



**Public Health Preparedness: Are We Ready for Disaster?
Alliance for Health Reform
Robert Wood Johnson Foundation
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ED HOWARD: Good afternoon, my name is Ed Howard, I'm with the Alliance for Health Reform and I want to welcome you on behalf of Senator Rockefeller, Senator Blunt, our Board of Directors, to this program on how well America is prepared to deal with both natural and man-made disasters. I should say up top, this is not an intellectual exercise and I want to illustrate that by stealing a sentence from a letter written by one of panelists today, Dr. Ali Khan of the Centers for Disease Control and Prevention. A couple of years ago transmitting the nation's first national strategic plan for public health preparedness and response, Dr. Khan chronicled what were then recent major disasters. This is the verbatim quote, "In the last five years alone, national and global health security have been threatened by incidence including Hurricane Katrina, West Nile virus, H1N1 influenza pandemic, bacterial contamination of food by E. coli and salmonella, the Deep Water Horizon oil spill, the Haiti earthquake and following cholera outbreak, and the Japanese tsunami and subsequent radiation release." Now that's a pretty breathtaking listing for only five years. Today, we're going to, maybe, speculate on what the next five years will bring and examine how well prepared we are to deal with that list.

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We're pleased to have as a partner today in sponsoring the briefing, the Robert Wood Johnson Foundation which has been helping Americans enjoy healthier lives and get the care they need for 40 years now and we're very lucky to have with us to co-moderate the program Dr. John Lumpkin who's senior vice president of the foundation and director of its health care group. I should note that before joining the foundation he directed the Illinois Department of Public Health for 12 years so he brings a great deal of experience and expertise to today's discussion, John.

JOHN R. LUMPKIN: Great, thank you all for coming. This is a very critical topic. From my viewpoint at the state of Illinois, I was actually charged with participating in the response to a number of disasters, some of which many of the people outside of Illinois may not have been familiar with, but we had major flooding in 1993 and I became quite interested in that because my background before I came into public health was in emergency medicine. As someone who's been involved in doing disaster planning for most of my career, I began to bring that as part of what we were doing in public health. I can tell you that that is a really challenging task. One of the things back in the late 90s that I thought was absolutely critical and it is more common place now, is that we would have a molecular biology lab. Up until then we would basically grow cultures in

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the lab. You would see what they may show in a day or two and trying to track an outbreak of disease was really challenging. With a molecular biology lab you can do DNA fingerprinting. I thought that was something that was really important so I had a conversation with the Bureau of the Budget and the governor's office when I did my annual budget and they said, yes, that sounds like a great idea. Next. The following year we had the same conversation.

Then we had September 11th. In 2001 we rapidly set up a molecular biology lab, fortunately, because we had thousands of samples that people had sent into the lab because they were concerned that this was going to be anthrax. Now that could be the end of the story; we increased our preparedness.

In 2002, there was an event that occurred in a small town outside of Springfield, Illinois, where a bunch of people had come to this music festival and they started coming down with E. Coli 0157. We had the molecular capability to do the fingerprinting that would enable to trace the individuals who were sick and had scattered across the country to this one particular site and one particular type of food.

Then in 2002 when West Nile hit our state the fact that we had a molecular biology lab enabled us to be able to respond to that outbreak and to run thousands of tests of people who thought they may have been infected with this disease. This is

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why we, at the Robert Wood Johnson Foundation, feel that this particular issue of preparedness is so important because its not just about responding to the major disasters that make the news, but that preparedness is also about making sure that our public health system is ready to deal with the small disasters, the small events, that can have an impact on how healthy people are and how they live their lives. We're pleased to be co-sponsors of this event and to recognize that what we're going to be talking about has an impact on everyone's lives as part of beefing up the public health system at the same time as beefing up the ability of this country to respond to major, catastrophic events.

ED HOWARD: Great, thanks very much John. Let me just do a little housekeeping here. You have written materials in your packets including biographical information about each of our speakers, PowerPoint presentation hard copies if we have them. If you're watching on C-SPAN or you're watching the webcast of our briefing on our website, if you have access to a computer you can not only watch along as the presentations are given, but you have access to those same PowerPoint presentations and background materials that the folks in the room have. There'll be a transcript of this briefing that'll be available in a couple of days on the Alliance website at Allhealth.org.

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In this room, I want you to know, of course, there is a green question card in your packets, you can write a question once we get to the Q and A session and you can also go to one of the microphones that is set up in the room where you can ask the question in your own voice.

If you're part of the Twitter-verse, you can take part using the hash tag @peppertalk, I believe it is. It's on the title slide that you see on the screens.

One last note, we're going to have a very good discussion about the preparedness of the public health system and I don't want you to think that we are not aware that there is another part of the responsive system that we don't have time to cover with any detail today and that is the preparedness of the healthcare system; hospitals, nursing homes, other entities, all have a part to play in being able to respond to the kind of disasters that we will be talking about. There is an assistant secretary for preparedness that has responsibility for other programs that are useful in this regard and we hope to turn our attention to that at some future point. So let's get to the program.

We have a terrific panel lined up for you and then we'll turn to your questions. We're going to start with Georges Benjamin. He's the Executive Director of the American Public Health Association which represents our country's public

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health professionals. He's a board certified internist. He's run APHA for more than a dozen years and before that he headed Maryland's Department of Health and Mental Hygiene so he's somebody who's familiar with public health and its role in dealing with different types of disasters at many levels. We're happy to have you back on our panel Dr. Benjamin.

GEORGES C. BENJAMIN: Thank you very much for having me here today. I'm going to start by just pointing out our new reality.

MALE SPEAKER: Microphone please.

GEORGES C. BENJAMIN: There we go, can you hear me now? Alright, I'm going to start by talking about our new reality; the fact that we're clearly in a dangerous world with dangerous people, both with and without state sponsorship. The technology that we have today, very, very different than technology we had 20, 30 years ago with very rapid scientific advancements and lots of people with knowledge of lethal organisms. I'll also point out nature. We often say that nature is the first terrorist just because of the enormous impact that nature can have both in creating infectious diseases as well as extreme weather events. Globalization is both a blessing and a curse; the fact that we can have rapid movement of infectious diseases across borders. We often talk about being one plane ride away from something very bad. We're

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also on one plane ride away from infectious foods. We're also one e-mail away from communication of very dangerous information that should be out of the hands of people that are very dangerous. We're certainly in a very very challenging world today. I think you've heard from both our earlier speakers here about the fact that we still have significant threats around. I'll just remind you that we currently have a Cyclospora outbreak which is a foodborne outbreak. We've had our recent pertussis epidemic which shows us a lot about our need to really refine our vaccination programs as well as some of the challenges we've had around the infrastructure for public health. The fertilizer explosion tells us a lot about what can happen even in fundamentally rural America; that every part of our community needs to be prepared. Of course, the annual run of tornados that we continually have through the Midwest each and every year that can devastate whole communities.

The importance of this is that public health is an essential role in all of these things. Of course, I point out even the Boston bombings. What many people don't know, of course, is that the central role of the Health Department in terms of responding because the Boston Public Health Commission actually oversees the emergency management and function in that city and, of course, they were heralded for their fine work in

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responding to this emergency. I remind you that they did good work in a staged event and things worked, tragically, as they should work but that tells you the importance of preparedness and if you talk to those folks they'll tell you that training, and preparedness, and resources, clearly made the difference in their response. I say that because public health needs to have a range of capacities and these are the capacities that public health needs to have. This is kind of a snapshot of that. We need to know when a new disease enters a community if we can't prevent it. we need to be able to measure it, do surveillance, track what it does, address the health threats, there is a range of capacities that the public health system needs to have and that's each and every community; not a selected number of communities, not just our big cities, each and every community needs to have these capabilities.

