communities; all this without a dime of taxpayer money.

We take equal pride in serving our communities in other ways, whether conducting the Nation's largest single-day food drive, as we do every May, watching out for the elderly on our routes, rescuing someone who has fallen or taken ill, locating a missing child, putting out a fire, or even stopping a crime.

Service and protection come naturally to letter carriers, one-quarter of whom are military veterans and who are glad to volunteer for their country once again, and all of whom have an affinity for the people in the neighborhoods they serve. The timing of today's hearing is fortuitous because of the exercise held last Wednesday in Louisville, which involved a contaminated truck containing a biological agent and the response of Federal, State, and local officials. Allen Harris, president of NALC Branch 14 in Louisville, reports with pride that several officials went out of their way to praise the dedication and energy with which letter carriers are engaged in this effort and that 60 percent of the letter carriers in Louisville volunteered, 323 men and women. Allen, himself an Air Force veteran, attributes this in part to the large number of military veterans in his branch. As Brother Harris puts it, they already know what it is to serve their country. More broadly, he says, the extraordinary level of participation reflects the sense of commitment all his letter carriers have to the neighborhoods they serve.

"It just makes sense; it makes you feel very proud," Allen said, "because you are doing something that is going to help the community. I have been on my route for 28 years. I have seen kids born, go to college, come home, and start their families."

Under the Louisville plan, letter carriers would deliver medicines to 750,000 people. Letter carriers would load 670 cases of medication into 2-ton vehicles from a depository to which the Federal Government would fly the medicines. Every home would receive two bottles of medication containing 20 pills apiece along with a flyer. I might add, this type of planning is nothing new to the Postal Service or to letter carriers. Indeed, it is one of the factors that led a recent British study to name the Postal Service as the world's most efficient system. In fact, Cities Readiness Initiative is one more example of the value of the unique universal network that it is and must remain the hallmark of the United States Postal Service.

In closing, let me say that we are fully aware of the solemn responsibility we bear as the foot soldiers for this critical homeland security program, whether in Boston, Philadelphia, Minneapolis, or elsewhere. It is a duty we readily accept. We appreciate the confidence placed in us by Presidents and Homeland Security officials from both parties. We are continually training and preparing to justify that confidence. Thank you for your attention and thank you for your service to our country.

[The statement of Mr. Peralta follows:]

PREPARED STATEMENT OF MANUEL L. PERALTA, JR.

APRIL 17, 2012

Good morning, Chairman Bilirakis, Ranking Member Richardson, and other Members of this very important subcommittee. My name is Manuel L. Peralta Jr., and I am the director of safety and health at the National Association of Letter Carriers.

It's an honor to have the opportunity to provide you with some information about how letter carriers are bolstering our National security by participating—on a volunteer basis—in a program designed to provide medicines to Americans in the event of a biological attack.

Our participation in today's hearing is timely, because just last week we conducted a table-top exercise for the Cities' Readiness Initiative in Louisville, Kentucky.

I will be as brief as I can, so that panel has the appropriate time needed to ask questions—and also because there is mail to deliver today. Six days a week, the letter carriers of the U.S. Postal Service deliver mail to more than 150 million homes and businesses throughout this country, providing the world's best and most affordable delivery service—and today is no exception.

First, let me provide an historical overview of our involvement with this program. In December 2003, just 2 years after the worst terrorist attack in American history, President George W. Bush asked the U.S. Postal Service to consider delivering antibiotics to residents of large metropolitan areas during catastrophic incidents—specifically the outdoor release of a biological agent.

President Bush and his homeland security advisers knew that no entity besides the Postal Service had an existing network in place that would be capable of carrying out such a mission. He knew further that letter carriers, who among other things are regularly named by the American people as the most-trusted Federal employees, were ideally suited for such a critical and complex task.

On Feb. 18, 2004, the Secretary of Health and Human Services, the Secretary of Homeland Security and the Postmaster General, signed a memorandum of agreement to establish policies and procedures for U.S. Postal Service distribution of oral antibiotics in response to a biological terrorism incident.

The result is the Cities' Readiness Initiative—a Federal program led by HHS and designed to help major U.S. cities increase their capacity to respond to a large-scale public health emergency and avert mass casualties by dispending oral antibiotics to the population within 48 hours.

President Obama further confirmed the value—and the bipartisan nature—of this initiative, through his Executive Order of Dec. 30, 2009, which directed the establishment of a Federal capacity through the U.S. Postal Service for the timely residential delivery of medical countermeasures following a biological attack. This Executive Order enacts recommendations made by the Commission on the Prevention of Weapons of Mass Destruction Proliferation and Terrorism, an outgrowth of the September 11 Commission.

