

**EMERGENCY PREPAREDNESS:
EVALUATING THE U.S. DEPARTMENT OF
VETERANS AFFAIRS' FOURTH MISSION**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
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**EMERGENCY PREPAREDNESS:
EVALUATING THE U.S. DEPARTMENT OF
VETERANS AFFAIRS' FOURTH MISSION**

WEDNESDAY, JUNE 23, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Adler, and Roe.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning, ladies and gentlemen. The Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, hearing on Emergency Preparedness: Evaluating the U.S. Department of Veterans Affairs' (VA's) Fourth Mission will come to order. This hearing is held on June 23, 2010. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks, and that statements may be entered into the record. Hearing no objection, so ordered.

I would also like to recognize Terry Araman, a veteran from Arizona, who is in attendance today. I want to personally thank Terry for your service and the good work you are doing to help veterans, especially the homeless veterans back home in Phoenix. Would you please stand, Terry? Thank you.

[Applause.]

On September 11, 2001, we witnessed one of the greatest tragedies in American history. Still today we all remember the horrific scenes of these terrorist attacks. Four years later in 2005, the Gulf Coast was hit by one of the biggest natural disasters the region has ever seen as Hurricane Katrina swept through the region, killing thousands and leaving many homeless and displaced. And sadly again, today, we see Gulf States struggling with yet another major disaster as the oil continues to spill.

These types of events highlight the critical need for Federal agencies to proactively prepare to effectively execute their Federal obligation, especially when called upon during emergencies. Today we will evaluate and examine the U.S. Department of Veterans Affairs' emergency management, preparedness security, and law enforcement activities to ensure the Department can perform the mission essential functions under all circumstances across the spectrum of threats, including natural disasters.

With several health care facilities and hundreds of doctors and health care professionals, the VA emergency preparedness posture, also known as the Fourth Mission, must be able to respond when needed and when called upon. The Federal Response Plan (FRP) is an important mechanism for providing coordination of Federal assistance and resources to areas that have been overwhelmed by disaster and emergency situations while supporting the implementation of the Robert Stafford Disaster Relief and Emergency Assistance Act. The VA's Office of Operations Security and Preparedness is responsible for directing and providing oversight for the Department's planning, response, and security programs in support of the FRP.

I am looking forward to hearing from the VA their emergency preparedness plans and how they coordinate and communicate with the other agencies, such as the Federal Emergency Management Agency (FEMA) and the U.S. Department of Health and Human Services (HHS), who are here today, to carry out their Fourth Mission. Every day we are reminded of the potential threats that are out there that may disrupt the American way of life and the freedoms we enjoy each day. The VA must be prepared to respond to these threats and offer their full support and resources to ensure that their role in the Federal Response Plan is integrated with other agencies to execute its mission.

[The prepared statement of Chairman Mitchell appears on p. 29.]

Mr. MITCHELL. Before I recognize the Ranking Republican Member for his remarks I would like to swear in our witnesses. I ask that all witnesses from all three panels if they would please stand and raise their right hand?

[Witnesses sworn.]

Mr. MITCHELL. Thank you. I would now like to recognize Dr. Roe for opening remarks.

OPENING STATEMENT OF DAVID P. ROE

Mr. ROE. Thank you, Mr. Chairman, and thank you for holding this hearing today. Early in this decade, our country faced two major incidents that reinforced the need for emergency preparedness. On September 11, 2001, our country was attacked in a blatant act of terrorism as the World Trade Centers in New York fell and the Pentagon burned. The first responders were called to action and a Nation mourned. Again in 2005, Hurricane Katrina struck the Gulf Coast with an unprecedented fury. People's homes were flooded or ripped apart and major evacuations occurred. The Gulf Coast is still rebuilding today.

Since the attacks of 9/11, the Committee on Veterans' Affairs has held four hearings on the subject of emergency preparedness. The last hearing was held on August 26, 2004. Today we will reexamine the role performed by the Department of Veterans Affairs in emergency preparedness and its response to national crises, whether the role continues to need serious upgrading or updating and reform.

In particular we will focus on the VA's role during wartime, natural disasters, or major terrorist attacks on U.S. soil. While FEMA and the Department of Health and Human Services tend to take the lead role when an emergency occurs, one cannot deny the large importance of emergency preparedness at the VA. With 153 hos-

pitals and hundreds of outpatient clinics spread across the country, VA stands in a unique position to provide emergency medical assistance in the event of an emergency.

VA has defined roles currently in both the National Disaster Medical System (NDMS) and the National Response Framework (NRF) in the event of national emergencies. Among the specialized duties of the VA are conducting and evaluating disaster and terrorist attack simulation exercises; managing the Nation's stockpile of pharmaceuticals for biological and chemical toxins; maintaining a rapid response team for radiological events; and training public and private National Disaster Medical Systems, medical center personnel in responding to biological, chemical, or radiological events. Among the emergency support functions (ESF) assigned to VA, which relate directly to the mission of the VA, are ESF 6, which includes mass care, emergency assistance, housing and human services; and ESF 8, which includes public health and medical services.

I am interested in discovering today what VA has learned from the events of 9/11, Katrina, and Hurricane Isabel, and how their roles relate to the overall emergency response mechanisms.

Following Hurricane Katrina in September of 2005, the Speaker of the House called together a Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina. The report, "A Failure of Initiative," was issued on February 15, 2006. I understand that Ranking Member Buyer was selected as a part of that Committee and worked on the report, and one of our own Subcommittee staff, Mr. Wu, was detailed to work on the Bipartisan Investigative Committee. I expect that we will hear from the Department that improvements have been made following this report as well as on recommendations made by the report from the Office of Inspector General (OIG) issued in January of 2006.

I am also curious as to what the VA commitment is to emergency management with both dollars and manpower.

And again, Mr. Chairman, I appreciate your holding this important meeting. And it is my hope that there will be good news, this will be a good news hearing that the VA is much better prepared to handle emergencies that come in the future.

And just as a point, both the Chairman and myself have been Mayors of our respective cities at home. And after 9/11 as the local City Commissioner and as a physician, and having a VA in our community, we were assigned, or really I assigned myself, to really evaluate local preparedness. And it was woefully inadequate, I found out. Whether it be smallpox, when I got myself immunized, whether it be H1N1, I know on a local level, where the boots hit the ground, we have made huge strides in being able to meet these needs. And I look forward today, Mr. Chairman, I know you have dealt with this as the Mayor of Tempe, and I look forward to hearing the testimony.

[The prepared statement of Congressman Roe appears on p. 29.]

Mr. MITCHELL. Thank you, Dr. Roe. At this time I would like to welcome Panel One to the witness table. Joining us on our first panel is John Hennigan, President and Chief Executive Officer for bt Marketing; Darrell Henry, Executive Director of the Healthcare Coalition for Emergency Preparedness; Barry Searle, Director of Veterans Affairs and Rehabilitation Commission for the American

Legion; and Neal Denton, Senior Vice President for Government Relations and Strategic Partnerships of the American Red Cross. And I ask that all witnesses please stay within the 5 minutes of their opening remarks, and your complete statements will be made part of the record.

First, I would like to recognize Mr. Hennigan.

STATEMENTS OF JOHN N. HENNIGAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, BT MARKETING, THE WOODLANDS, TX; DARRELL HENRY, EXECUTIVE DIRECTOR, HEALTHCARE COALITION FOR EMERGENCY PREPAREDNESS, WASHINGTON, DC; BARRY A. SEARLE, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND NEAL DENTON, SENIOR VICE PRESIDENT, GOVERNMENT RELATIONS AND STRATEGIC PARTNERSHIPS, AMERICAN RED CROSS, WASHINGTON, DC

STATEMENT OF JOHN N. HENNIGAN

Mr. HENNIGAN. Thank you, Mr. Chairman. Chairman Mitchell and Members of the Subcommittee, I would like to thank you for the opportunity to come here today as a citizen who has been involved with not just the medical industry here and abroad, but as an elected official in Montgomery County, Texas.

I have been fortunate enough to travel extensively throughout South America, Europe, and here in the States in the health care arena. I have witnessed firsthand the differences between government facilities and those in the private sector, and can state without question the improvements I have seen in the VA facilities. A perfect example is the Michael E. DeBakey VA Medical Center (VAMC) in Houston, Texas. Prior to this health care system being built, in my opinion, our facilities were old and less than adequate for the veterans in our area.

Before going into my testimony I would like to give this Subcommittee a brief background of myself for you to have a better understanding of why I feel privileged to be able to speak to the future needs of our veterans, and to offer a fresh pair of eyes to emergency preparedness and planning within the VA Department going forward.

I mentioned earlier that I am an elected official in Montgomery County, Texas. I am a board member of the Montgomery County Hospital District (MCHD) and have been since 2006. I am currently serving as Vice Chair of this Board for my third consecutive year and in addition Chair our Legislative Committee. The Montgomery County Hospital District is the sole provider of emergency ambulance service for Montgomery County, Texas, serving a rapidly growing population of 460,000 residents. MCHD responds to 42,000 calls for service each year.