I also want to point out that a prepared community is one of resilience, so I'm going to use, for the sake of discussion today, the definition of resilience that we use in national security strategy, but functionally, it basically means the ability of a community to get back on its feet, to be able to respond quickly when you have something bad happen or you have changing conditions. Then recovery is very important. If you think about the various disasters that we've had over the last 10, 15 years and you think about the capacity of the

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various communities to recover, that tells you a lot about the internal capacity of communities. All communities have strengths, but communities are different and I think the goal we have is to make sure that all of our communities have the resilience that's necessary for them to adapt to and recover very quickly from a disaster.

We know that too many Americans don't take their individual preparedness seriously, they are under prepared. There have been lots of surveys. This is an example of a survey done last year that, basically, says that half of individuals haven't done some of the simple things that are necessary to be prepared, and that's a significant problem that we need to begin to address. I know the American Public Health Association has been working with the public to try to address some of these, what we call our Get Ready Campaign. Our Get Ready Campaign is a campaign that's designed to build resilience. Our goal is to try to make sure that every American can protect themselves, their families, and their communities from serious, preventable health threats. We've done that by creating a series of resources to try to allow communities to become prepared. We have gotten very engaged in the social media world so that we have blogs, and e-mails, and Twitter activity. We've had events, we have a cat calendar and a dog calendar, all kinds of things to remind people that it's

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important to get prepared and try to engage them in very, very active ways to try to improve their health, both of their families and of their community.

I'm going to leave you with one final note because we're all in this amazing time of trying to ensure that we get universal access to healthcare for all Americans, but I need to point out that even when we achieve a well functioning healthcare system of the highest quality that provides that care at an optimal cost, we don't have that yet, but we're all working to do that, even when we achieve that, and if every American gets the platinum level health plan, for those of you who aren't familiar with the ACA, that's the highest level plan, that's the one we all want if we could afford it, if each one of us had that and a little plastic card to go along with it, we would still need a robust public health system that is prepared to address that. It's very important to understand that most of what we do in medical care is not done by—most of what we do in preparedness is not done by the healthcare delivery system. A lot of this stuff is done by the public health system and I think when you hear from the other speakers, they will talk a lot more about that in greater detail than I can this morning. With that I thank you, and Ed, I'll turn that back over to you.

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ED HOWARD: Thank you Georges. We're going to turn now to Dr. Ali Khan from whom I stole a sentence a few moments ago. Dr. Khan directs the Office of Public Health Preparedness and Response at the Centers for Disease Control and Prevention. Note that duality of purpose; preparedness and response. Dr. Khan was a primary force behind CDC's bioterrorist preparedness program, directed its response to the 2001 anthrax attacks which some of you may recall actually shut down this very building, the Hart Senate Office Building at the time. Dr. Khan is an internist, and a pediatrician, and we're very pleased to have you with us today.

ALI S. KAHN: Thank you.

ED HOWARD: Press it and wait for a moment. Don't press it again. Now try it.

ALI S. KAHN: Technology in action. Good afternoon everybody. Thank you, Ed, very much for that very generous introduction.

I have the wonderful responsibility and the amazing honor to support the nation's health security efforts. This is to make sure that Americans are safe 24/7 from all public health threats no matter what their nature, foreign or domestic, whether they're bioterrorism, chemical terrorism, whether they're natural disasters, whether they're pandemics,

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large spills, or the routine public health threats of every day that you read in your paper.

Now what was very clear, thank you Georges, from your initial presentation is that while public health events are clearly local and state events, there are fiscal, political, and economic ramifications of those events that require a national response. That's why, increasingly, over the last couple of years we have been talking about public health and the context of ensuring this nation's health security. Our secretary, Secretary Sebelius, was at CDC earlier this week and during the course of our conversation with her, she actually mentioned that we should think of CDC and our public health functions more broadly as part of ensuring our national security altogether.

As part of our activities, let's see if this piece of technology works. Not that I need these. Can I tell you in one slide what we do? A couple of things, we're responsible for establishing national strategy and policy, make sure for national health security, make sure we're driving innovation and continuous improvement in our public health programs. We're very fortunate to have about 1.3 billion dollars to help fund those activities not just at CDC, but with our state and local health departments, and we also run some critical operations that many of you are likely aware of; the Emergency

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Operations Center, this is the public health fusion center for the nation and as we talk with our national and other domestic partners, we run the strategic national stockpile. This is almost a 4 billion dollar stockpile of materials we hold in trust for Americans for any large public health threat to make sure that we can get life-saving medications and materials to Americans when they need them after a public threat. Then, finally, we also run the Regulatory Select Agent program here in the United States that regulates 300 labs that have the most dangerous pathogens in the world.

The crown jewel of our program, without a doubt, is our state and local preparedness program, and we put out approximately 600 to 700 million dollars a year, still, to our state and local health departments to prepare them for all public health threats. This is a reflection of the reality of public health and I think why Dr. Benjamin preceded me, which is public health doesn't happen at CDC, public health happens at your state and local level. That's where the initial detection occurs, that's where the initial response occurs, and we need to make sure that our communities are ready for public health threats, and are able to respond to them when they occur.

Over the last couple years we have structured this preparedness program around capabilities consistent with the

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national preparedness goal. What this slide I have presented for you shows how we support those 15 capabilities at the state and local level. These funds go out, not just to the 50 states, a couple of large cities and territories, but they go out, essentially, to 1200 public health departments across the United States. At the end of the day, it gets quite diffused, but you'll see from these slides that about a fifth of the dollars go out for core epidemiology, disease investigation, disease monitoring work, and the same thing is true for laboratory activities, then the next big chunk for community preparedness. That's how these dollars are being used in your communities.

Now what I'd like to do is make that a little bit less abstract. I'm missing that slide. There you go. I want to make that a little less abstract. I can talk about capabilities and monies to capabilities, but how does this translate to what's happening in your communities? All you have to do is open up the newspaper to understand what public health is doing in your communities and what these resources are doing in the communities to help with disease tracking, emergency operations systems, communication efforts. The Cyclospora outbreak, for example, which I believe we're up to about 550, 560-odd cases, our EOC is currently activated in response to that, and those same set of capabilities help for

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all sorts of other foodborne outbreaks that you may hear about. Today we released an alert—I think it was yesterday we released an alert to all state and local health departments and all clinicians about a solution of calcium that was contaminated with a bacterial product that wasn't sterile, so we released an alert to get those off the market, make sure that our patients weren't being infused with this contaminated calcium carbonate. Many of you know the story of the fungal meningitis outbreak, 750 cases that occurred. These were preparedness—there's multiple resources that were brought to play to respond to this outbreak, but that included preparedness activities to make sure we had epidemiologists who could investigate this outbreak, to make sure we had tracking systems, to make sure we could set up an emergency operation system, to make sure we had those relationships with law enforcement to potentially track down people who we couldn't, otherwise, track down to tell them, excuse me, we'd like you to go see your clinician to see whether or not you may have been infected with these contaminated steroids.

The West Nile outbreak, we were very fortunate to be able to help our colleagues in Texas. I think last year there were about 5, 6,000 cases of West Nile, about a third of them actually occurred in the—anybody from Dallas? No takers, lucky for you. Okay, about a third of the cases last year occurred

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in Dallas. We were able to use public health preparedness resources to help them with mosquito spraying and abatement efforts. An example there, the same thing you already heard about the Boston Marathon and how, we, in conjunction with our partners in the Hospital Preparedness Program, were able to get the community ready for that bombing and other such events. I could go on with Sandy and influenza A, but just examples that this isn't abstract. This is what's going on in your communities every day to make sure that you're protected from public health threats.

This is to give you a reality of the situation of what's happened to public health funding within your state and local health departments over the last decade. Maybe, riffing off of your comment, I would like to have platinum level public health for all Americans if we can arrange that moving forward, but you'll see there's been over a 40-percent decline in funding for public health preparedness and response activities within your communities.