Both Presidents, responsible for protecting the American people, knew no other agency is capable of doing this—because no one else goes to every address in America, 6 days a week. Further, no one knows the neighborhoods like the letter carriers.

To date, seven cities in six metropolitan areas have become involved in this effort—Seattle, Minneapolis, Louisville, Philadelphia, Boston, and San Marcos and Vista both within the county of San Diego. They are in varying stages of preparation. Each program involves a great deal of planning and the participation of a variety of State, local, and Federal agencies—but one constant is the role of the letter carriers, who are essentially where the rubber hits the road.

We are glad to volunteer for this mission, and to accept the somber responsibility that comes with it. We look upon this not as a chore, but as another form of service. The Nation's letter carriers, whom I am privileged to serve as an elected officer of the National Association of Letter Carriers, take seriously our role, embedded in the Constitution, of uniting the country by providing universal mail service to every corner of this country, binding this vast land together and unifying individual communities. All this, without using a dime of taxpayer money.

And though it is not a term and condition of our employment, we take equal pride in serving our communities in other ways as well, whether conducting the Nation's largest single-day food drive, watching out for the elderly on our routes—or occasionally finding ourselves in the position of rescuing someone who has fallen or taken ill, locating a missing child, putting out a fire, or even stopping a crime.

In that spirit, we are particularly gratified to be able to serve our county in the program I am discussing today. It is a plan to which we are committed and for which we are ready. Why is that? Because service and protection come naturally to

letter carriers, one-quarter of whom are military veterans and are glad to volunteer for their county once again—and all of whom have an affinity for the neighborhoods they serve, their customers, and the families they watch grow over the years.

I mentioned that the timing of today's hearing is fortuitous, because of the exercise held just last Wednesday, which made Louisville the second city, after Minneapolis, to be formally designated as a pilot city in the Cities' Readiness Initiative. This followed the March 21 signing ceremony at Louisville City Hall with top officials. The president of NALC Branch 14 in Louisville, Allen Harris, took part in the 7-hour exercise, which involved a contaminated truck containing a biological agent. He did so along with Federal, State, and local officials from the FBI, county sheriff's departments, city and suburban health departments, postal inspectors, police departments, Health and Human Services, and other agencies.

Allen reports, with much pride, two things I will share with you. One is that a number of these officials went out of their way to praise the dedication and energy with which the letter carriers are engaged in this effort. The second is that 60 percent of the letter carriers in the Louisville branch of the National Association of Letter Carriers signed up—323 men and women out of 573—to undergo the training, and deliver the medicines if and when needed. That is in part due to the large number of military veterans in the branch, according to Allen, himself an Air Force veteran.

As Brother Harris put it, "They already know what it is to serve their country." More broadly, he says, the extraordinary level of participation is attributable to the sense of commitment all his letter carriers have to the neighborhoods they serve.

"It just makes you feel very proud," Allen said, "because you're doing something that's going to help the community. I've been on my route 28 years. I've seen kids born, go to college, come back home to start their families. It's almost like you're a part of their family."

Already, Branch 14's union hall has been used some 10 times by Louisville authorities for training and meetings, because it can accommodate up to 220 people. Under the Louisville plan, letter carriers would deliver medicines to 750,000 people in 225,000 households in the city and suburbs in the event of a biological incident. Letter carriers would load 670 cases of medication into each of their 2-ton vehicles, from a depository to which the Federal Government would fly the medicines. There are 48 bottles of medicine per case. Every home will receive two bottles of medication containing 20 pills apiece, along with a flyer. That has two advantages—it makes distribution simpler and faster, and it also staggers the times residents would return to get more medicines.

I might add that this type of planning is nothing new to the Postal Service or to letter carriers—indeed, it is one of the factors that led a recent British study from Oxford to name the U.S. Postal Service the most efficient in the world. In fact, the Cities' Readiness Initiative is one more example of the value of the unique universal network that is—and must remain—the hallmark of the United States Postal Service.

In closing, let me say once again that we are fully aware of the awesome nature of the responsibility we bear as the foot soldiers for this critical homeland security program, whether in Louisville or Boston, San Diego or Minneapolis, or elsewhere. It is a responsibility we readily and fully accept. We appreciate the confidence placed in us by Presidents and homeland security officials from both parties—and we are continually training and preparing to justify that confidence.

Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

Mr. BILIRAKIS. Thank you. Thank you for your service to our country. Also I thank you for your testimony and thanks for your patience. I will go ahead and get started. I will recognize myself for 5 minutes for questions.