The Montgomery County Hospital District serves a pivotal role during disaster response. The agency and staff have taken a lead role in developing the tools to coordinate emergency medical service (EMS) mass response for coastal community evacuation and post-landfall response. MCHD's dispatch center was the coordination point for the mass EMS response into East Texas following Hurricane Rita. The lessons learned from that incident contributed

greatly to the statewide success during Hurricane Ike, the largest EMS deployment in United States history.

MCHD coordinates public health preparedness and medical branch operations in Montgomery County during large-scale operations, including the 2009 H1N1. Currently, MCHD is coordinating a regional effort to develop EMS mass response to no-notice catastrophic situations as part of the Regional Catastrophic Planning Grant program. Our Hospital District Chief Executive Officer serves as the Chairman of the Southeast Texas Regional Advisory Council. This organization is the grant recipient and administrative entity overseeing hospital preparedness using funding for the nine counties of the Houston region.

Mr. Chairman, Subcommittee Members, my company has been involved with several startup organizations or corporations that are attempting to rise to another level. These companies have asked me to come in and assess current status, where they have been, and set goals to achieve where they would like to get. Through this process I have had clients who have benefited by programs that were well intended but lacked long-range planning. The reason I am here today is that I believe that I can plant the seed for new ideas in the hope that this Committee, and our Veterans Affairs Department, can nurture those ideas to benefit our veterans.

And finally, I want to once again thank you for this opportunity to testify before this Subcommittee.

[The prepared statement of Mr. Hennigan appears on p. 30.]

Mr. MITCHELL. Thank you very much. Next, Mr. Henry.

STATEMENT OF DARRELL HENRY

Mr. HENRY. Thank you for inviting us to testify today. Natural disasters such as earthquakes, hurricanes, and floods are often frequent reminders that we must be prepared when disaster strikes. And since 2001 the Nation has understood the importance of planning for acts of aggression against innocent citizens. The Healthcare Coalition for Emergency Preparedness was formed in an effort to raise awareness and educate people about often overlooked issues in plans to maintain health care facility operations during a crisis, and to develop efficient methods to reduce health care costs in that area. One of the largest hindrances to what we call operational security revolves around transportation constraints to the hospital itself, or such impacts on key suppliers and vendors.

While we address a lot of issues in our full testimony today I would like to focus on one of the issues we have found often overlooked in operational sustainable planning, and that is adequate attention relating to the safe disposal of regulated medical waste, also known as infectious waste.

Until the mid-1990s, most health care facilities incinerated materials onsite, but the Federal Government banned that practice. The current practice for most health care facilities is to manage infectious and contagious waste by transporting such materials over our Nation's highways, through our cities and neighborhoods, by non-clinical commercial truckdrivers to a regional facility to be treated and disposed of. Under a widespread community emergency, facilities would be inundated and supply management would be stressed.

The Joint Commission requires health care facilities to be self-sufficient for 96 hours. However, the volume of hazardous medical waste would dramatically increase when there is a surge on a hospital's capacity due to a large population suddenly contracting a contagious disease, such as in a pandemic, or a natural, or man-made disaster. In addition, the U.S. Government Accountability Office (GAO) and other reports have warned that waste disposal would be near impossible for quarantined or isolated health care facilities that have outsourced the responsibility of sterilizing contagious materials.

Because the primary method of controlling the spread of infection and avoiding pandemic is quarantining, the developing of an onsite approach to waste disposal appears to be the most appropriate one. Further, various reports by health officials and other experts have recognized that onsite medical waste treatment is the best practice for emergency preparedness and pandemic response.

Taking an onsite sustainability approach not only helps address a hospital's ability to handle a crisis, but also issues with offsite providers that would occur in the case of a pandemic or crisis. Vendor problems, including transportation constraints and staff shortages, would be out of control of a health care facility. Fortunately, modern, affordable technologies exist that can cleanly, safely, and economically sterilize infectious and contagious medical waste on the premises of health care facilities.

We would also like to point out that installing onsite waste sterilization equipment at VA facilities would provide ancillary and immediate benefits for the VA beyond emergency preparedness, including cost savings and carbon emission reductions. Expenditures for onsite treatment of infectious waste is perhaps the only preparedness tool that would pay for itself from the day of installation as this equipment often produces a return on investment, a payback between 18 and 36 months.

We estimate that onsite treatment using sterilization equipment can produce an average cost savings of \$1.6 million per hospital, which would equate to about \$190 million if installed at all 117 VA Medical Center hospitals that are currently relying on offsite vendors to haul and treat their waste. Further, regarding the VA's ability to comply with Executive Order 13514 to reduce carbon emissions, the Coalition has developed a carbon footprint calculator that can calculate in real numbers the reduction in pounds of CO₂ emissions each year for those facilities that install onsite waste processing.

We have constructively urged that onsite sterilization capabilities be added to the VA's list of best standards and practices, as well as to the list of mission critical components in their emergency plan. Currently, 24 VA facilities process their waste onsite. We know that many facilities would like to add this component to their capital budgets but thus far have not done so. We do know that there are groups within the VA that are looking at this very issue and recognize that onsite medical waste treatment could benefit VA facilities from an everyday operational aspect as well as emergency preparedness.

Our Nation remains vulnerable in the area of contagious waste management during a pandemic or crisis. We have produced alter-

natives that should be a best practice for emergency preparedness and facility operations at the VA. Again, thank you for the opportunity and I look forward to your questions.

[The prepared statement of Mr. Henry appears on p. 32.]

Mr. MITCHELL. Thank you, Mr. Henry. Next, Mr. Searle.

STATEMENT OF BARRY A. SEARLE

Mr. SEARLE. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to present the views of the American Legion concerning this extremely important, but sometimes neglected topic. The American Legion applauds the foresight of this Subcommittee in bringing this topic back to a place of importance.

As was seen during Hurricane Katrina, the flooding in Oklahoma City and Nashville this year, as well as Iowa, and the Dakotas last year, and tornadoes across the U.S., a natural disaster is only days, hours, or minutes away. Additionally, a weapon of mass destruction can turn an urban area into a mass casualty area, crippling communications and overwhelming traditional emergency services. Prior planning and coordination are the difference between managing a disaster effectively and adding to the chaos and suffering.

The Department of Veterans Affairs has developed policies and has given guidance concerning emergency preparedness. There is no question that the VA Central Office understands and accepts its responsibility to prepare for and execute its Fourth Mission, support of national emergency preparedness. While the American Legion applauds VA for its approach to preparedness, we are concerned that there may be a lack of oversight and feedback at the regional office, Veterans Integrated Service Network (VISN), and facility levels. The American Legion is concerned that preparedness may be overshadowed by primary day-to-day operations. This would potentially lead to confusion and delay in a disaster situation in an attempt to organize a response.

A January 2006 OIG report on emergency preparedness in Veterans Health Administration (VHA) facilities stated that at the national level VHA has developed comprehensive initiatives and directives to address emergency preparedness training, community participation, and decontamination activities. However, at the facility level, VA employees do not consistently receive emergency preparedness training and emergency plans do not always include some critical training elements as required.

VA's Emergency Management Strategic Healthcare Group has as part of its mission statement an approach that, "assures the execution of VA's Fourth Mission, to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans as well as to support national, State, and local emergency management, public health, safety, and homeland security efforts."

VA's 2009 Emergency Management Guidebook, a well-organized framework identifying duties and responsibilities, goes into great detail concerning training to include sample scenarios, which cover a wide range of incidents including hurricanes, earthquakes, multiple bus accidents involving numerous injuries. What we were not able to determine is a feedback mechanism to confirm implementa-

tion at the regional office, VISN, or facility level. The American Legion's System Worth Saving Task Force annually conducts site visits at VA Medical Centers nationwide to assess the quality and timeliness of VA health care. We have found there is a wide range of actual response preparedness across VHA. We believe that this range is symptomatic of the decentralized nature of VA.

The American Legion and other veterans service organizations have been briefed on 38-foot vans primarily tasked with providing veterans counseling outreach, but specifically designed and adapted for medical purposes during disaster relief efforts. In particular, each has satellite communications capability critical in a disaster situation. This is an excellent program that shows how a specific component can be utilized to fulfill multiple roles when the demand exists. During 2009, massive flooding which overwhelmed portions of the Midwest, in Fargo, North Dakota, where regular VA Medical Center operations were impacted by the flooding, VA dispatched three mobile Vet Centers for use as triage clinics to help bridge the gap for the community until regular operations could be restored. However, during recent discussions with a group of facilities directors it was found that some had no knowledge of the mobile clinics' existence. Such a valuable resource must be a part of an ingrained knowledge of any facility director or the value of these tools will be lost.

Also, the Atlanta Medical Center coordinated with and utilized staff members at local hospitals to provide medical services for individuals injured in the Haitian earthquake under National Management Disaster Assistance Program. Unfortunately, we have also found that at the local level there is in some cases a lack of awareness of the responsibility of facilities to prepare for non-veteran casualty assistance. Additionally, it was discovered that turnover and shortage of personnel at most facilities require emphasis on standardized procedures, quality review, and individual training, as well as documentation of that training.