Let me end with these two slides. We are always trying to improve our program. There's a couple of things that we would still like to do. One is continue to ensure that we enhance global health security efforts. As you heard, pathogens don't need passports, right? They are crossing borders and once upon a time we used to have a couple of

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uniformed officers here from the public health service. We used to be lucky when the incubation period to get some place was shorter than the time to get here. If you were on a ship and you were coming here to the United States, we pretty much knew that you had yellow fever on that ship and we can quarantine the ship. Nowadays, if you take a plane and you can be anywhere within 24 hours, that's shorter than the incubation period of some of the deadliest diseases in the world. You walk into the port already infected, ready to go in a new place. We need to think globally about protecting Americans.

How do we improve our biosurveillance efforts, how do we improve our disease monitoring activities in the United States? How do we take advantage—a number of the efforts around electronic health records? Looking at other sources of information such as animals, we need to do a better job with that.

One of the key things that I've noticed in my experience with disasters; pretty much all of the disasters you heard about at the beginning of this presentation I've had some opportunity to participate in them. I've done 20 years, Ebola, Rift Valley fever, Marburg outbreaks, over my life time and what's become very clear to me is how we get judged as a society during a response is how do we respond to the needs of the most vulnerable populations in our communities and we need

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to get that right. The vulnerable populations in our communities, be they children, be they people with other disabilities, they can't be annexes to our plans, they have to be integral to how we think about responding to make sure that we meet their needs. How do we continue to improve the efficiency of our programs? Then finally, an effort that we're heavily involved with the Robert Wood Johnson Foundation is how do we improve the measurement of preparedness activities? We already have a wonderful way to do that with Trust for America's Health. Somebody may be in the audience. Hi, Darra [misspelled? 00:27:36], how are you? They put out a yearly report that's a snapshot of critical things that they want to focus on and we're currently working on a national preparedness index, which is a state-by-state effort to look more collectively and comprehensively at public health and at healthcare preparedness activities to think about how do we address gaps, how do we improve those efforts, and how do we improve the science of our preparedness?

With those priorities, I think what I want to leave you with is this, there're a lot of continued challenges to public health preparedness activities and health security, ensuring our nation's health security. Natural and emerging infectious diseases—all I have to say is MURs and H7N9 and everybody knows what I'm talking about. We're always just at the cusp of

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another pandemic. I try to be very careful to remind people that fear is not a public health measure or a public health strategy, but I think knowledge is a public health strategy, to recognize that how a small disease like SARS in a small, little community all of a sudden can go global given the right circumstances. Modified versions of microbes, do-it-yourself microbiology makes that, increasingly, likely, evolving terrorist threats, from car bombs, to backpack bombs, to bombs that come in printer cartridges. Terrorists are always rethinking their strategies and we need to be always evolving our strategies to be ready. Obviously, the continuing economic crisis and what that's done to public health preparedness funding. Then climate disruption effects and what that could mean for natural disasters in the United States, thank you.

ED HOWARD: Great, thank you very much, Dr. Khan. A comprehensive and very useful picture of what's going on.

We're going to turn now to Rosanne Prats who is the Director of Emergency Preparedness for the Louisiana Department of Health and Hospitals. That puts her smack in the middle of coordinating among federal, state, and local agencies that are dealing with and preparing for disasters of various types. She has a rich and varied background in health administration roles. She was around during the Katrina days in Louisiana and

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she's been with the Department for more than 20 years. We're really pleased to have you with us today.

ROSANNE PRATS: Good afternoon. I think I was one of the last panelists to be picked up on this very distinguished panel.

I thought I would talk to you from what I know in terms of—my strength is more in operations. Usually, I'm never at a loss for words. From an operations perspective if you told me that the problem is Katrina, I've been through Katrina, Rita, Gustav, Ike, the Mississippi oil spill, recently tropical storm Isaac last year. Some of the operation concerns that we have is, if you said, okay, how are we going to evacuate half of our coastline in a 38 hour period? I know who to go to. I know how long it's going to take. How many hospitals do you have in your respective communities, in your state? How many do you expect will be evacuated or not? How many can help themselves? How many will need the state's assistance? How many of those will need federal assistance? I can tell you. Today, even last night, I was talking to some of my colleagues here, too, that all of the sudden I find myself not coming up with some words or anxious about what I would say to you as policy makers. I find that we are asking for your help to advocate for dollars to be returned because of the things that I know in terms of operations. I can tell you just from—American Red

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Cross has a 23 square foot per person—when we come up with capacity numbers for a building. That's slowly been increasing as recommendations are made through groups such as yourself to have special requirements for pediatrics or children, that we should have play areas, that we should have various things for children so that capacity's now increasing to about 52 square foot per person. What does that mean in terms of operations? That means the number of buildings you had before the capacity is now just lower. If you could have fit 300 people in a building using American Red Cross standards, now you might have to find two buildings to fit the same number of people. The things that you advocate for will definitely have an impact on our operations.

In terms of issues from the planning perspective, the grants that we have, the HPP grant and the FEP, it has allowed us to, what we call war game with each other and sit in the same room with public health, hospitals, your military department, emergency management, so that you can really try to figure out the what-ifs. You start to figure out where your partners are coming from or what's really behind them in terms of resources. From the response perspective or operations perspective, we do know that the states will be asking for assistance when it comes to DMAT teams or other types of federal assistance that the states typically ask for; funds to

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assist with those DMAT teams, to assist with training so that they could come to the states to help work and play alongside of our state and local partners.

We do ask our hospitals to surge up in terms of planning, but at the same time, the Stafford Act doesn't allow for reimbursement when it comes to response so there're still some issues in terms of disconnects that still has to occur, the Hospital Preparedness dollars and the FEP dollars do advance the planning. We've become crisper, more organized, in terms of how we're going to approach a response, but, again, there's still some things that we do know that we need to address and when it comes to the response itself and how will health and medical get reimbursed, whether that be giving money through FEMA or giving more money to DHHS so that they can help with some of those response efforts.

Finally, in terms of a point, it's the changing landscape. We say that you're only as good as your last disaster. Each disaster is a different monster. You really can't compare Katrina to Sandy, they're just different. The populations are different, your vulnerabilities are different. If we could give out boot straps to everybody, perhaps, the burden on the state or government—both local, state, or federal, wouldn't be as demanding, but we will always have some vulnerable citizens. The definitions from what used to be just

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ADA definitions of challenge in terms of being blind or being in a wheelchair are now broadening because of all of the grants that we have, you increase the number of vulnerable citizens that you have which are now more of children, pediatrics, you can tell just with the range of grants that we have, most of the grants will always identify other types of vulnerable citizens. During a storm when you have a lot of sheltering going on, you're really trying, in that shelter environment, to hook them up to various types of social programs that are out there that don't necessarily all connect up. An 18-year-old young lady that might be pregnant might have a social program that you can connect them to but not the same thing for an 18-year-old young man. Those are just age differences, vulnerable differences, and some disconnects when it comes to social programs.

Again, on the changing landscape, what will the Obamacare issues bring when it comes to response? Different insurance payments, I'm sure there might be some vulnerable citizens in that arena as well, and I think if we have some think-tank discussions at the policy level as to how we can best leverage dollars so that we can all be more responsive in our own communities I think that would be best for this industry; both public health, the emergency preparedness and

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response community, along with the HPP industry as well,
thanks.

ED HOWARD: Just so we know what we're talking about,
HPP is the health system, hospital-

ROSANNE PRATS: Hospital Preparedness Program, yes.

ED HOWARD: Very good, alright, thanks very much
Rosanne. We're going to turn finally now to Jack Herrmann who
is a Senior Advisor and chief of Public Health Preparedness at
the National Association of County and City Health Officials,
NACCHO. One of his principle duties there is to strengthen the
preparedness and response capabilities of local health
departments. He has a deep background in mental health aspects
of disasters and he's a licensed mental health counselor in New
York. Jack, you bring some special viewpoints to this and some
special expertise, and we're very pleased to have you join us.