For all the witnesses, I am interested in your use of rapid diagnostic capabilities. Good diagnostics, whether through physical exam or through a piece of technology, are indispensable to providing appropriate care, in my opinion. Diagnostic devices are also considered medical countermeasures by BARDA. How important are rapid point-of-care diagnostics to the first responder community? Would it be useful if you had quick, easy-to-use diagnostics or biological or chemical threats to help inform your response? Whoever would like to go first.

Chief GILLESPIE. Mr. Chairman, thank you for the opportunity to address that question.

I have got to say, it is extremely important for us to use all the tools that we have available to us to help determine the safety of our citizens and the safety of our responders. I can say that what has happened over the last 20 years, last 10 years particularly, from my point of view in the fire services is we have made huge strides. We have made tremendous leaps in our ability to recognize a problem and how we deal with that. Much of that happened post-9/11, and we made a lot of changes in how we approach a situation. We know that we can't rush into every particular situation. The sooner we can get in, the sooner we can get in, the sooner we can deal with the problems. So, with immediate diagnostic equipment, whether it be skills or technology, it certainly is important to us. I will give you a quick example: We responded in the Las Vegas valley to a ricin incident. Maybe you didn't hear about it. That is because none of the first responders, none of our public were injured or killed because of that particular incident. Because our first responders were able to determine that they had a serious problem that may be of a chemical-biological type-nature. The person who was doing that died from their exposure to the products but none of our responders were because they were able to diagnose this early on and keep from becoming contaminated at the scene.

Sheriff NOCCO. Thank you, Chairman.

I concur. Any time we can be proactive instead of reactive is going to make us safer. Going back to anecdotes, our agricultural unit has detector devices out there in the field, and we were able to detect—it was actually a dentist office that had abandoned their location. However, with the X-ray machine, there was small chemicals or radiological materials still left behind. The place had been abandoned. Because of the detection devices, we were able to be proactive out there and remove it.

So I concur that anytime we can be proactive out there, it is going to be beneficial for us. Along with what the chief said, it is the training aspect of it. The more training we can provide our first responders, the better they are going to be. We can give them all the equipment they need, but it is the training that is going to make them safer.

Mr. BILIRAKIS. Would anyone else like to respond?

Mr. LOCKWOOD. Yes. Just as the technology with your cell phone, the devices and items that we utilize continually change and the technology continues to improve. As we continue to watch grant dollars continue to dwindle, it becomes more and more difficult to stay current with those technologies because they are not exactly cheap as they roll out the new technology. So I think that those diagnostics, whether it be the training or the new tools that we are provided, we have to be looking at, are they being considered sustainment costs? Or are they being considered a new technology that allows us to do a better job of meeting the needs of our communities?

Mr. BILIRAKIS. Thank you. All right. We will move on.

This question is for Chief Gillespie. Your testimony cites some important concerning studies about the availability of the first responder workforce during a pandemic. One study you mentioned

found that only 49 percent of survey participants would be both willing and able to respond, and the other found that 80 percent would not report for duty in the absence of personal protective equipment or vaccination. We shouldn't have to ask responders, in my opinion, to make a choice between doing their job and protecting their own health and that of their families.

Given that antibiotics and vaccines are plentiful, it should be a fairly easy to lift to help responders—and I know you all agree—to achieve the peace of mind they need to help them do their job. Why has this taken so long? What is your opinion on this? What do you think the barriers to reaching this desire in State are, and is it a matter of cost? I think not. Or is it a matter of culture? I would like to hear from Chief Gillespie and anyone else wishing to respond.

Chief GILLESPIE. Mr. Chairman, thank you for the question.

What do I think the cause of this is? From my opinion, probably over-analyzation.

I have got to say that our people very much understand the nature of the problems that we have out in the field. If somebody has the ability to provide us a tool to perform our jobs, to be able to protect our citizens and protect ourselves and our families, I just don't understand why there would be any reason to delay this. I just don't get that at all.

I am from the Las Vegas area. So I am going to use a Las Vegas analogy here for you. Every day that goes by is going to have a cost to it. It is like rolling the dice. You roll the dice in Vegas, and sometimes you win. But sometimes you lose. Every day that goes by, we are taking that chance that our first responders won't need those things that are available to us today. So it is very frustrating when we hear that it is there. It is available. It just hasn't been delivered to us yet.

Mr. BILIRAKIS. Appreciate it. If anyone else wishes to add something? Okay. Thank you.

I will now recognize our Ranking Member for 5 minutes or so. We are going to try to do a second round.

Ms. RICHARDSON. Mr. Peralta, it is good to see you again, sir, as always. Can you describe for us—I thought it was interesting you didn't mention in your testimony—the potential impacts that are being imposed on the Postal Service, how you would view those impacts or changes, how that could impact your ability to effectively participate in this model?