Emphasis on rural health care clinics and telehealth in order to assist veterans will continue to expand the VA's outreach and disburse critical assets and make them available in the case of an emergency. As was shown during the flooding in Fargo, North Dakota, should a VAMC's operation be degraded due to natural disaster, a relatively close rural clinic or clinics with functional telecommunications could be developed as a staging area for direct resources and to some degree triage areas for evacuating casualties until the VAMC could resume full operation.

In conclusion, the American Legion realizes the importance of VA's Fourth Mission, not only to the veterans that the VA serves but to the Nation as a whole. In our resolution in 2008 we urged the Secretary of Veterans Affairs to take an active role in development and implementation of plans to enhance Federal homeland security initiatives, and that Congress provide VA with the funding necessary to further enhance its capability to act as a backup to the U.S. Department of Defense (DoD) and FEMA. We believe that at the national level VA is serious in this mission. However, we feel that additional followup and reporting on activities on the local level is essential to ensure that Central Office policies actually are being executed.

Thank you again for the opportunity to provide insight and analysis on this issue on behalf of the American Legion and its more than 2.5 million members.

[The prepared statement of Mr. Searle appears on p. 37.]

Mr. MITCHELL. Thank you, Mr. Searle. Mr. Denton.

STATEMENT OF NEAL DENTON

Mr. DENTON. Good morning, Chairman Mitchell, Dr. Roe, Mr. Adler, thank you for your attention to emergency preparedness today. Your timing is impeccable. This is a critical time of the year, as the Red Cross is currently responding to tornadoes, floods, and wildfires. At the same time we are preparing for what looks to be a very active hurricane season. I am going to highlight three points in my written testimony that speak a little bit to the partnership between the Red Cross, the Department of Veterans Affairs, and others here in this room when it comes to disaster response.

You are familiar with our mission to provide relief and help communities prevent, prepare for and respond to emergencies. What you may not know is that we meet our mission through a national network of nearly 700 chapters that respond to around 70,000 disasters annually. That is about 200 disasters every day. The Red Cross also provides support to members of the military, veterans, and their families, and supplies nearly half of the Nation's blood supply, and teaches life-saving skills in communities across the country.

The Red Cross is a charitable organization, not a government agency. We depend on volunteers, and the generosity of the American public to perform our mission, including donations of time, of money, and of blood. Whether it is a hurricane, or a heart attack, a call for blood, or a call for help, the American Red Cross is there. And that is my first point. Trained and experienced Red Cross volunteers and staff in your hometowns are on the front lines when emergencies occur in their communities. Our national system supplements the local chapter presence with staff or additional resources whenever necessary.

My second point speaks to the importance of strong partnerships. Identifying new partners and strengthening existing partnerships is a key priority for our organization. We strive to be an effective leader and valuable partner before, during, and after a disaster strikes. In recent years, we focused more of our resources on coordinating and strengthening key relationships with our Federal partners like the VA and FEMA. With support from FEMA, we have full time Red Cross employees to staff each of the FEMA regional offices, the National Disaster Housing Task Force, and FEMA headquarters. In a disaster response capacity, the American Red Cross sits at the same table with the VA during planning and exercises and operations. We both serve as a support agency for the National Response Framework, and work closely together on ESF 6, providing technical support for mass care, emergency assistance, housing, and human services.

The VA and the Red Cross also are collaborating with the DoD, HHS, and FEMA as we develop a more reliable patient and evacuee tracking system. The Red Cross is also excited about a possible opportunity with the VA to address the challenges of caring for

loved ones who suffer from chronic illness or temporary or permanent disabilities. Red Cross Family Caregiving and Nursing Assistant programs help develop skills in personal care, nutrition, home safety, and legal and financial issues. Training builds confidence and instills knowledge that a caregiver will need when providing support to a veteran.

Our partner outreach extends beyond traditional disaster response agencies. We are committing to fostering a culture of collaboration, diversity, and inclusion in all of our partnering efforts. We continue to rely on a list of longstanding partners in a disaster, such as Southern Baptist Disaster Relief, Salvation Army, Catholic Charities, Hope Worldwide, the National Association for the Advancement of Colored People (NAACP), the National Council of La Raza, Legal Services Corporation, the National Baptist Convention, National Disabilities Rights Network, Save the Children, Tzu Chi Buddhist Foundation, and on and on. These groups provide invaluable expertise and together, as partners, we continue to strengthen the country's capacity to better meet the needs of the diverse communities we serve.

My last point, and perhaps the most important point, is encouraging community and citizen preparedness. Last summer the American Red Cross Emergency Preparedness Survey indicated that half of Americans have experienced at least one significant emergency where they have lost utilities for 3 days, they could not return home, they were unable to communicate with family members, or had to provide first aid to others. Although 89 percent of those surveyed believe it is important to be prepared, far fewer are actually ready for an emergency. Families need to gather together at the dinner table to make an emergency communication plan and identify a meeting place should they become separated during a disaster.

To help military families prepare for emergencies, the American Red Cross, FEMA, ready.gov, and others co-hosted the military family preparedness event held recently at Fort Belvoir, June 5th. Together, we distributed some 1,500 preparedness kits to active duty, retired, Reserve soldiers and their families in the parking lot at the Post Exchange (PX). This September, as part of the National Preparedness Month, we are planning to conduct similar events at three military installations across the U.S. and two locations overseas in order to raise awareness of being prepared and to help families prepare for emergencies. It is a promising start but there is still much more we can do.

In conclusion, as we enter this 2010 hurricane season we are pleased to be working with FEMA's strong leadership team with Administrator Fugate and the leadership in the executive branch. The Red Cross stands ready to help those in need. We are working hard to improve our efficiencies and to increase individual community preparedness. Thank you for allowing us to be here today. I look forward to any questions you may have.

[The prepared statement of Mr. Denton appears on p. 40.]

Mr. MITCHELL. Thank you. I have a question for anybody who would like to answer this. In reviewing the National Response Plan there is a myriad of Federal resources called upon in response to

a crisis. How do we determine if the agencies will be able to work together? Yes, just go ahead.

Mr. HENNIGAN. Thank you, Mr. Chairman. I can speak from experience in Montgomery County when we had Ike occur. We first had Rita hit the Gulf Coast and it was truly total confusion. And what we found, contra lanes in the freeway to try to evacuate people on the Gulf Coast, was a disaster. It was done too late. Communications between EMS, fire stations, police, sheriff, State police, were inappropriate.

Since that time, prior to Ike, we all went on the same frequencies. We developed a program where contra flow of lanes was done well in advance versus a 24-hour mandate, get out of town. So I think a lot of it is can the communities, in this case with the VA, can the community officials communicate to the VAs and vice-versa on the same frequencies? Whether it is radio, whether there is a set plan or one organization that coordinates all the different entities as we are doing in Montgomery County right now, can that happen? And when that happens, it just makes life a lot easier for everybody because you only have one source to go to and they will do the, they will delegate the appropriate things to do.

Mr. MITCHELL. You know, there is again a myriad of agencies involved in all of the emergency preparedness. And again, let me just ask others, how do we determine if these agencies are able to work together? Sometimes I think there is a miscommunication of who has what role to play. How can we determine that?

Mr. SEARLE. Well sir, as far as the DoD/VA interaction, one of the things that we see that is very positive is on a day-to-day basis now in the attempt to develop the lifetime virtual records. It has established communications between DoD, VA, and the public sector, actually, as far as transferring public information on veterans. The hope of the American Legion is that that will have started a crack in the dyke, if you will. There is no question that stove piping exists and it has to be broken down through the national framework, response framework. And people have assigned positions, jobs and responsibilities. For example, the American Legion is not telling VA how to do that, but it is reasonable that they would be under the ESR 8 as a support function, that they would not be in a lead function in this case. But there is a framework there for telling people what they should be doing and feeding into it. But I think that VA has taken some serious steps in making a coordination with other entities, be it DoD and civilian doctors, for example, which will eventually help with the system. It is not going to solve the whole thing, but at least it is a starting point.

Mr. DENTON. Mr. Chairman, if you do not mind I would like to say something on this, too. So much of this builds on exercises, the national level exercises that bring groups together for tabletop exercises in advance so that we get to know who the players are and what their capacities are, what it is they are going to bring to the table and what it is that they thought we were going to bring. During these exercises, we discovered, "No, that is actually something we need to resolve somewhere else." So much of this really happens on a local level too.

You know, I mentioned in my testimony the event we just held at Fort Belvoir, where we had a military family preparedness

event. At that parking lot there in the PX, all of the players who would respond to a disaster at Fort Belvoir were there. It was a bright, sunny day and we were handing out preparedness kits. But the other thing that was going on was we were meeting the others in the community who would be responding to a disaster if something were to happen there. Having a chance to talk to each other, connect with each other, and talk a little bit about what our roles and responsibilities are if something were to happen. The more of these that happen on a local level, I think, the more success we are going to have.