JACK HERRMANN: Thank you Ed. I also want to thank the
Alliance and Robert Wood Johnson for the invitation to today's
briefing and I'd like to start my remarks more from a personal
nature. August and September represent very poignant and
bittersweet months for me in my professional career. Four
weeks from now, we'll be celebrating, not really celebrating
with happiness, but celebrating as a milestone, the anniversary
of 9/11. I vividly remember being deployed that morning to New
York City from my home in Rochester, New York, and as I drove

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in and came up on the landscape of New York City, saw the billowing smoke in the air and then entered lower Manhattan and drove over litter and debris from the World Trade Center towers that had collapsed only hours before and was volunteering with the American Red Cross and working with the New York City Department of Health and Mental Hygiene to take care of the mental health needs of families affected by one of the world's most tragic acts of terrorism. A couple years later in 2003, I responded again to New York City. I happened to be there that day for a Red Cross disaster training when the blackout occurred. In the early hours of that blackout there was a psychological angst that was cast over the city because many people thought this might be another act of terrorism. Over the course of that night, spent time with the Red Cross staff and volunteers deploying disaster action teams across the city to over 80 fires in eight hours.

Finally, in just a couple of weeks, August 29th will mark the eighth anniversary of Hurricane Katrina, a storm that caused almost 1500 deaths and displaced 1.5 million people. Many of you already know the tragic stories that came out of that devastating disaster.

These events and many others that have occurred since then, to use an overplayed phrase, took a village to respond to. A critical member of that village is local health

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departments. I'm here today representing NACCHO, the National Association of County and City Health Officials, a non-profit, national organization, that's the voice of our nation's 2800 local health departments. We attempt to be a leader, a partner, a catalyst for local health departments so they can ensure the conditions in their communities to promote health and equity, combat disease, and improve the quality and length of life, and protect the overall health of those who live there.

A lot of people really don't know what their local health department does. I'm going to switch to a map here and try to articulate here that local health departments are county, city, metropolitan, district, and tribal governmental agencies; they report to mayors, city councils, county boards of health or county commissions. Some local health departments are units of their state government. Some are locally controlled, and others share that authority between the state and local government. As I said earlier, every day, local health departments work to protect and promote health and the well being for all the people in those local communities.

If you look at the demographics of the 2800 local health departments across the country, the majority of those, well over 60-percent, cover jurisdictions that are small; under 50,000 population. The minority of our health departments,

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about 5-percent of local health departments, serves the large metropolitan areas but they cover almost half of the nation's population. These are urban centers like LA, New York, Chicago, and DC. As I have tried to emphasize in my earlier remarks, all disasters strike locally and local health departments are a critical part of our community's first response to disease outbreaks, emergencies, and acts of terrorism.

Over the past year, local public health has engaged in the response to and recovery from many major events which some of my co-panelists have talked about, both man-made and naturally occurring. Hurricane Sandy that ravaged the mid-Atlantic and east coast, the Boston Marathon bombing, and the fertilizer plant explosion in west Texas, are examples of those, and the list of activities that you see in this slide represent the capabilities that local public health brings to bear in response to those disasters. Those are the capabilities that Dr. Khan outlined earlier and that are represented in the CDC's public health preparedness capabilities national standards for state and local planning document.

With Super Storm Sandy, we heard about many of the challenges in response to that weather event. Local health departments experienced, though, their fair of challenges.

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Even though we see those as largely successful events, they still were challenging to local health departments. The New York City Department of Health and Mental Hygiene had to coordinate a variety of public health services in some of the hardest hit areas of the storm; hiking up high rise apartment buildings in an effort to reach out to vulnerable populations; making sure they had food, water, and life-sustaining medications; supporting shelters for displaced persons; and working alongside hospitals that needed to evacuate before or during the storm. In New Jersey, health departments partnered with their state and federal agencies to provide emergency services to residents and have activated their local medical reserve corp units and other volunteers to take care of the health and welfare of those impacted by the storm. If you haven't seen the Robert Wood Johnson video highlighting the heroic efforts of the New Jersey state and local health departments, go to their website and take a look. It really is a well done video.

Many lessons were learned from Hurricane Sandy. One of the most important for health departments is the need to ensure coordination with partners ahead of time so that no one or no community goes unassisted. Another lesson learned was the importance of understanding the influential role that social media can play in the disaster and how local health

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departments need to be able to anticipate and meet the expectations of the people in their communities during a response.

The Boston Marathon bombing in April of this year involved the health department and their medical reserve corp coming out in full force. In fact, they had spent many months planning to participate in that Marathon and were already on the scene of that world-renowned event. There were nearly 200 Boston Health Department personnel overseeing medical activities and treating runners with injuries and health problems in medical tents along the marathon route. When the bombing occurred they were able to respond within seconds, contributing life-saving measures to those who were injured. Officials in Boston cited the joint hospital, public health, public safety training and exercises that they had been conducting over the years as critical to the success of that day.

Finally, in west Texas with the fertilizer plant explosion this past April which was only a couple days after the bombing, the McLennan County Public Health Department worked with the Waco McLennan County Office of Emergency Management to respond to that event. They also activated their local MRC unit in the immediate aftermath of the disaster and assisted in the coordination of the mental health case

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management with local mental health authorities. They also described longstanding partnerships between the health department, local hospitals, state level agencies, and emergency management with creating the mutual trust esprit de corps that greatly contributed to the success of that public health response.

Public health preparedness and response is not just limited to large scale disasters. Local health departments performed critical roles in other health related incidence that occurred over this past year and as we talked about some of those this morning; the fungal meningitis outbreak in October 2012 where health departments were conducting contact tracing, vaccination tracking, and were the local boots on the ground doing the investigations in 23 states that led back to the source of that outbreak that killed almost 50 people and required scores more to seek life-saving medical treatments. Health departments in the impacted state were also responsible for contacting healthcare facilities that received products from the compounding pharmacy to ensure that those facilities stopped using these products that potentially could have sickened or killed many more.

Some of you may have heard about the hepatitis outbreak in Tulsa. It was allegedly resulting from unsanitary conditions and improper sterilization procedures used at a

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local dentist's office. An investigation screening and massive multijurisdictional testing campaign was executed by Tulsa and Oklahoma's Departments of Health. The Tulsa Health Department actually had to set up free testing clinics for the 7,000 patients who may have been exposed and there were over 70 confirmed cases of hepatitis and three HIV cases, though, this could have potentially led to more cases of HIV and hepatitis if it were not for the efforts of local health departments.

Other infectious disease outbreaks occurred throughout the country this year in Sheboygan, Wisconsin. There was a TB outbreak requiring the local health department to activate their incident command system and conduct a large scale TB testing and monitoring outreach campaign in the Sheboygan school system and also work with the county's purchasing agent to find an apartment to isolate an individual who was diagnosed with multi-drug resistant tuberculosis.

Previous and current investments in preparedness largely contributed to Sheboygan County's public health department being ready to handle that TB outbreak. Previous training and exercising along with the health department's partners helped them better understand the role of ICS and follow ICS principles and those partnerships also helped them work together seamlessly and amplified the key public health messages that had to go out around this incident to the public.

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Finally, many of you, no doubt, have heard about the recent outbreak across the country of cyclosporiasis. It has affected 19 states and resulted in almost 550 cases to date and the hospitalization of 34 individuals. LHDs along with state and federal partners were also responsible for helping trace and identify the source of the parasite back to prepackaged salad mix. Local health departments continued to conduct investigations and interviews today with suspected patients.

The takeaway of these events is that preparedness is not a static process but, yet a process that requires ongoing planning, training, and exercises, and the sustainment of capabilities to protect the nation's health and welfare. Preparedness happens before an event occurs, not during. A local fire department does not sit back and wait for a fire and then decide to out and buy a fire truck to respond to that fire. When you think about it, though, that's exactly what we do during a disaster. Think back to the big bolus of federal funds that went out the door after 9/11, Hurricane Katrina, H1N1, and more recently, Super Storm Sandy. Investments in public health preparedness need to be made in advance if we expect a successful response. With that said, the preparedness capabilities of local health departments today that they have used to respond exist because of the investment of dollars, the investment of time and resources, personnel, provided at all

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levels of government, local, state, tribal, territorial, and federal, as well as those from the nonprofit and private sectors. However, as critical public health programs, including those in preparedness are caught, the ability to sustain, the capabilities and capacities for local health department response, diminishes.