Mr. PERALTA. Example: The elimination of door-to-door delivery letter carriers would no longer be able to deliver the product, the medicine, to your home. As there is some legislation that proposes to have centralized delivery at the end of the neighborhood. If I am delivering the product to you at your home, you don't have to leave your home to get that medication. If I have to put it at the end of the street in a cluster box—picture yourself in our gray years of life taking that walk, fearful, wondering what is going on, to get my meds. Put it at my doorstep. Let us serve America at your porch.

Ms. RICHARDSON. Thank you, sir.

My next question also for you is, the anthrax attacks in 2001 were particularly harmful for many of our postal workers. I was cu-

rious, are there any lessons learned that you have been able to take that would also apply to this program as well?

Mr. PERALTA. In 2001, one of my predecessors, Al Ferranto, was the director of safety and health. At that time, the Postal Service very actively got involved in briefing the NALC, keeping the NALC informed and in the loop as to what was going on and literally trying to make sure that we are not exposing ourselves to any type of a hazard, nor the American people to any type of a hazard.

We needed to make certain that the mail was safe to deliver. As a result of that, there has been a lot of technology applied, radiation to protect against the anthrax in the mail. The lesson learned is, we have to work together, all of us, to protect America.

Ms. RICHARDSON. Thank you, sir.

My last question here for you: Are there any resources or additional support that you would feel that the letter carriers would need to fulfill this assignment?

Mr. PERALTA. I think it leaves the question to be answered by the experts. How more do we protect the first responders? The speakers at this table, this panel, speak very importantly of the need to protect those first responders. Whatever is learned needs to be passed on to all those first responders.

Ms. RICHARDSON. Are you guys at all currently included in any first responder discussions?

Mr. PERALTA. We are involved in our element of the plan. We are briefed as to where we are going, what new cities we are rolling it out in. Then the membership is informed that we are not going to be put at risk as first responders until the experts detect that it is safe to start the delivery of the antibiotics to the community.

Ms. RICHARDSON. But I mean, other than this particular program, have the letter carriers ever been included in first-responding situations or——

Mr. PERALTA. I apologize. I cannot answer that. I don't have a recollection off the top of my head.

Ms. RICHARDSON. Okay. If you could supply that to the committee, that might be helpful.

My next question is for Mr. Lockwood. Over the past 2 years, Homeland Security grant programs have been dramatically reduced. Can you discuss how cuts to the grant funding has affected the first responders' ability to do training and acquire necessary equipment? Because that will be something that we are going to be voting on very shortly.

Mr. LOCKWOOD. Obviously, any time we lose any funding, it makes an impact. But in the first years of the grants, obviously, we saw a rollout of a lot of equipment. The issue is that, as I stated before, we have the issues of maintenance or replacement of equipment that we have purchased over the course of time. Then there is the additional training that goes along with that. Some of the areas that we have provided equipment and training to are not things that we necessarily do on a daily basis so that the currency requirements for training is more because it is not a daily hands-on activity that somebody may be dealing with. So we are constantly having to try to make decisions about how to do more with less.

Ms. RICHARDSON. Okay. Thank you for your answer.

My last question would be to the four of you. Is there anything that you would like—we have the ability after a hearing to forward additional questions to the panel. Are there any questions—I always hate when we have two panels because you don't really get an opportunity to say, wow, you know, they should have asked this question. Is there any question that you would like us to ask Panel I that would be helpful on your behalf?

We can start here with you, Chief Gillespie.

Chief GILLESPIE. Thank you, Mr. Chairman and Ranking Member. I would say—not that I have a question for the panel. We have already stated forth the charges that we need help from you, as Members of Congress, to provide services to our citizens.

But I want to say thank you, also. You end up listening to a lot of folks here many times, I am sure just asking. I want to say thank you for the opportunity that I have to be here and be participatory in some of the major things that Members of Congress have done for the emergency services. I will state specifically the D band broadband network issue. Thank you so much for what happened with that. You heard some of our problems down here down the road on interoperability. That is just a small tip of the iceberg. Thank goodness we have the opportunity to deal with it, though. It is going to take a little time. We have got to plant the trees to make the shade for later in the future, but at least we are on the right track. Thank you for that.

Ms. RICHARDSON. Sure, thank you.

Mr. LOCKWOOD. Mine I guess is not so much a question but a statement. I would like, as we look at this specific topic going forward with medical countermeasures, to get the message across that not necessarily does one size fit all and that we have got to be open to new methodologies and processes that will allow us to move forward and advance. We find that there are days where we are so ingrained in the processes that we are in, that we struggle with trying to find better ways to do things.

Ms. RICHARDSON. Thank you.