Mr. MITCHELL. I just was looking at the Federal Response Plan and the VA has a support role, with four different agencies that have the primary response. We have a support role with DoD, there is one with the American Red Cross, there is one with the General Services Administration (GSA), and also HHS. And I just want to make sure that everybody understands their role, in support of a primary role. Thank you. Dr. Roe.

Mr. ROE. Just a brief comment, Mr. Chairman. To start with, I think in my background as a battalion surgeon in the military, and as a physician, and we have a hospital, a VA hospital, a mile from our main hospital, a 500-bed hospital with a medical school in our community, and Mr. Denton, you are absolutely right. I have participated as a surgeon in mass casualties. And they will overwhelm any system. The planning has to start at your house. In my home, we have a benevolent dictator, that is my wife. But we have a communications plan in our own family that we get together. As the Mayor of our city, just as the Chairman did, we have a book that establishes command and control. You have to know who is in charge when you start. When a disaster occurs there has to be someone who is responsible in a chain of command. Otherwise, it is a disaster. So we very carefully in our city planned and had many training exercises on what happens if we have a hazmat spill on the interstate? What happens if we have a smallpox outbreak? I got myself re-inoculated to participate in that because I had to go down to the hospital and provide the health care that we need.

So you are absolutely right. All this nationally is good a few days later. As I explained to the people at home, we have 150 police officers, we have 60,000 people in this town. You do the math. We cannot get by your house every day. You are going to have to make sure you have water, blankets, canned food, and so on. And we go over that, and we sent a briefing packet out to every family in our community that this is what you need to plan for. And we have 110 firemen, and so on. So that is correct.

These services come in later. And obviously what you learn very quickly in a hospital is, is you do not, you know, your bunion now is not an emergency. You put that off for 3 years, you can put it off another 3 years. You stop all elective procedures and you go strictly to your emergency. And even that will be overwhelmed very quickly in a mass casualty of over 25 or 30 people. It does not take very many to overwhelm a system.

And I agree with the Chairman, very clearly you need to know who supports what because this is a very complicated national system and we found out the failures of it in Katrina. And I think the local folks in New York City did an incredible job on 9/11. I was

absolutely amazed at how the local police, fire, and EMS did their job.

A comment, Mr. Denton, on what you said. If you would just, I will stop right there and let you make a comment, and then I have one more question, Mr. Chairman.

Mr. DENTON. Well, I agree entirely and I would take it one step further. Once you have a plan for your family, once you have a plan for your loved ones, think of your neighbors, like the elderly resident across the street, or that person down the road who may have some disability that requires some sort of special attention. Are we thinking about those folks, too? Because it might be 24, 48 hours before somebody can get down your street, before one of those Red Cross emergency response vehicles can come down the street. How folks are prepared to take care of themselves and their community is the beginning of this entire discussion.

Mr. ROE. I think you are right. I think you saw that in Nashville, when folks did take care of their neighbors. That is a great point, and you do that. I think, Mr. Henry, I mean just a couple of questions on the waste. The reason I think hospital systems have done this is that they feel like it can be more efficiently done somewhere else. If they felt like it would save them money I think they would do it. And I would like to see some more data on that for VA because if 24 VAs are doing that and I guess another 130 are not, then the question is if it saves money why has VA not done that? I think local hospitals, where we are typically, turf this out because it saves them money. They do it for that reason. Not because of a mass casualty, they do it just for the, I mean, you may deal with one mass casualty or you may never deal with one.

Mr. HENRY. And that is why we looked at the cost estimates separately. We found that when you install the stuff onsite it is about a third less cost than shipping it offsite. The offsite came by accident, as a convenience when the Federal Government pretty much, vis-à-vis the Environmental Protection Agency regulations, banned onsite incineration. Most of the facilities shut down their incinerators as a temporary fix. They moved to bringing in haulers to take the stuff offsite and treat it. Over time, that function kind of moved into the environmental section of the hospital. And it just became more of a janitorial exercise. And when you are looking at installing this equipment, this is capital budget costs, and the evaluation for purchasing capital budget costs are different. And it is a multiple-year thing. And certainly on the first-year basis to bring that in, the cost would be higher to install the capital equipment than that budget line item for that year to haul it offsite. However, when we are looking, you know, over a 5-year payback period there is significant savings for the facilities themselves.

Mr. ROE. I am going to just very briefly, I would, I agree with that. I mean, but any business would look at not just the first, if any business looked at capital costs the first year, nobody would do anything, because nothing ever pays back, or if you are the luckiest human being in the world, it pays you back in the first year you have it. So I would like to look at that. I think you said, I think we need further study on that. If it saves the VA \$190 million, we can look at the pros and cons of it.

Mr. HENRY. Okay, right.

Mr. ROE. I yield back, and thank you.

Mr. MITCHELL. Thank you very much. And I thank you for your service to your communities, and for coming here today and testifying at this important event. Thank you.

Mr. HENNIGAN. Mr. Chairman? With your indulgence?

Mr. MITCHELL. Sure.

Mr. HENNIGAN. I was under the impression we would have an opening statement, and come back and give testimony. I failed to give you the testimony that I have brought forth to this Committee. It is in writing, it will certainly be in the record. But if you could allow me the 3 minutes remaining on the time that I did not use to give my testimony?

Mr. MITCHELL. Yes, go ahead.

Mr. HENNIGAN. Thank you very much. Mr. Chairman and Committee Members, in evaluating the request to speak to you today concerning emergency preparedness of the VA systems along with the companies I am involved with in both the private and public sector, I drew from our lessons learned in Montgomery County, Texas. Those lessons taught us that there are key topics necessary to address in preparation of such catastrophes. Those areas include communications, action, and review of the new programs available.

In our case in the Gulf Coast, hurricane season repeats itself every year so that preparation becomes a fine tuning issue versus starting from the unknown. In my review of the VA Web site, I found it easy to find information and locate facilities. This is a large part of the successes we have had in Montgomery County, with the ability to communicate with our residents and it falls under the communications necessary to serve the people the VA is charged with caring for. The need for our veterans to be able to communicate to the VA is essential and in scrolling through the Web site there are several toll-free numbers to do this. My question to this Committee, and I do not know the answer, is are we doing enough for them communicating using other forms of contact?

In addition, since every area of the country has known weather disasters—fires, mudslides, earthquakes in the west, tornadoes in the mid-section of our country, hurricanes and flooding in the Southeast and Northeast—are there plans in place through the Veterans Administration that educate our veterans where to go and what to do to prepare? Since the Veterans Administration has divided the country into what I now know as 21 VISNs, would it be beneficial for each zone with known potential catastrophic issues to communicate to their constituency what to do, where to go, if such an issue occurs?

Are our facilities prepared in case of a catastrophic event in each zone? An example, what we did after Rita was to identify what went wrong, and there was plenty, to determine how best to resolve those problems. A few problems MCHD incurred during Rita that were addressed and solutions found: power outages, no fuel, no refrigeration, evacuation problems. Again, I believe advance solutions can be found with our knowledge of weather-related issues in geographic areas in the United States.

The new programs, does the VA integrate new communications programs to benefit our veterans on an ongoing basis? Is it working with local officials with this communication? Is there a method that

rewards staff members that create programs to better serve our veterans? What is the mission of the VA, and is it communicated with those who have to achieve it? There are always entrepreneurs who can identify problems and create solutions. Are we making the opportunities available to them to introduce themselves and become a supplier to the VA? I was pleased locally to find out that there was support from the Veterans Affairs on H.R. 114, in assisting our veterans who have been inside the ropes, understand the problems, and have creative solutions. Are we listening to them?

And I will not go through the rest. I know it is on the record, sir. But I wanted just to take a chance to thank you again for allowing us to speak before this Committee, and hopefully come up with some solutions.

Mr. MITCHELL. I thank you, and those are very good questions. Thank you very much.

At this time I would like to welcome Panel Two to the witness table. For our second panel we will hear from Captain D.W. Chen, Director of Civil-Military Medicine, U.S. Department of Defense, who is accompanied by Christy Music, Director of Health Medical Policy, Office of Homeland Defense and Americas' Security Affairs, U.S. Department of Defense. Also joining us is Dr. Kevin Yeskey, Deputy Assistant Secretary and Director for the Office of Preparedness and Emergency Operations, Department of Health and Human Services, and Steve Woodard, Director of Operations Division, Response Directorate, Federal Emergency Management Agency, U.S. Department of Homeland Security (DHS).

Because of a delay in DoD finding a witness that could speak to their role amongst other Federal agencies in emergency planning, they will not be giving an opening statement but will be available for questions.

I would now like to recognize Dr. Yeskey for the Department of Health and Human Services.