Let's look a little bit at how local health departments support their public health missions including public health preparedness. This chart illustrates the funding sources for local health departments. You can see that federal funding makes up about 20-percent of the health department's overall budget, the remainder coming from fee for service, state and local tax assessment, or other funding mechanisms. However, almost 60-percent of local health departments rely exclusively on federal funding to support their preparedness activities. Four of the nation's largest cities receive direct federal funding from public health preparedness through the CDC Public Health Emergency Preparedness Grant Program and ASPRS Hospital Preparedness Program while the rest of the local health departments rely on an allocation of these grants past through the state health department. It's also important to point out that FEMA's Emergency Management Grant Program is separate from those previously mentioned public health grant programs, but it's not duplicative. This program ensures that our first

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responder agencies, police, fire, EMS, have the resources they need to respond to disasters large and small.

The takeaway message here is, when any federal grant program is cut, it has significant, and sometimes dangerous impacts on the programs that rely on those funds. In fact, a survey conducted by NACCHO in the latter part of 2011 found that almost 60-percent of health departments cut or eliminated one public health program area as a result of federal funding cuts. In that same year, almost a quarter of the local health departments had to reduce or eliminate their preparedness programs because of these funding cuts.

I'm quickly out of time, but this next slide shows that since 2008 we've lost almost 44,000 jobs in the local public health work force and that those jobs represent real activities in local health departments. These are the people who are there to prepare for disaster, respond to disaster, conduct immunization clinics, and would, potentially, be used in the event that that community needed to distribute and dispense life-saving medical counter measures in the aftermath of a disaster.

Dr. Khan has talked about the significant cuts that have been seen in public health emergency preparedness funding, the CDC FEB Grant, and the Hospital Preparedness Grant. The Hospital Preparedness Grant is in further jeopardy as the

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President and the Senate have proposed 114 million dollar cut in fiscal year 14. Remember, those HPP funds largely support public health departments, hospitals, and healthcare coalitions to prepare and plan for disaster.

Just to draw your attention, again, these cuts have created significant and real impacts on local health departments, as I've been mentioning, and this slide talks about health departments in Wisconsin; and Kentucky; and Fredrick County, Maryland; who have had to either shutter their immunization clinics or layoff staff who largely would be the people that they would rely on to either prepare and create their plans for disasters, or actually respond to disasters.

Finally, our takeaways and recommendations; undoubtedly, the US public health system is more secure than it was prior to the events of September 11th and anthrax attacks because the federal government and the public's taxes have supported critical public health preparedness programs. We built a strong and vibrant national preparedness capability that begins and ends at the local level, and we need to sustain those investments. The local public health community acknowledges the need for science-based measures to prove our capabilities and show a return on the investment to Congress and the people. Some can say that successful responses to some of the events I talked about is witnessed to and returned on

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such investments. We have to remember that a state of preparedness is not an end state, it's a process. Every cut in preparedness funding has tangible and real-life consequences for your constituents and the communities you serve. The support of training and exercising through the public health grant programs I mentioned keep communities agile for response and resilient through the recovery. Investment in LHDs provides the staff and services necessary to support long-term recovery and the continued support and investment in the development of critical public health capabilities and capacity at the local, state, regional levels, ultimately, builds us a nation prepared and protected.

ED HOWARD: Thank you very much, Jack. Let me just ask one question to clarify something. If you get back to Jack's slide on the job losses over time, your note talked about 4,300 jobs being lost—

JACK HERRMANN: 43,000.

ED HOWARD: I'm sorry, in 2012.

JACK HERRMANN: Oh, 2012, yes.

ED HOWARD: But also 4,000 positions being created so that there was a small net loss, is the 43,900 a net loss?

JACK HERRMANN: As you can see, that 43,900 represents real people in positions that were identified in public health to provide public health services in local health departments.

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Even though the figure for 2012 may look promising and bright, that doesn't account for the impact, sequestration will have on those jobs and positions in health departments.

ED HOWARD: Okay good, thank you. Now we get to the point where you can join the dialog if you would like. As I mentioned, there are microphones to which you can come to ask a question in person, in which case we would ask you to identify yourself and keep the question as brief as you possibly can. There are also green question cards in your packets. You can write the question out, if you hold it up, someone from the staff will snatch it from your fingers and bring it forward. I would also encourage the members of the panel and, of course, Dr. Lumpkin, our co-moderator, to join in at any point in this dialog that you feel the need to. So, you sir, have the first question in this sequence.

AL MILLIKAN: Thank you, Al Millikan, AM Media; in recent months, have there been any changes, additions, new partnerships, taking place with volunteers, particularly those affiliated with religious communities?

JACK HERRMANN: Can I address that?

ED HOWARD: Please.

JACK HERRMANN: Working with faith-based organizations and other organizations in a community has long been the practice in local health departments. They recognize they

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can't do it alone. For many years there have been efforts and attempts to link with a variety of partners including faith-based organizations. As you look across the country they are reaching into those organizations to populate medical reserve corps, Red Cross teams, disaster, mental health teams, so I would say that it is common practice to reach into those organizations and ensure that they're there. Those communities are there to be able to help out during disaster.

AL MILLIKAN: In any way are they replacing any of the lost jobs, professionals?

JACK HERRMANN: It's a touchy subject. There are some positions in health departments, staff positions in health departments that just because of HR, the law, can't necessarily use volunteers, but I have to tell you in speaking directly with health departments, because of the attrition that they've seen over these years, they've had to rely on medical reserve corps and other volunteer assets in their community to conduct preparedness outreach campaigns to go out and do staff health fairs, things like that on behalf of the health department.

JOHN R. LUMPKIN: To put this into a little bit of a perspective, one of the things that has impressed me at the disaster sites that I've seen is the role of volunteers. The American Red Cross, for instance, is the one organization that

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is slated by Congress to be actively participating in disasters, but when I went down to some of the relief efforts related to Katrina, it was the Southern Baptists who were serving the meals and they do that all up and down the east coast and west coast and in the recovery period the Mennonites have an incredible system of helping people put their homes back together.

One of the cuts that happened and one our staff who came to the foundation came from a health department in New Hampshire. They laid off the staff who was involved in doing contact tracing for sexually transmitted diseases, which would include HIV, so if that outbreak that happened in Texas had occurred in New Hampshire they wouldn't have had the staff. That's not something that volunteers can do. It takes training in public health. What happens is when those individuals get laid off, this happened to me in my agency when I was back in Illinois, when they laid off they get hired by the private sector. If those jobs are then created, again, or if there's some backfilling, it's very difficult for public health agencies to hire people with those kinds of skills, those public health skills which are very hard to hire. It does create a lasting deficit in the ability of the public health system to respond.

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ED HOWARD: Very good. I have a question for Dr. Khan. You've mentioned the preparedness index that CDC was having put together and I wonder if you could elaborate on what purpose that's going to serve, when it's going to be available, what elements are going to be included.

ALI S. KAHN: Dr. Lumpkin serves as the chair of the governance group of the preparedness index so let me start and then hand it over to John. This is conceived to be a state-by-state comprehensive index of preparedness with over 150 odd measures in healthcare and public health that are publically or pseudo-publically available. The index process is designed to drive preparedness within our communities, provide objective evidence and concrete things, actionable things our communities can do to improve their preparedness, and then to drive the science. We're very big on accountability and we need to really measure preparedness in our communities. We've gotten a lot better over the last couple of years and we want to continue to improve those measures of preparedness. This is an effort that's being shepherded by the Association of State and Territorial Health Departments and Dr. Lumpkin, as I said, serves as our chair of that governance group, since this is many partners coming together it is not CDC alone. John, would you like to take over [interposing]?