Sir, you are up for your first-year anniversary in the job.

Sheriff NOCCO. Yes. It has been a long year. One comment. Mr. Polk brought up a very good point. He said, a voluntary program. There is the anthrax vaccine. It is five shots over 18 months. I would encourage that to continue to be voluntary. There was a study done that—Florida was included in the study—that 64 percent of law enforcement officers are willing to take this vaccine. I think as long as it is voluntary—there is a lot of education done for it—then we will get even more participation. So I would think that when you mandate things, I think people get scared and they get reluctant. When it is a voluntary program, people are more willing, and I think the educational component is huge for the success.

Ms. RICHARDSON. Thank you.

I yield back.

Mr. BILIRAKIS. Okay. I will recognize myself for 5 minutes or so. You are welcome to stay. I think we still have some time for some more questions.

This one is for the sheriff, your county being right outside of Tampa. As a major city and one that receives funding through the

Cities Readiness Initiative, Tampa no doubt has plans that it has exercised to receive National medical supplies and dispense them to the public. Given your proximity to Tampa, has the Department of Health and Human Services engaged you in any of this planning? Do you feel that your role and the expectations of your personnel are clear when it comes to distribution and dispensing of medical countermeasures in or around the Tampa area?

Sheriff NOCCO. Thank you for your question, Chairman. To be blunt about it, our members are not in the circle. I can tell you, our emergency operation center, which is not under the Sheriff's Office, may be involved. But directly our Sheriff's Office has not been at the table. The city of Tampa and the county of Hillsborough are doing a very good job putting our efforts together.

As we proceed, the Pasco Sheriff's Office is a willing participant. The city of Tampa is utilizing our our resources. We are sending our people down for possible demonstrations. We are sending them for mass arrests. We are working that in conjunction. But as to a distribution, if an outbreak was to occur, no. I can also tell you very bluntly that our deputies do not have the equipment to respond if such an incident occurred, God forbid an anthrax or any type of chemical or biological attack occurred while our deputy is on the front line, they would not have protection.

Pasco County, as you know, is literally 10 minutes outside the city of Tampa at points. We have major critical components that are going to be involved with the RNC that are secondary locations, and unfortunately, we do not have the equipment nor have we received any of the funding. We are working with the city of Tampa. However those types of conversations we have not been a part of.

Mr. BILIRAKIS. Well, that is unfortunate. We have to do something about that.

This next question is for Mr. Lockwood. I am interested in your perspective on the consolidation of grant programs and the impact that it has on projects with a medical focus, such as those previously funded by the MMRS. Then, has your ability to maintain and sustain the medical preparedness capabilities you previously attained using grant funds been impacted? What is the proper balance, in your opinion, between infusions of Federal versus State or local funding? I know you have a lot of interest in this.

Mr. LOCKWOOD. Well, MMRS is clearly one of the areas that supports us specifically in the first responder community with the—at least in our area, we have some prepositioned countermeasures that are available to our first responders. The problem with those, obviously, become—there is a replacement cost. There is a cycle where those medications will expire, as with all the other medications.

I think that one of the other issues is that as this consolidation process takes place, it is more like a block grant program. While they will say it is more flexible, it is actually less flexible in the sense of we see a degrading of some of the programs we have been able to put together. There will be programs in my anticipation across this country that have been built and, at the end of this, may no longer be I believe to sustain their operations based on just the way the new structuring has taken place related to the consolidation.

I do also want to point out that there is the 16 grants, but there is also the HHS grants for public health preparedness, et cetera. One of the problems we have had in this process is the coordination between the two of those. We understand that that is being taken care of in this next grant cycle. We may have one guidance under DHS aside telling us we need to do something, but then there is conflicting language related to what is in the CDC public health preparedness or ASPR grants.

But I do see that going forward, we are going to continue to meet challenges in our ability to meet not only the first responders' abilities from a medical countermeasures standpoint, but I think that we are going to have these same problems related to community-based programs.

Mr. BILIRAKIS. Thank you.

Chief, in the absence of a dedicated med kit, one option to provide pre-event planning for the first responders is to establish a dedicated local cache or stockpile. Is a cache approach a decent alternative to med kits? Have you established such a cache in your city? Anyone else want to respond on this, your feelings on this? What do you think, is it a good alternative to a med kit?

Chief GILLESPIE. Mr. Chairman, first of all, we have not established one in our area. Second, it is probably better than what we have, which is not being included in the first tier. But certainly far down the list of being able to be utilized and keep our first responders in the job, responding, knowing their families and themselves are protected immediately. As you have heard, there is always a delay out there. One of the things that we have in emergency services is a lack of time. Time is important to us. That is how we measure our success in many ways is how quickly we can respond and how effectively we respond.