STATEMENTS OF KEVIN YESKEY, M.D., DIRECTOR, OFFICE OF PREPAREDNESS AND EMERGENCY OPERATIONS, DEPUTY ASSISTANT SECRETARY, OFFICE OF PREPAREDNESS AND EMERGENCY RESPONSE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; STEVEN C. WOODARD, DIRECTOR OF OPERATIONS DIVISION, RESPONSE DIRECTORATE, FEDERAL EMERGENCY MANAGEMENT AGENCY, U.S. DEPARTMENT OF HOMELAND SECURITY; CAPTAIN D.W. CHEN, M.D., MPH, USN, DIRECTOR OF CIVIL-MILITARY MEDICINE, FORCE PROTECTION AND READINESS POLICY AND PROGRAMS, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY CAPTAIN FRANCESCA C. MUSIC, MS, MT (ASCP) SBB, DIRECTOR OF HEALTH MEDICAL POLICY, OFFICE OF HOMELAND DEFENSE AND AMERICA'S SECURITY AFFAIRS, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF KEVIN YESKEY

Dr. YESKEY. Chairman Mitchell and Dr. Roe, I appreciate the opportunity to testify today on my Department's role in the National Response Framework, and how we coordinate with the Department of Veterans Affairs in our response efforts.

HHS supports DHS as the overall lead in the coordination of incident response. The HHS Secretary leads all Federal public health and medical response to emergencies and incidents covered under Emergency Support Function 8 of the National Response Framework. Within HHS, ASPR, the Assistant Secretary for Preparedness and Response, coordinates the national ESF 8 preparedness and response actions, including medical care, public health surveillance, patient movement, and fatalities management. In carrying out this responsibility, we depend on support from our interagency partners, including the Department of Veterans Affairs.

There is a longstanding tradition of collaboration between HHS and VA staff in emergency preparedness activities, beginning with extensive collaboration on the creation and management of the National Disaster Medical System. HHS deploys public health and medical assets to an affected area utilizing personnel from NDMS. When NDMS Disaster Medical Assistance Teams that provide acute care for victims need to be augmented with additional clinicians, we have turned to the VA and they have provided us with appropriate personnel. Most recently, the VA provided three surgeons and two anesthesiologists for our medical teams deployed in response to the earthquake disaster in Haiti. In the hurricane season of 2008 VA provided personnel to completely staff two of our Federal medical stations.

HHS, Department of Defense, and VA all have key functions in moving patients through the management of Federal Coordinating Centers (FCC), which recruit hospitals to participate in the NDMS and coordinate in the receipt of evacuated patients in host cities. FCCs are critical to both patient movement and definitive care for those evacuated in a public health emergency. During the 2008 hurricane season VA-managed FCCs coordinated the receipt of medically evacuated patients in Arkansas and Oklahoma. When NDMS was activated for the Haiti earthquake, VA personnel coordinated the receipt and distribution of patients evacuated to Florida and Georgia to receive life-saving definitive care.

HHS has developed playbooks for 14 of the 15 national planning scenarios as a guide to our response to disasters such as earthquakes and hurricanes. The VA provides significant input into these playbooks as they are developed and revised. At the request of the VA, HHS has placed a full-time liaison in the VA's Office of Public Health and Environmental Hazards to provide continuity of communications between the two Departments in the area of preparedness and response. Similarly, the VA provides liaison officers to the HHS operations center when HHS responds to events. Finally, HHS and VA participate in joint training exercises at a variety of levels. Our regional emergency coordinators and VA area emergency managers participate in exercises at the State and local levels. VA staff participate in tabletop exercises at the HHS headquarters level, and VA and HHS jointly participate in national level exercises. VA staff also participate in our annual ESF 8 Integrated Training Summit.

In conclusion, HHS regards the VA as an integral partner in our preparedness and response activities. The VA has provided expertise in the development of our preparedness plans and clinical support needed for crucial medical care required by victims of disas-

ters. HHS's partnership with the VA is strong and extremely cooperative. It is one that enables both Departments to serve our Nation in times of emergency.

Thank you for the opportunity to testify today, and I will be happy to answer questions that you may have.

[The prepared statement of Dr. Yeskey appears on p. 43.]

Mr. MITCHELL. Mr. Woodard.

STATEMENT OF STEVEN C. WOODARD

Mr. WOODARD. Yes, good morning, sir. Chairman Mitchell, and Ranking Member Roe, and other Members of the Subcommittee, I am Steve Woodard, Director of Response Operations within the Response Directorate at the Federal Emergency Management Agency. And we would look forward to our continuing work with Congress to ensure that our Nation is prepared for all disasters.

As you all know, incidents begin and end locally, and most are wholly managed at the local level. Cognizant of this, we must manage these events at the lowest possible jurisdiction, supported by additional capabilities when needed. State and local governments are closest to those impacted by incidents, and have always had the lead in response and recovery. During response, States play a key role coordinating resources and capabilities throughout the State, and in obtaining resources and capabilities from other States. Many incidents require a unified response from local agencies, nongovernmental organizations, and the private sector, and some require additional involvement from neighboring jurisdictions or the State itself.

A small number require Federal support. To be most effective, disaster response must be quickly scalable, flexible, and adaptable. To meet the challenge of that uncertainty, we have developed the National Response Framework with our Federal partners. The Framework is a guide for how the Federal, State, local and tribal governments, along with nongovernmental and private sector entities, will collectively respond to and recover from all disasters, particularly catastrophic disasters, regardless of their cause. The Framework recognizes the need for collaboration among the many entities and personnel involved in response efforts at all levels of government, nonprofit organizations, and the private sector.

The Department of Veterans Affairs, the second largest Federal department, is one of the many agencies supporting the Framework. VA is a supporting agency for public works and engineering, emergency management, mass care, logistics, public health, and medical services. VA can provide available resources requested directly by FEMA, or by the primary agencies in charge of the emergency support functions, most frequently from Dr. Yeskey and the Department of Health and Human Services, the primary agency for Emergency Support Function 8.

During disasters, VA can assist the Secretary of HHS by coordinating available hospital beds, and providing additional personnel, supplies, technical assistance. VA also provides technical assistance to FEMA in support of the housing task forces established in response to a disaster. VA has also provided staffing assistance to call centers.

Our Nation must be prepared to meet all challenges. I want to assure you that we are committed to further improving the Nation's response capabilities and to strengthening the coordination with the interagency at all levels of government. FEMA recognizes that disaster events, regardless of magnitude, can be devastating to the people and communities affected. We appreciate the support and look forward to our continued partnership with VA, and thank you for the opportunity to testify, and look forward to any questions the Subcommittee may have.

[The prepared statement of Mr. Woodard appears on p. 44.]

Mr. MITCHELL. Thank you, Mr. Woodard. I would like to ask a couple questions of Captain Chen. Captain, could you please explain to us a situation where the VA would support you in the VA's Fourth Mission, and walk us through the process?

STATEMENT OF CAPTAIN D.W. CHEN, M.D., MPH, USN

Captain CHEN. Mr. Chairman and distinguished Members of the Committee, I would also like to thank you very much for inviting us to participate in this panel this morning.

In response to your question, the VA and the DoD have a long history of working together collaboratively on emergency preparedness and response. One of the areas that is a key area that we work with them day-to-day is wartime casualty care. By statute from Congress, a Memorandum of Understanding (MOU) or interagency agreement was signed in 2006 between the Department of Veterans Affairs and DoD whereby the Department of Veterans Affairs sets aside beds and care for a potential surge in combat casualties. And as part of that MOU, the VA and DoD work together on Patient Receiving Centers, PRCs. These are PRCs at VA Medical Centers where there are training and teams available in the event of patient receipt and regulation and transport to VA Medical Centers. And a lot of work is put into developing these PRCs and tracking systems through USTRANSCOM to make sure that potential patients are assigned to appropriate hospitals in the VA system. Part of the spinoff of that is that collaborative work also has benefit in terms of our continuing work with the VA in terms of domestic national preparedness and in supporting our Federal partners and leads, such as HHS and DHS.

We also have a national disaster medical assistance participation through DoD where the DoD and the VA work together with HHS, both in patient transport using our transport capabilities. And also DoD hospitals and VA Medical Centers serve as FCCs, as Dr. Yeskey mentioned, Federal Coordinating Centers. And we work very closely together with community hospitals in recruiting them to set aside beds in private hospitals in the event of, one, wartime casualty surge, and number two, national emergencies.

Mr. MITCHELL. Excuse me, Captain Chen. Let me just go back a second. There is the Stafford Act. And let me just read part of this. The Robert T. Stafford Disaster Relief and Emergency Assistance Act is the principal legislation governing the Federal response to disasters within the United States. And you are talking about wartime casualties. What I am asking you is, how often do the VA and DoD coordinate for this Fourth Mission of the VA, which is to coordinate and be a support to DoD? Is there any coordination at

all in this Fourth Mission? And second, could you give me the last time when DoD called upon the VA to activate this Fourth Mission?

Captain CHEN. The Fourth Mission is something that both the DoD and the VA, as support agencies to the National Response Framework and ESF 8, when requests for assistance are actually tendered to the Department of Defense, we support the States and localities and our Federal partners and HHS in providing assets and capabilities if they are available at that time. DoD and VA work very, very closely on the domestic national preparedness activities vis-à-vis our work through the National Disaster Medical System and through the wartime casualty care because work on those things actually is relevant and has benefit back to the Fourth Mission that you mentioned.