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JOHN R. LUMPKIN: Yes, let me also say that one of the reasons why this index, and it was the process that has been initiated by the Centers for Disease Control and Prevention as well as for the Association of State and Territorial Health Officials, and our foundation is happy to have had an opportunity to participate in that process, is that states believe that preparedness is, actually, part of their charge also, but it's really challenging to figure out where are you going to spend your next dollar if you're going to increase preparedness? How do you know whether or not what you've done has increased preparedness, and if you are trying to do work how do you do quality improvement within preparedness? This index is designed to be initiated by the CDC, but not part of the process of reviewing grants and that's a critical component. It's not to review how well the state is doing on the grant from the CDC or the grant from the office of the Assistant Secretary for Preparedness and Response, it is a tool for states to use working with local communities, local health departments to assess their level of preparedness, and to use it as planning and quality improvement. The first numbers will be coming out in October. It will not be designed to rank or compare states. Again, it's going to be able to help them measure an initial one, and then over time, how their work and preparedness is progressing.

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ED HOWARD: Terrific, yes ma'am.

ELE HOM: Hi, my question is for Mrs. Prats.

ED HOWARD: Would you identify yourself?

ELE HOM: Sure, my name is Ele Hom. I'm a reporter with CQ. You touched a little bit on issues with the Stafford Act. Can you just elaborate a little bit more, particularly on the issue of reimbursements?

ROSANNE PRATS: The Stafford Act is whenever there's a natural disaster you'll have the Stafford Act kick in which is pretty much the FEMA rules for what gets reimbursed or what does not get reimbursed. Usually you'll have that reimbursement flow versus non-Stafford Act issues which are more of you have a company at fault. Let's say like the BP oil spill then they would say BP has to make it whole so they would be the company that would pay for damages. I'm not trying to really compare them but there usually has to be a funding stream so that you can get various things reimbursed.

ELE HOM: Was that an issue with Hurricane Katrina at all, the reimbursement?

ROSANNE PRATS: Yes ma'am.

ELE HOM: Okay, thank you.

ED HOWARD: John.

JOHN R. LUMPKIN: Yes, if I could just add, there are some things, and it's worth looking at the Stafford Act. The

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Stafford Act says that the federal government only pays for bringing a, whether it's a hospital or it's a community, back to where it was before the incident occurred. That is understandable because if you've got a house and you have a 20-year-old furnace, you don't want the Stafford Act to be replacing the furnace, and the windows, and the roof, if they're not damaged. One of the peculiarities are is that if you'll remember from Super Storm Sandy the NYU hospital closed down in lower Manhattan. It closed down because when the storm came they had moved their generators up to the higher floors but they had kept the fuel down at the lower floors because it was a little bit safer. When the water flooded the sensors recognized that as being, perhaps, a fuel spill and it cut off the generators and they lost power. The generators were operating, now they're going to rebuild it, the Stafford Act would not provide resources when they rebuilt the hospital to move the fuel from the basement up to the higher floors. There are some, I think, instances where there needs to be a little bit more common sense in some of the provisions because, sometimes, it is very hard set and the way the policy was developed is very clear to understand but sometimes there are unintended consequences.

ROSANNE PRATS: Dr. Lumpkin's very right, and there's other subtleties to it too when it comes to patient care. If

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you are a hospital and you just absorbed all these people that started to evacuate to shelter, so they don't meet admit criteria. If they met admit criteria then they'd get Medicare, Medicaid, third party reimbursement, but anything else, if you were just sheltering, the hospital could not claim any of those costs through the Stafford Act, in fact there's no other means for them to claim any of those sheltering costs. I'm not sure HHS has that money and we have reports, anecdotal, at this point, no full study as to if hospitals will continue to shelter and surge. We know that their operational costs go up through the roof 50-percent. If you have a neurosurgeon today you can pay them during normal business, but during a storm they're going to start decompressing their facilities, they might start helping with the sheltering operation, but the hospital still has to pay those operating costs and there's nowhere to claim some of those costs. If you just take it from a storm environment, that's like three to five days. You might lose some funds, but what happens if you have a pandemic flu, for instance, and you're out months, five weeks to months, what happens to those types of surge costs? I'm not sure that there's really a solution for the public health issues that might come up related to surging.

ED HOWARD: Yes, go right ahead.

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ALVENIA MCQUEEN: Hello, my name is Alvenia McQueen and I'm with the Senate committee on Small Business and Entrepreneurship with Senator Mary Landrieu as the chair and my question is particularly to Mr. Herrmann, but also to either of the panelists, and that is: what kind of preparedness techniques or preparedness are you getting ready for when it comes to small businesses because as we know, a lot of times people are at work when these disasters occur, so what's happening in terms of keeping employees safe or even when, from an actual disaster, but even if something were to occur at the workplace?

JACK HERRMANN: That's a great question and the quick answer is not enough, but what local health departments are doing are finding ways to partner with businesses, small and large in their community to help them understand how to develop a continuity of operations plan so that in the face of disaster they'll be able to take care of their employees and be able to carry out business which is important to the economy of those communities and you raise issues like what would happen in a disaster like a flu pandemic where many of these individuals may have to be out of work because they're sick or they're taking care of sick family members and that business has to be shut down, and in small communities all business is vital and so those are the types of issues that health departments bring

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to the table with businesses to help them work through how is your business and how are your employees prepared to handle a disaster if it strikes them.

ED HOWARD: Dr. Khan.

ALI S. KAHN: That's a really thoughtful question. I've heard a figure bandied around that over 40-percent of small business close after disaster so clearly this is a real impact on small businesses. You heard about some of the efforts at the local and state health department. There're other national efforts and actually FEMA does a lot of work as part of the critical infrastructure work to try to help business think about continuity of operations; how do they protect their workers. It's important, I think always try to mention prevention in this theme which is supply chains, there's all sorts of other elements and if we can try to understand what's going on in communities quickly about outbreaks, then they'll be information available to businesses for them to understand what is the impact on their business. I spent two, three months in Singapore helping them respond to the SARS outbreak. Some of you may know Cathay Pacific; large airline almost went out business because nobody wanted to go to Southeast Asia anymore. There are global impacts of these outbreaks and significant economic impact.

GEORGES C. BENJAMIN: Let me add one other thing.

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ED HOWARD: Yes, Georges.

GEORGES C. BENJAMIN: Let me also add, think of small community providers as small businesses. As we often are very much concerned about the hospitals, but the truth of the matter is that while they're challenged, any time these big disasters occur all the small community-based providers have all the same challenges. They lose infrastructure. The healthcare capacity for this nation is really in the outpatient setting not the hospitals. That's a big capacity that we lose and that's particularly true for people who are in vulnerable populations, substance abuse, mental health providers, and primary care providers.

ED HOWARD: If I can, we've got a question that relates to the supply chain that Dr. Khan was talking about, but it does get us back to hospitals. Give us your thoughts, the questioner asks, on the vulnerabilities that hospitals have in relying on offsite providers of support services such as linens, and gowns, and waste disposals, other items that keep a hospital running in a time of a pandemic or a natural disaster and if it's a problem, what in the world could you do about it?

GEORGES C. BENJAMIN: It's a planning issue for communities. One of the things that we were doing literally right before 9/11 was looking at that exact question, the supply chains in the state of Maryland, and what we discovered

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was every hospital had a wonderful plan and they all relied on the same provider to provide those resources. What's happened is in many communities as EMS planners are looking at that they're challenging the supply chain to make sure that there are both back up suppliers so there's redundancy in the system working with hospitals and hospital associations and I know that's an issue for the Assistant Secretary for Preparedness and they are very much aware of that as an issue that needs to be continued to be resolved.