Every second that goes by, when we have to go chase down something or we have to go to a different location, it makes it more difficult for us to meet those time requirements. So while it is better than not having something available, it is not an ideal situation for us.

Mr. BILIRAKIS. Thank you.

Sheriff.

Well, whoever would like to respond.

Mr. LOCKWOOD. I just wanted to state that we do have some prepositioned cache in the greater Hartford area. But one of the things that I have talked about this on more than one occasion is the three-event theory; that is, there is the event. Our secondary event is our ability to distribute our medications under that guidance that we were given to first responders before opening the public pod. Then there is the third tertiary event of actually distributing to our general public.

The problem becomes—is that there is a 12-hour lag time most likely for those prepositioned medications to get to us, to get them out. Secondarily, now we have a resource issue of having to distribute our medications at the time of need to our first responders, therefore slowing the response to the third event. If we were able to preposition the medications in these med kits in personnels' homes, we wouldn't do away with what we would greatly reduce that secondary event of having to try and distribute our medica-

tions, our countermeasures to our first responder community, therefore allowing us to get in a more rapid approach to be able to get to the general community in a timely manner. So while prepositioning is an option, and it is definitely better than what the current alternatives may be, the ability to close our gap to be able to get to the community as a whole would be best served by having the prepositioned kits.

Mr. BILIRAKIS. Sheriff.

Sheriff NOCCO. Mr. Chairman, I agree.

There is a term that is used, keeping your head in the game. There is no doubt first responders are going to go in and risk their lives. However, there is another side of it. We are all human, also. We have families; we have children that we care about. When these situations occur, it is not going to be an 8-hour shift, then you go home. These are going to be days and days on end. We may never get back to our houses. So to ensure that our families are taken care of, that we don't have to worry about their well-being, it is going to allow first responders to be better in their duties. It is going to make us better as an agency in our response to the community. So if we can have these caches in the houses, I absolutely agree, that is the best way to do it. If it is going to be prepositioned in our police stations and our fire departments and fire stations, that is better than nothing, as the Chief said. However, keeping them in our houses, being able to explain to our loved ones how to use them in case we are not home when a disaster occurs, I can tell you, it will allow first responders to be better in their duties.

Mr. BILIRAKIS. Sheriff, a question for you and again, anyone else who wants to chime in. Security is a concern throughout the medical countermeasures dispensing process, whether in traditional pods or by going door-to-door with letter carriers. What support, financial or otherwise, does local law enforcement want from the Federal Government in order that you can provide the needed support to postal, public health, and other authorities involved with dispensing these drugs in an emergency? How can we help you? What support do you need from us?

Sheriff NOCCO. God forbid this ever occur, it is not going to be a situation that would be isolated just to our county. As I can imagine, something like this would affect a whole region, possibly a State. Immediately, our resources would be drained. We would have to call in the National Guard. We would have to call in other resources to go with the mail carriers as they go house to house. I mean, I can't tell you how many mail carriers we have in Pasco County. But with a population of over 500,000 roughly, including our seasonal residents, I can tell you right now that we wouldn't have enough deputies to walk with them all because we have other concerns. You are going to have traffic issues. You are going to have security issues. You may have a possible crime scene that we are taking care of.

When most of the time people think of a terrorist incident, it is one location. Now they have two or three locations possibly where they are going to try to spread us as thin as possible. The other agencies where we try to ask for mutual aid, they are going to be stretched just as thin. So I can tell you most importantly what we would need is more personnel. More personnel, the better. Then

along with personnel, we are going to need resources. You know we are going to need food and water. We are going to need to sustain ourselves. So the initial is personnel, send us bodies. After that it is going to continue to say, we need more food. We need clothing, we need things to keep us going for days and weeks.

Mr. BILIRAKIS. Thank you.

Last question for Mr. Lockwood. If you were to implement a voluntary anthrax vaccine program in your jurisdiction, this would require a well-organized approach and good occupational health infrastructure to achieve, given the current five-dose regimen over the 18 months. You mentioned that you touched on this. What options are in place to do this?

Mr. LOCKWOOD. Well, I think that no communities are the same. So I can tell you that in most of our larger communities, we have occupational health within our municipalities or our governments that would most likely be able to—once given the guidance and the established protocols on how the program would be implemented, I am sure they would be able to implement it. But just like with anything else, we have local emergency management offices. There may be one individual with a community of 3,000 people, and we have some that have an emergency management office with 1 million people. I can't answer the question from across the country as to how they would all implement it. But I would think that just like you—here would be my best answer: In those areas where you have given us the tools and we have been able to be successful with them, if you are able to give us this tool, I am sure we will find a way to be successful with it. I don't think that should be the stumbling block to this. Because I think that no matter what, we would be able to get those programs in place because it is really about protecting the people that work for us.