Mr. MITCHELL. I understand about the wartime again. But I am asking about the natural disasters, where DoD is part of the response team, and they are, the Fourth Mission of the VA is to work in support with DoD. And I am asking again, how often do you coordinate with the VA? And when was the last time that the DoD called upon the VA to activate this?

Captain MUSIC. I would like to take that, if you do not mind, Chairman Mitchell. For natural disaster response through the National Response Framework, where HHS is the lead of Emergency Support Function 8, Public Health and Medical Response, we and the VA are supporting Departments as you are well aware. We work almost daily with Health and Human Services, DHS, and the VA, the other three partners of the National Disaster Medical System. Through the National Disaster Medical System, directorate staff as well as their senior policy group, as well as the Emergency Support Function 8 Senior Leader Council for Patient Movement, wherein we discuss the role of patient movement, as well as definitive care, the transport of the civilian populations that we aeromedically transport from a military airfield or civilian airfield to a point of debarkation, another airport. And we, in conjunction with the Veterans Affairs Federal Coordinating Centers, arrange for ambulance or other medical transport of those patients into civilian National Disaster Medical System hospitals, of which there are about 1,800, that we have under memorandum of agreement, along with the VA, for medical treatment as inpatients.

So to answer your question more specifically, we coordinate with them daily, certainly two to three times a week.

Mr. MITCHELL. With the VA?

Captain MUSIC. Yes.

Mr. MITCHELL. Thank you. My time has expired. Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman, and to Mr. Woodard's response, is that you are right. If you are in a local natural disaster, look out the window, and FEMA is not going to be there. The local troops are going to be there, and you are going to have to take care of yourself. Once again, I think one of the things that we saw was we had planned exactly 30 years ago for one of the biggest emergencies that I have seen to move a hospital, to move everyone in a hospital, when you have to evacuate. That is one of the biggest disasters that can occur on a local level. And we took months planning to move a hospital, people on ventilators, and critically ill peo-

ple, and so forth. And we are going to do it again in our community in about 2 weeks. So that planning is going on now. When you have to do that in an emergency basis, I guess the question I have, do all the VAs across the country, the 154 hospitals, have a plan where if you had to do an emergency evacuation, can they do that? Are there plans in place to do that?

Dr. YESKEY. Yes, I mean I think we have to let the VA answer the question about the specific hospitals. We agree with you that moving patients is extraordinarily difficult to do, particularly the critical care patients. When we do have to do that, if those hospitals are in harm's way and they cannot shelter in place and safely take care of those patients, we have worked on exercises and plans at the local level to support the State and locals in that process utilizing Federal resources. We have used NDMS personnel to do that. DoD has provided the critical care transport with the medical personnel on their aircraft, and then VA supports the receipt of those patients in the host cities by being able to arrange the ground transportation and distribution of those patients to the host city facilities.

Mr. ROE. I know we had, I know before Katrina there was a tabletop exercise on that. And did we act on any of that? Dr. Yeskey, you may not know. But I know there was a tabletop exercise about a year ahead. Was there anything done? Because it certainly looked like it was not, or nothing was acted on. Of course, that was a disaster that just overwhelmed all of the local and State agencies.

Dr. YESKEY. Yes, sir. A couple of things have been done in response to some of those lessons learned from Katrina. One is in preparation for the 2006 hurricane season, we went to Louisiana, then over the subsequent years went to the Gulf Coast States, and then to hurricane prone States, to look at hospitals' and nursing homes' capabilities of sheltering in place versus evacuation. And we looked at those capabilities and determined in a number of areas that they had the capability to shelter in place, or the localities through mutual aid, Emergency Management Assistance Compact (EMAC), had the ability to do that through agreements among hospitals and State planning. We also noted that in some cases States did not, and localities did not, have the ground transportation capability to do that. So FEMA and HHS worked together on developing a first regional ambulance contract, then a national ambulance contract, that provided ambulances, air ambulances, and paratransit seats for people who did not quite need an ambulance but could not go by regular conveyance. We set that up. That contract has been utilized several times in the past couple of seasons very successfully. That is a very tangible effect of joint planning and working with the States and locals on assessing their needs and trying to determine a way forward with that.

Mr. ROE. I think Katrina was certainly a template and if we study that, probably those lessons learned during Katrina have prevented things in the future. I know certainly in Tennessee with our floods in Nashville, and Clarksville where I am from, it worked very well. It was obviously a loss of life, unfortunate, but less than it would have been, I think. And I think those agencies all worked very well. I am not even sure that the national agencies even got involved until later in the event.

Mr. Chairman, I have no further questions. I yield back.

Mr. MITCHELL. I would like to ask a question of Dr. Yeskey. In the event of a national emergency or a terrorist attack, how many beds are available currently? And in addition to this, does HHS in conjunction with the primary and support agencies have enough stockpiled items to carry out its mission?

Dr. YESKEY. Sir, I will try and answer the first question at least completely. I may have to get back to you for the second question because that somewhat varies on scenario. We, through our hospital preparedness program—it is a cooperative agreement program managed at HHS that provides States with funding to develop hospital preparedness—we have developed a system called HAvBED. It is Hospital Available Beds in Emergencies and Disasters. Every State implements that and they have reporting requirements that within a couple of hours they need to report back the status of the hospital beds that would be available. In any event, and also in the National Disaster Medical System, those participating hospitals are required to provide bed counts for us and we test that quarterly for bed counts there.

So in the event of a national emergency like that, we would go ahead and we would start HAvBED bed counts and we would also look at the NDMS bed counts as well. In addition, we work with the American Burn Association to look at burn centers to see where those beds are available. Those numbers fluctuate on a daily basis. I cannot give you an exact number on how many beds we have, but those are the processes by which we would determine what beds are available. Then we would work on how, with DoD and VA through the Federal Coordinating Centers, how we would distribute those patients to hospitals that were able to accept them.

Mr. MITCHELL. And one last question. Can HHS tell us right now whether any of the medications in the pharmaceutical stockpile is expired?

Dr. YESKEY. That, I will have to get back to you with a formal answer on that. But we try and make sure that as many of the medications that we have in the stockpile, that we can rotate through their shelf life, we do. But I can get back to you with a formal answer on that, sir.

[Dr. Yeskey subsequently provided the following information:]

Within HHS, the Strategic National Stockpile (SNS) is managed by the Centers for Disease Control and Prevention (CDC). The SNS is a repository of antibiotics, chemical antidotes, antitoxins, vaccines, antiviral drugs and other life-saving medical materiel. The SNS mission is to deliver critical medical assets to the scene of a national emergency. During a public health emergency, State and local public health systems may be overwhelmed. The SNS is designed to supplement and re-supply State and local public health agencies within the United States or its territories in the event of an emergency.

Medical countermeasures held in the SNS expire on a routine basis. However, the SNS is managed to maintain minimum levels of each product in viable, ready to use condition. Depending on several cost and inventory management factors, expiring medical countermeasures may be tested for shelf life extension, disposed of and replaced with new product, or disposed of without replacement. These actions are undertaken by CDC to maintain the Federal capability to support State and local response while seeking maximum value for the funds appropriated to the SNS.

Mr. MITCHELL. Thank you all very much for your service, and thank you for your testimony.

At this time I would like to welcome Panel Three to the witness table. Joining us on our third panel is the Honorable José Riojas, the Assistant Secretary of Operations, Security, and Preparedness, U.S. Department of Veterans Affairs. He is accompanied by Kevin Hanretta, Deputy Assistant Secretary for Emergency Management, Office of Operations, Security, and Preparedness; and Dr. Gregg Parker, Chief Medical Officer for the South Central VA Healthcare System, VISN 16.

Mr. Riojas, you have 5 minutes if you would. And I will let you know that your testimony is part of the record. Thank you.

STATEMENT OF HON. JOSÉ D. RIOJAS, ASSISTANT SECRETARY FOR OPERATIONS, SECURITY, AND PREPAREDNESS, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY KEVIN T. HANRETTA, DEPUTY ASSISTANT SECRETARY FOR EMERGENCY MANAGEMENT, OFFICE OF OPERATIONS, SECURITY, AND PREPAREDNESS, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND GREGG SCOTT PARKER, M.D., CHIEF MEDICAL OFFICER, VETERANS INTEGRATED SERVICE NETWORK 16, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. RIOJAS. Thank you, Mr. Chairman. Mr. Chairman, Ranking Member Dr. Roe, we appreciate the opportunity to appear before you today and provide an overview of the Department of Veterans Affairs state of preparedness in carrying out our Fourth Mission, that being to provide service to the Nation when needed while continuing to maximize service to our Nation's veterans.

I am accompanied today by two outstanding professionals, Mr. Kevin Hanretta, Deputy Assistant Secretary for Emergency Management; and Dr. Gregg Parker, who is our Chief Medical Officer for our South Central Veterans Integrated Service Network, VISN 16, whose geographical area of responsibility includes New Orleans, Louisiana. Both officials served in VA during Hurricane Katrina, Mr. Hanretta at the headquarters level and Dr. Parker on the ground in New Orleans. They are key leaders today that bring a perspective of experience, lessons learned, and improvements that have occurred within the Department.