JOHN R. LUMPKIN: And that really ties into a comment that Jack and a number of the other speakers made which is that preparedness is not a destination it's a journey. Every time you do a disaster drill and you work through that you begin to ask questions and you solve problems and then when you drill again you find other problems. The first disaster drill I ever worked for was when I was at the University of Chicago in the emergency department and we'd scheduled a drill at 9:00 and we're sitting down in the ER and 9:00 came and went, 9:15 came and went, finally at 9:30 the operator gave us a call in the emergency department to tell us that there was this mock drill. It turns out that the operator was given a call up list and the emergency department was all the way down at the bottom. You wouldn't have known that until you've gone through a drill or gone through a disaster. I'm on the board of a hospital that

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discovered things related to our power supply after Super Storm Sandy so we are having to make changes. This is a process and every time we go through it the system gets better and that's the reason why we say that it's a journey. Hospitals are required to have disaster plans. They're required to train and drill on those on an annual basis at a minimum and through those they're beginning to learn how to deal with issues. When someone says, well what about the linens and what about the other, so I think it really describes the importance of ongoing preparedness.

ED HOWARD: Dr. Khan.

ALI S. KAHN, MD, MPH: I couldn't agree more I think that question really gets to the heart of this issue that you can't do preparedness in isolation. I'm always reminded during certain responses when nursing homes plan to evacuate each other because they hadn't spoken to each other and so essentially they're going to send patients to each other and that was their response plan. I think this really talks to the wonderful work being done by the hospital preparedness plan as they think about hospital coalitions. It talks about the work being done by your local health and state health departments. When they talk about community preparedness, you really have to integrate your plans and look cohesively at what you're doing in your community and I also want to remind you all, you

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individually have a role to play to protect yourself, protect your family, and protect your communities.

ED HOWARD: Yes, if you go back to your slide showing that half of the folks who were surveyed didn't have that kind of a plan, it gives you some sense of the dimensions of that part of the problem. Yes, go right ahead.

DANIELLE: Hi, my name is Danielle, I'm representing an organization called Amplify and towards this idea or piggybacking off this idea of preparedness, my question relates to the exchange of data and receiving data when networks go down in disasters. I am kind of talking about the black box issue. A lot of the exchange of data is reliant upon broadband or towers that may be affected in the scent of an emergency disaster and I was curious about any efforts to go about that to try to eliminate issues that arise from this?

GEORGES C. BENJAMIN: Let me start by saying it would be nice to even have that problem because our biggest problem is still the lack of having all the information in a data system anywhere and building a robust electronic medical records system. When you build that you do have to build the redundancy you talked about. I think that is very important. There's not a proof of concept here. After Katrina, it was very clear that those systems that had electronic medical records that the ability to reconstruct patient's medication

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lists and medical problems and things were enhanced. We did see that, again, lesson learned from Katrina, fast forward to Super Storm Sandy, those hospitals in New York that, again, had a robust system and, of course, New York City's health department has put in place a fairly robust medical records system and they were also able to very rapidly reconstruct that information. It does rely on, not just having the information in one place, but having a robust, hardened, backup system and, maybe, two for that data and a capacity to rapidly reintegrate the networks when they have those disasters and plans to do so.

ED HOWARD: Anybody else? Okay, yes go ahead.

ADE JULIO: thank you, my name's Ade Julio and I'm with an organization called The Secure ID Coalition. My question actually piggybacks very nicely off of your question, when we talk about electronic health records and having data on us that can benefit when and how people are treated in an emergency situation, and I'm reminded of a story out of San Antonio, Texas last year when there was a demonstration at the CDC and the American Medical Association did about having smartcards on people which had some key information on them, like allergic to penicillin, diabetic, which allowed for better treatment, and there was one group that—the first group, I think, was the normal population like we would be now without any information and the second population had the cards that had the

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information on them, secured readers, encrypted and all that stuff so it wasn't dangerous in a regular setting. I just was wondering if you guys had heard about that and what you would think about something like this.

ED HOWARD: Jack.

JACK HERRMANN: Actually I participated in that exercise so I'm very much familiar with it. I think a couple things, anything we can do to better prepare the public to tell us, public health and healthcare, what kinds of medical conditions they have, what kinds of medications they have, other kinds of illnesses that, ultimately, are going to make them vulnerable in the aftermath of disaster, is important information to have, but it's not the only thing and its not a panacea. First, you have to get people to remember to take the card with them when they run out of the house. Then you have to make sure that the sites that they're going to show up in have the ability to read that card. Then the third thing is you have to have the staff that know how to interpret that data and understand that data so that they can protect that patient's health. It is an important mechanism—it could be an important mechanism in saving lives and ensuring that people get the right help when they need it.

ED HOWARD: Jack, was there any resistance to that initiative on the basis of privacy concerns?

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JACK HERRMANN: Interesting, the AMA did a series of surveys and public engagement, while it was an issue that was raised, it wasn't one that was enough to say we can't look at this as an option. Clearly, people will always be concerned about where their private information is going and as we've experienced over the last number of months with releases of information in people wondering how much access the government has information on them too, it will always be a concern, but the overarching message is we need to look at what's in the best interest of the people and, in this case, we know that many people come to shelters during a storm having a number of medical illnesses, many of them only know, well, I take a white pill before I go to bed, I take a purple pill in the morning. They don't know the name and the dosage of their medication. Anything that the public health and healthcare community can have access to, to help them better treat that individual, I think is warranted.

ADE JULIO: Thank you.

ED HOWARD: I've got a question that, maybe, Rosanne can take the initial crack at. In past disasters, many people would not evacuate when told they could not bring their pets with them. What steps are being taken to ensure the safety of animals in future disasters? What do you do about dogs in Louisiana?

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ROSANNE PRATS: Well I think if I die I'd want to come back as a pet because you'd have a lot of stuff you'd be provided and you'd be well taken care of, but that is true. During Katrina there were instances of—people become very attached to their pets and they would either get separated or they could not bring their pet with them. We do have some very robust plans when it comes to enabling of an evacuation; that's both with coach buses and along with the coach buses there are other types of vehicles so that you can put the pet on those vehicles, usually tagging along behind the coach bus.

People have different types of pets. They're not always Fifi, small little dogs. They can be large animals and you have other people on the bus, of course, the people that have vulnerable issues, don't want to have the pets on the bus with them, so you get into all kinds of operational, logistical details when you're trying to organize an evacuation. Of course, not only the big dogs but you've got snakes and some people put the snakes in a bag, call it a Cajun suitcase; you're plastic bag, you stick it in there and something comes crawling out and you might have other people that have gerbils and its not a very good situation.

Yes, we have pet cages; we have the vet community and the volunteer community that truly become very engaged with trying to assist with type of evacuation. We've got not only

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general shelters but we've got pet shelters along with it and then it'll have people that can go visit their pets to help take care of their pet because they know what their pet likes to do or not like to do and they calm down, as well.

While I have your attention, the larger evacuation is not only the human evacuation but is the evacuation of cattle. You would not expect that just in talking with health and medical, but planning alongside your partners—I didn't realize this but every time you have sea water get into the eyes of cattle they go blind. Did you know that? Okay, so I guess I taught you something today. You have an evacuation and we have to EMAC. I don't know if you know that word EMAC, but it's a state-to-state contract of trying to get some assistance from other states. We have to EMAC cowboys and their horses to come down and help with an evacuation of cattle. We have all kinds of evacuation lanes that go on between human movement, pet movement, cattle movement, hospital movement, nursing home movement, and the state is right in the middle of your local communities and all of these needs, and they're just, sometimes, overwhelmed. Again, we're advocating that we do need these grant dollars to help up with planning.

ED HOWARD: Jack, what about the snakes?

JACK HERRMANN: The snakes, I've seen many a snake in my travels. You know we chuckle about this, but really pet

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preparedness is very, very serious. In fact, the reluctance of people to leave their pets does create threats to injury and death. Health departments, as part of their planning criteria have to talk about what they are doing to work with their community in order to prepare for how individuals might evacuate with their pets or what kind of plans they have in the event of disasters in their community. Organizations like the American Red Cross are working with national and local organizations, veterinarians, to increase pet preparedness, and medical reserve corps are even looking for veterinarians and other animal specialists to work alongside other healthcare professionals to be able to respond to pet needs during disasters.