Mr. BILIRAKIS. Anyone else want to respond to that? First of all, I want to thank you all for being so blunt and frank and giving us all this information. This was very, very informative. But also I wanted to give you an opportunity to come up with—just like the sheriff talked about, the interoperability and then we discuss the grant programs. Anything else that should be on our radar screen? Any priorities of yours? How can we help you? I wanted to give everyone an opportunity to respond.

Chief GILLESPIE. Mr. Chairman, thank you for the opportunity.

One of the things that you asked here was, how could you administer a program? I can tell you that the International Association of Fire Chiefs is a 501(c)(3) organization that has had the opportunity to work on major programs like this across the country dealing with our entire country on intra-State mutual aid systems and developing programs to get them all tied together. This would be a great opportunity for something like our international organization to be involved in and help get this delivered out to the members of our communities, our fire service communities, around the country and our other responders.

And I would also like to say that if you are looking for beta test groups, I can tell you that the Las Vegas valley is ready to help be beta test group for your anthrax vaccines and for your med kits. Believe me, we are ready. We believe we are on the front lines of and in the sights of the terrorists and anything we can do to pro-

tect our people out there, we would like to do it before it happens. Thank you.

Mr. LOCKWOOD. I guess my only point would be that from an emergency management standpoint across our Nation, we have different-sized offices, different-sized organizations. Some of these grant dollars are the only things keeping the doors open. I just caution that—trust me, we all know that these are difficult times and that we are all doing our best to do more with less. But as we have looked at different programs that were potentially coming out or cuts to programs, we may find ourselves in a situation where the very thing we are looking to rely on won't be there if we continue to cut as deep as we are cutting.

So I acknowledge the fact that you guys have a great deal of work to do, but I just caution you that at the end of the day, the only thing that keeps our lights on in some places are some of the minimal funds that we actually do see.

Sheriff NOCCO. From the Sheriff's Office standpoint where we are located, I go back to its interoperability; that is our No. 1 priority. It is almost like going back to the basics. That is a basic fundamental issue in law enforcement is to be able communicate because what we are talking about today is a worst-case scenario. These are things that we don't even want to have nightmares about, but they could come true. However, from our standpoint, it is what we deal with every day, the disasters that are not to this scale. However, communication needs to be there. That is the fundamental core of what we do. It is how we operate, and it is how we can be successful. A perfect scenario is, the other day I was travelling down the road. I was in my vehicle. There was a Florida highway patrol trooper next to me, and there was a Tampa police officer in front of me. I cannot just pick up my radio and talk to them. If a robbery had happened or something had broken loose right in front of me, unless they saw it, there is no way we can immediately communicate. So I think, from our standpoint, it is going back to the basics, and it is communication.

Mr. PERALTA. Mr. Chairman, if possible, whenever you have that need, include the letter carriers and Postal Service.

Mr. BILIRAKIS. Okay. Well, thank you very much, again. Thanks for making the trip and thanks for your patience, again. I guess it has been a couple of hours. But again, it was well worth it, as far as I am concerned.

I thank the witnesses for their valuable testimony and the Members for their questions. The Members of the subcommittee may have additional questions for you, and we ask that you respond in writing. The hearing record will be open for 10 days. Again, we are always available for any input, any suggestions you might have. Without objection, the subcommittee stands adjourned. Thanks again.

[Whereupon, at 4:20 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS SUBMITTED BY CHAIRMAN GUS M. BILIRAKIS FOR JAMES D. POLK

Question 1a. In response to President Obama's Executive Order on medical countermeasure (MCM) distribution, your office has taken the lead for the Department of Homeland Security (DHS) on the conops plan for mission-essential personnel of the Executive Branch. The Office of Health Affairs (OHA) has also spearheaded an MCM strategy for DHS employees, and oversees the purchase and storage of MCMs for the DHS workforce, which includes stockpiles of countermeasures.

What is the current process for prioritizing DHS' MCM procurement strategy? Is specific threat or risk assessment information utilized in procurement decisions?

Answer. Response was not received at the time of publication.

Question 1b. Is there a process for OHA to share lessons learned or best practices from developing DHS' MCM program with other departments and agencies, or with first responders who may be trying to develop their own programs?

Answer. Response was not received at the time of publication.

Question 2a. The DHS Medical Countermeasures Program is intended to contribute to National resilience by ensuring the timely distribution of essential medical countermeasures to DHS mission-essential personnel in the event of a biological attack. The fiscal year 2013 budget requests $1.9 million to fund medications, training, program support, and planning activities for this program.