Mr. Chairman, you and this Committee have a history of supporting VA and we appreciate that support. I have dedicated my adult life to preparedness. In my experience there are three critical elements to a good preparedness program: people, plans, and practice. We are fortunate in VA today to have all three. Dedicated people, ranging from our Secretary of Veterans Affairs who takes preparedness extremely seriously and participates in our training exercises personally, to our youngest volunteers, newest volunteers, who have placed themselves in our volunteer program in the event of an emergency. We have robust plans that cover intra-VA organizations and are interlinked with those of our sister and brother agencies across our government. And we have practical experience as well as exercises. Practical experience through our support during Katrina, Hurricanes Gustav, Ike, and more recently support that was mentioned in Panel Two, during relief operations for

Haiti. We do not practice in isolation and we ensure that both our plans and our execution are done in a crosscutting manner with other stakeholders involved.

We will continue to assess and improve our preparedness efforts, but I am confident that we are prepared now to respond to our Nation's call as needed during this hurricane season or in response to any other national emergency. Again, thank you for your support, time, and interest in this very important topic, and for providing the best for our Nation's veterans, who deserve nothing less. I look forward to your questions.

[The prepared statement of Mr. Riojas appears on p. 48.]

Mr. MITCHELL. Thank you. I have just a couple of quick questions. First, how would you rate the management of the pharmaceutical stockpile that the VA has?

Mr. RIOJAS. Mr. Chairman, with your permission, I would like to offer a couple of different layers of response to these questions.

Mr. MITCHELL. Sure.

Mr. RIOJAS. Because we have experts that can tell you from a practical than kind of a top level assessment, give you on the ground assessment. And then I can offer a Department-level review.

Mr. MITCHELL. Sure.

Mr. RIOJAS. Dr. Parker.

Dr. PARKER. Good morning, Mr. Chairman, and thank you for the opportunity. I have a 25-year history as a naval officer, and during the course of that I had the responsibility for war planning and disaster planning in Southeast Asia. So I can contrast and compare the DoD system as well as the VA system.

I am pleased to say that I have not seen better management on the ground and in the field for the disaster medical management of the caches. They were predeployed in all of our areas. We have a couple of areas in my region that because of space and post-Katrina disasters we have not yet replaced the caches. But we have them pre-staged and co-located with other facilities so they can be responded in a timely manner.

The drugs are rotated on a periodic basis so that as they come up for expiration they are used. There are a few classes of drugs, like Chloride and Atropine, that we do not have a daily use for. They are strictly for biomedical disasters. And so they do expire and we replace them. But I would say with all honesty in having been there that this is an excellent program. It, I am not sure that it could be better managed. It has been very well done.

Mr. MITCHELL. Very good. And a question maybe as kind of a followup, in the event of a national emergency or attack, how many beds does the VA have right now? Not only just the number that are authorized but the number that are operational?

Mr. RIOJAS. Mr. Chairman, I would offer that, that is a dynamic figure. I did not bring one with me today. I do not know if you have a rough order of magnitude. But what we would do is we assess the probability of them being utilized. We have a robust dialogue and a line of communications with the VISNs and with the Medical Center directors to be able to give that on a short notice basis. I do not have that answer today.

[The VA subsequently provided the following information:]

To provide the Committee/Congressman more insight into the availability of VA hospital beds, the Department's Veterans Health Administration (VHA) staff reviewed statistics spanning Fiscal Year 2010 (Oct 2009–Sept 2010).

As detailed in the chart below, during Fiscal Year 2010, VA had approximately 5,000+ available hospital operating beds that could be used during an emergency at any given time.

Please reference the notes related to the below table for details regarding the beds.

The Department of Veterans Affairs anticipates having a real-time capability to track, manage and report bed capacities when the VHA Bed Management System is implemented systemwide.

The following chart represents the average beds among all VA Medical Centers. We're providing totals for all of FY10 to give you an idea of the month-to-month variation.

Time Period (FY-Month)	10-OCT	10-NOV	10-DEC	10-JAN	10-FEB	10-MAR	10-APR	10-MAY	10-JUN	10-JUL	10-AUG	10-SEP
Hospital—Avg Operating Beds	17,259.6	17,270.5	17,276.9	17,277.6	17,276.8	17,266.4	17,260.9	17,257.3	17,258.1	17,257.8	17,260.6	17,263.4
Hospital—Avg Daily Census (ADC)	11,942.4	11,689.6	11,522.0	11,592.7	11,630.9	11,677.7	11,650.6	11,616.6	11,595.4	11,756.0	11,972.2	12,195.2
Hospital—Avg Daily Available Beds	5,317.2	5,580.9	5,754.9	5,684.9	5,645.9	5,588.7	5,610.3	5,640.7	5,662.7	5,501.8	5,288.4	5,068.2

Methodology: The average monthly hospital ADC subtracted from the average monthly hospital operating beds will result in the estimated average available beds by month.

Notes:

- (1) ADC = Average Daily Occupied Beds (Census).
- (2) Hospital Beds include only the following bed services: Blind Rehabilitation, Intermediate Medicine, Internal Medicine, Neurology, Psychiatry, Rehab Medicine, Spinal Cord Injury and Surgery.

VHA anticipates having a real-time capability to track, manage and report bed capacities when the Bed Management System is implemented systemwide.

Mr. MITCHELL. Fine. And a question about your budget, which maybe you do not want to answer this. But is your budget sufficient? And secondly, what would you do with another \$20 million?

Mr. RIOJAS. Mr. Chairman, we are able to execute the plans that we have in place right now with the resources that we have been given. Should we be given more money I would sit down with our, we have an integrated process team that is looking at our initiative and how we are expanding several of our capabilities. And I would offer that opportunity to the team as a whole, because it is a blend of people, technology. It could be something along the lines of training or exercises. And today I would not exactly know where to put that without dialogue with the entire team. I have the personal assessment that it would probably go in the realm of technology but I would like to confer with all of those stakeholders across the Department before I put a requirement on the table.

Mr. MITCHELL. And the last question, I assume that the VA has an emergency response plan. And if you do, when was it updated? And how often do you update it?

Mr. RIOJAS. I will let you—

Mr. HANRETTA. Mr. Chairman, we review it, the last formal plan that was signed was signed by Secretary Nicholson in 2005. We review it, update it every year. And we follow it. The biggest revision, of course, came with the National Response Plan being revised to the National Response Framework, where VA now has responsibility to support seven of those fifteen emergency support functions. And so we continue to update our plans. And with the Office of Operations, Security, and Preparedness we are able to do that and focus on a daily basis.

Mr. MITCHELL. And one last thing. In the first panel, Mr. Henry talked about, and Mr. Roe even mentioned it again, about infectious waste. And I would assume that you would be looking at this, if it is a cost savings, and take a look at what was presented from the first panel. And Mr. Henry had also talked about weather related emergencies. And we all know that there is a hurricane season, and tornado, and flood season. And I assume you do not wait for these to happen. You know, I live in an area where we do not have, knock on wood, many of these natural disasters in the Phoenix area. But there are some that continually have them, year after year. And I would hope that these are well on the radar for your response?

Mr. RIOJAS. Mr. Chairman, absolutely. We try to predict as much as we can, that is a function of our Integrated Operations Center, to take a look at the seasons. And there are cycles, obviously. There are several wildfires that we have been tracking in Arizona right now. So on a daily basis we track not only their distance from our own facilities but the impact on the veteran populations in those areas. So we do take a very deep look at natural occurrences, be they hurricanes, tornadoes, wildfires, or even earthquakes, and take a serious look at how we can preposition and be prepared to serve veterans, or if needed beyond, in those areas.

Mr. MITCHELL. And if Dr. Roe would just indulge me just a second, I want to talk to Dr. Parker. Since you are the one that is on the ground, what was the VA's involvement with Hurricane Katrina?

Dr. PARKER. If I might make it a little more personal, I grew up on the Mississippi Gulf Coast and my parents lived in Gulfport at the time. My father has since died, but my mother lives there now. On a personal level I insisted on being there because they were not able to evacuate, or would not evacuate. So I was in the storm, in Katrina, rode it out. And as part of the VA as soon as we got them settled, I immediately went back up to the regional office and then we deployed many personnel. And I believe it was 1,200 VA personnel into the field, into the South Louisiana, South Mississippi area. I oversaw the deployment of 13 mobile medical clinics over a period of at least 6 to 8 weeks, some of which actually operated on a near permanent basis in Southeast Louisiana while those clinics were then stood up, if you will, under the Capital Asset Realignment for Enhanced Services (CARES) System. We opened up additional community outpatient clinics at some of those sites, in Hammond, Louisiana, in particular.

So the VA was very, very involved. When we went to the field we were going to support veterans. But with the mobile medical clinics, and having grown up there and lived there, and also deployed into other areas across the world, I knew that we were not going to be able to go and support just veterans. And as part of the response plan we supported anybody who came into the clinic. And as some of you are aware, I believe during that 6- to 8-week period we saw about 15,000 patients in those clinics. About 11,000 of those were not veterans. Most of the care that we provided were pharmaceuticals and immediate capabilities.