ED HOWARD: Anyone else want to throw in a pet comment? Okay, we've got several questions that people have submitted by card that we'd like to get our panel's response to. As we've seen, this person writes, over the past several years, climatological disasters, natural ones, have been occurring more frequently and with greater severity, often leading to infectious disease outbreaks, and/or technological catastrophes. What steps, if any, are CDC and NATO taking to address the ramifications of climate change, specifically, at the state and local level, which I guess means, Rosanne, if you

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want to chime in on that we'd like to hear that or Georges, as well.

ROSANNE PRATS: I guess, just from, again, an operations standpoint, natural disasters, we have approximately 30 state-declared disasters a year, usually that means a state starts to lean forward and notify all the local, or we call parish, departments to start being ready to respond, whether that be to flooding, tornados, et cetera. So what are we doing? We have a lot of frequent—we call it, we're the live lab. Its no longer just chart a plan, we're actively engaged, we're trying to be in response. We do eat up a lot of funding for that. I guess that's just another plug for, yes, we are seeing that increase of disasters and that is requiring the states and the locals to start ramping up at least 30 times a year.

ED HOWARD: How about nationally?

GEORGES C. BENJAMIN: The American Public Health Association has been working very diligently since about 99 with CDC, ASTLHLO, and NACCHO to do a series of things. Number one, first of all, just brings awareness to public health practitioners; number two, to try to strengthen their skills in helping build capacity in their communities to do two things. Number one, adaption; trying to figure out how to adapt their communities, and to be involved in the mitigation aspects of

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it. What does all that mean? Number one, one of the challenges we have with all of these very severe climate events is one, rebuilding in the same places, not changing the way we're building, not putting up sea walls when they need to be up. One of the lessons learned, I think, from Katrina that we saw and heard John talk about in New York was that hospitals are now moving their generators from the basements is where we used to put them and putting them in other places including on higher floors. You do learn new lessons when you do that and John talked about the fuel lesson. We have a lot of older cities and a lot of the older cities still have wires in the air. Those are very vulnerable to trees falling on them and disrupting power lines.

I think getting public health at the table so that their part of the discussion, we're often thinking about public health being now at the table for hurricanes and tornados, but also think about extreme weather events, things that are too cold, we've seen a lot of extreme weather events when things are getting lots of snow and ice, et cetera, in places that were not designed to get snow and ice. The housing isn't built for very cold weather, the same things happening in places that are getting very hot weather for prolonged periods of time. Those places are much more at risk for heat related injury, particularly when you have prolonged heat, high humidity for

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three or four days. Building those plans so that you can address, educating communities, making sure you have water to drink, identifying where vulnerable populations are so that when the power goes out you can get to those people and get them plugged in to some place that's either cooler, or where they can get their medical needs met, or if they're dependent on electronic equipment for medical equipment or these kinds of things getting them there, all of those are the kinds of things that have to happen, they have a very strong public health role in doing that, but as Jack said, most of this happens at the local, community level, and requires people training skills and expertise to make that happen.

ED HOWARD: We have time for just a few more questions; one from a congressional staffer asks, what's being done to ensure that populations with language barriers are aware of the services that are available during a disaster?

JACK HERRMANN: If I could take that, this is also—we talk about all the important issues that go into disaster preparedness and certainly this is one of those that ranks right up there. When an individual is here and their primary language is not English, it presents a vulnerability for them, especially, in a predominantly English-speaking society where there may not be services to translate those important educational materials and other information into different

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languages that those individuals speak in those communities. Let me call out Seattle, King County, who has done an amazing job with this. They have found a way to work with partners to translate many of their disaster preparedness materials into multiple languages that reflect their community, but they first needed to go out and find out what languages people spoke in those communities and work with the leaders of those communities whether they were religious or, otherwise, to help translate those materials and educate those communities about what they needed to do during times of disaster, what services would be available to them and how they could take care of themselves and protect their family members.

GEORGES C. BENJAMIN: Let me add the Get Ready Campaign that we have at APHA. We've got fact sheets in about 50 languages, so the Get Ready Campaign is very much designed for individuals in the community to get ready and so we're working hard to get everything we have in multiple languages. I can't tell you that everything is in—I don't think we have everything in 50 languages, but we have 50 different languages for the various fact sheets that we have.

ED HOWARD: Let me just ask, as we're dealing with these last questions, that you fill out that blue evaluation form that you'll find in your packets so we can respond to your wishes and your needs in future programs.

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For the panel, the questioner asks that you speak to social media and how state and local health departments are using social media for preparedness and response. Jack, you're our leadoff hitter.

JACK HERRMANN: Alright, social media has just exploded on the disaster preparedness front. I had one of the fortunate opportunities to be in the Red Cross National Headquarters Disaster Operations Center during Hurricane Sandy and part of my job, a volunteer at the time, was to work on monitoring social media and better understanding what were the public health and mental health challenges that individuals were experiencing and writing over social media technology. We were flooded with thousands upon thousands, millions upon millions of tweets and Face book posts, and other things of people talking about the disaster and the experiences they were going through at the time and it was a lesson that, somehow, we have to do better at being able to monitor social media and quickly respond to the needs and expectations of those individuals and communities. It creates quite a demand on public health in an effort to better understand how the community is using social media technology to communicate what their needs are and more importantly an outlet for situational awareness as to what's happening in those communities during times of disaster.

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GEORGES C. BENJAMIN: I can tell you that nationally at APHA our Twitter account—we've got a quarter of a million people on our social media activity. The Twitter account for APHA is @GetReady. When something happens we're always putting out information so that people can begin having a conversation and get information about the event.

ALI S. KAHN: Similarly, at the CDC we've embraced social media for a number of different purposes. Classically, people think of it as a way to share information. We have the third largest government Twitter feed, but it's also a way to listen to our communities. We do monitor social media aggressively and we're about to put out a project that'll be available to our communities called Project Dragon Fire as a way to understand what's going on in their community very quickly and take action based on it and link to other agencies. In today's day and age this is a wonderful way to get targeted information out to our communities.

ED HOWARD: Great, I think we are at the point where I'd like to call on Dr. Lumpkin for a closing remark or two.

JOHN R. LUMPKIN: Thank you, again, to the panel for coming and for all of you for listening and asking really probing and important questions.

I think, perhaps, the most critical takeaway is that if you think about being in a place where you have state or local

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government who's going to be responsible for helping your community recover from a disaster, you don't want those individuals to be exchanging business cards at the site of the disaster, you want to know that they've been talking to each other.

You've also heard that it is equally as important for people to know and think about this because the time to think about a disaster is not when the hurricane is bearing down on your house, you want to think about the escape routes before that. All of that means that these mechanisms need to be in place, they need to be tested, and people need to be reminded. Many years ago back when I was in state government, around many of the nuclear power plants we handed out pills for iodine because if there is a disaster people should take iodine to protect their thyroid. How many of those people know where those pills are today? This process of ongoing preparedness of making the system, reminding people, is what will enable us to have the best outcomes so that the people of this country can, not only survive, but survive in a way that will enable them to quickly recover and return back to their normal ways of life.

ED HOWARD: Great, thank you very much John. Let me just say, A, don't forget about those evaluations, B, I want to call attention to Erin Buchannan [misspelled? 01:39:39] on our staff, who is finishing up an internship at George Washington

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University and who did the bulk of the work on this briefing as an exercise that was both academic and real world. Thank you very much Erin [applause]. Yes, absolutely.

There is something that John Lumpkin can't do and that is to thank the Robert Wood Johnson Foundation for its involvement in the shaping, and the support, and the co-sponsorship of this briefing. Let me reiterate John's thanks to the panelists and ask you to help us thank them for an extremely useful and rich discussion on a very tough topic [applause].

[END RECORDING]

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