What proportion of DHS mission-essential personnel is covered by currently stockpiled MCMs?

Answer. Response was not received at the time of publication.

Question 2b. What portion of the requested $1.9 million is intended to replenish expiring lots of existing stocks of MCM, and then to acquire new countermeasures?

Answer. Response was not received at the time of publication.

Question 2c. What proportion is designated for acquisition of new classes of MCMs, such as postassium iodide or influenza antivirals?

Answer. Response was not received at the time of publication.

Question 3. What threats should we be thinking of protecting first responders against, in addition to anthrax?

Answer. Response was not received at the time of publication.

Question 4a. Beyond that which was provided in your testimony, can you please provide further details about the voluntary anthrax immunization program that your office is developing? Specifically:

What is the time line for implementation?

Answer. Response was not received at the time of publication.

Question 4b. What are the expected outcomes?

Answer. Response was not received at the time of publication.

Question 4c. What is the financial arrangement with the localities chosen to participate—that is, what costs will they bear, and what costs will the Department bear? How much will these costs total?

Answer. Response was not received at the time of publication.

Question 4d. If fully implemented beyond the pilot stage, will interested participants be able to use Federal grant dollars to purchase the vaccine and implement the program?

Answer. Response was not received at the time of publication.

Question 5a. A number of first responders expressed concern to the committee that Federal grant funding does not apply to medical countermeasure acquisition for local stockpiling purposes.

Can you clarify whether this is actually the case? What exactly does the grant guidance say with regard to expenditures of grants on medical countermeasures, and which Department of Homeland Security grant programs, if any, are applicable for this purpose?

Answer. Response was not received at the time of publication.

Question 5b. Has the Office of Health Affairs worked with the Federal Emergency Management Agency to provide guidance on the use of grant funds for medical countermeasures?

Answer. Response was not received at the time of publication.

QUESTIONS SUBMITTED BY CHAIRMAN GUS M. BILIRAKIS FOR EDWARD J. GABRIEL

Question 1. For the purposes of the antibiotic med-kit program that the Office of the Assistant Secretary for Preparedness and Response (ASPR) is developing, how is the term "first responder" defined?

Answer. Response was not received at the time of publication.

Question 2a. A number of first responders expressed concern to the committee that Federal grant funding does not apply to medical countermeasure acquisition for local stockpiling purposes.

Can you clarify whether this is actually the case? What exactly does the grant guidance for relevant Department of Health and Human Services grant programs say with regard to expenditures of grants on medical countermeasures?

Answer. Response was not received at the time of publication.

Question 2b. In BARDA's vision, since the antibiotic med kit for first responders would be a commercial kit paid for by the responders, and something that States or local jurisdictions would essentially take ownership of once Federally approved, will the current grant structure allow for the purchase of such supplies through Federal grant dollars?

Answer. Response was not received at the time of publication.

Question 3. What is the ASPR's approach to working with the FDA and ensuring that the FDA understands that med kits are a first responder and an ASPR priority? How will you ensure a successful partnership?

Answer. Response was not received at the time of publication.

Question 4. How do you envision that the pre-attack dispensing of medical countermeasures to the first responder workforce would be tracked? What kind of guidance will your office provide to participating localities with regard to tracking who has received what medications, incidence of side effects, and related occupational health matters?

Answer. Response was not received at the time of publication.

Question 5. Beyond antibiotics for anthrax, what do you envision med kits for first responders could contain? What threats should we be thinking about for first responder protection in addition to anthrax?

Answer. Response was not received at the time of publication.

Question 6. How important are rapid, point-of-care diagnostics to the first responder community? Is BARDA investing in these? Please provide a list of such diagnostics that have been developed and/or acquired.

Answer. Response was not received at the time of publication.

Question 7. Can you provide a list of countermeasures and vaccines in development designed specifically to ensure the continuity of first responders, or that are being developed for the general public but would have collateral benefit for first responders?

Answer. Response was not received at the time of publication.

QUESTIONS SUBMITTED BY RANKING MEMBER LAURA RICHARDSON FOR EDWARD J. GABRIEL

Question 1. What specific plans have been made to protect the protectors? Can you provide a list of countermeasures and vaccines in development designed specifically to ensure the continuity of emergency services?

Answer. Response was not received at the time of publication.

Question 2. When can an FDA-approved med kit be distributed to emergency services providers?

Answer. Response was not received at the time of publication.

Question 3. Following the request from OHA for resources to protect the Federal workforce with countermeasures, can HHS specify what resources have been deployed to protect local and State responders? What plans are in place for this protection?

Answer. Response was not received at the time of publication.