So in summary, a robust response on the part of the VA, well coordinated, well coordinated with the local activities. Every clinic

that we put in place was coordinated with either the local Mayor or the community leaders.

Mr. MITCHELL. One last question about that, what is the status of the VA hospital now? I understand that it really had a lot of damage during Katrina.

Dr. PARKER. There were two hospitals that suffered significant damage during Katrina. There was the second facility in the Gulfport-Biloxi area, the one on the beachfront was essentially wiped out. And the New Orleans Hospital, which is in Downtown New Orleans, it remains closed. There is, are two major construction projects at each of those locations. In fact, groundbreaking will take place Friday for the new New Orleans Hospital, the replacement hospital. And construction is underway at the moment where the Gulfport campus was consolidated to the Biloxi campus, and all of the beds that were lost in the Biloxi-Gulfport area are being reconstructed on one campus. That was part of the CARES plan before Katrina and it was accelerated post-Katrina.

Mr. MITCHELL. Thank you. Dr. Roe.

Mr. ROE. First of all, thank you all in general for your service to our country, and Dr. Parker, and all of you for service as veterans and then as public servants now. So thank you for that. And I know Dr. Parker, I understand by reading your bio, you are a VISN Director also?

Dr. PARKER. VISN Chief Medical Officer.

Mr. ROE. Chief Medical Officer?

Dr. PARKER. There is somebody that bosses me around, too.

Mr. ROE. Probably, and in my case more than one. At your end, when the OIG issued his report in 2006 on the VA and Katrina, there is specific training that is supposed to take place. Is that documented in each, so that is done every year? Because I know sometimes you get so busy in patient care you put off the plans for doing something else. You are working hard everyday.

Dr. PARKER. Dr. Roe, I appreciate the question and I share some of the concerns that the American Legion expressed. Let me say within our region, post-Katrina and to this day, all of the senior leadership and mid-level management leaders in the facilities have undergone incident command system training. They are well versed in it. We hold at least annual training. The most recent training that we held was in, the week of March 25–26, the coordinated VISN 8, 7, 17, and 16 where we trained people in Atlanta. I can assure you that within our region the training is ongoing. The formal training is scheduled, the informal training is on a daily basis. Each of the facilities has emergency managers. We at the VISN have one full-time person managing the emergency preparedness.

Mr. ROE. Now, just a comment, one of the things we have to do as a Nation, and we are seeing it again expose itself in the Gulf, is that people in this country are losing faith in the ability of those of us who are in these positions to be able to handle an emergency. And I think obviously when it goes well, nobody notices as much. When it goes poorly, everybody notices, it is on TV 24 hours a day. But Katrina could have been done much better. I think we could say the Gulf could have been done much better, and we will learn from that experience in the Gulf.

But I think to be able now, because I know that in my own practice the last thing you did was plan for another train wreck. You were having it hard enough just doing your job everyday. But I think there has to be time put aside, and the VA is a huge, 300,000 employees, and I do believe Secretary Shinseki is very sincere. I have spoken to him about doing this. But there has to be time put aside, even though the employees want to get down and take care of patients, and see people, and they have more demands on them than they have time, I think this is extremely important to be sure we are documenting this across the VA system. That is a system we do have some control over and we will make it work well. And I do think there have been tremendous improvements. I know locally at our own VA certainly there have been since 9/11.

And Mr. Chairman, I yield back.

Mr. MITCHELL. Thank you, Dr. Roe. Well, you know, the issue that we have been talking about will require some appropriate followup. And I ask for all agencies to work with the VA so that we can better serve our Nation's homeland security interests. And did you have one other thing?

Mr. ROE. Mr. Chairman, just one brief question. I am sorry. But during Katrina, and this probably has been addressed, but patients were moved all over the country, and have done very well. But we did not notify their next of kin. They did not know where they were. Have we resolved that problem? Because, you know, that is your biggest fear. You know? When someone in your family is gone somewhere, it is the unknown. They may be fine, but if you do not know that they are not fine, your mind will tell you a lot of things.

Mr. HANRETTA. Dr. Roe, may I address that? You are absolutely right. During Katrina, because of the magnitude of the disaster, we were not able to do all of the identification and notification necessary. Since Hurricane Katrina, HHS, under HHS' leadership under the National Disaster Medical System, has really focused on patient tracking. They have come up with a system, the Joint Patient Assessment and Tracking System, that is being used, and the most recent example was during the Haiti earthquake evacuation. VA was activated, set up the Federal Coordinating Centers in Tampa, Florida and then in Atlanta, Georgia. And HHS used the patient tracking system during that evacuation. And we did track over 100 patients successfully. And so we think in place now is the system that can handle the NDMS requirements.

Mr. ROE. Thank you. And Mr. Chairman, I do want to thank each of them, and all the folks that have testified today. I believe we are better prepared. But you have to continually do that. And that is the, I mean I know we are better prepared than we were for 9/11. We certainly are in our local community and in our State. It showed during this last disaster down in Nashville. But it is an ongoing mission. Because you can never prepare for all the contingencies. I can promise you, you think you thought of them, you have not.

But I want to thank you all for being here today. Mr. Chairman, I want to thank you for holding this meeting.

Mr. MITCHELL. Thank you. And again, I would reiterate what Dr. Roe says. Thank you all for your service, and your continuing service. And as a result of that, this hearing is adjourned.

[Whereupon, at 11:29 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

Thank you to everyone for attending today's Oversight and Investigations Subcommittee hearing entitled, *Emergency Preparedness: Evaluating the U.S. Department of Veterans Affairs' Fourth Mission*.

On September 11, 2001, we witnessed one of the greatest tragedies in American history. Still today, we all remember the horrific scenes of these terrorist attacks. Four years later, in 2005, the Gulf Coast was hit by one of the biggest natural disasters the region has ever seen, as Hurricane Katrina swept through the region, killing thousands and leaving many homeless and displaced. And sadly again, today, we see Gulf States struggling with yet another major disaster, as the oil continues to spill. These types of events highlight the critical need for Federal agencies to proactively prepare to effectively execute their Federal obligations, especially when called upon during emergencies.

Today, we will evaluate and examine the U.S. Department of Veterans Affairs emergency management, preparedness, security, and law enforcement activities to ensure the Department can perform the mission essential functions under all circumstances across the spectrum of threats, including natural disasters. With several health care facilities, and hundreds of doctors and health care professionals, the VA's emergency preparedness posture, also known as the Fourth Mission, must be able to respond when needed and when called upon.

The Federal Response Plan (FRP) is an important mechanism for providing coordination of Federal assistance and resources to areas that have been overwhelmed by disaster and emergency situations, while supporting the implementation of the Robert Stafford Disaster Relief and Emergency Assistance Act. The VA's Office of Operations, Security and Preparedness (OSP) is responsible for directing and providing oversight for the Department's planning, response and security programs in support of the FRP.

I am looking forward to hearing from the VA their emergency preparedness plans and how they coordinate and communicate with other agencies such as FEMA and HHS, who are here today, to carry out their Fourth Mission.

Every day, we are reminded of the potential threats that are out there that may disrupt the American way of life and the freedoms we enjoy each day. The VA must be prepared to respond to these threats and offer their full support and resources to ensure that their role in the Federal Response Plan is integrated with other agencies to execute its mission.

Prepared Statement of Hon. David P. Roe, Ranking Republican Member, Subcommittee on Oversight and Investigations

Thank you, Mr. Chairman, for holding this hearing.

Early this decade, our country faced two major incidents that reinforced the need for emergency preparedness. On September 11, 2001, our country was attacked in a blatant act of terrorism, as the World Trade Centers in New York fell, and the Pentagon burned. First responders were called to action, and a Nation mourned. Again in 2005, Hurricane Katrina struck the Gulf Coast with an unprecedented fury. People's homes were flooded or ripped apart, and major evacuations occurred. The Gulf Coast is still rebuilding today.

Since the attacks of 9/11, the Committee on Veterans' Affairs has held four hearings on the subject of emergency preparedness. The last hearing was held on August 26, 2004. Today, we will reexamine the role performed by the Department of Veterans Affairs (VA) in emergency preparedness and its response to national crises and whether that role continues to need serious updating and reform. In particular, we will focus on the VA's role during wartime, natural disasters, or major terrorist attacks on U.S. soil.

While the Federal Emergency Management Administration (FEMA) and the Department of Health and Human Services (HHS) tend to take the lead role when an emergency occurs, one cannot deny the large importance of emergency preparedness at the VA. With 153 hospitals, and hundreds of outpatient clinics spread across the country, VA stands in a unique position to provide emergency medical assistance in the event of an emergency.

VA has defined roles currently in both the National Disaster Medical System and the National Response Framework (NRF) in the event of national emergencies. Among the specialized duties of the VA are conducting and evaluating disaster and terrorist attack simulation exercises, managing the Nation's stockpile of pharmaceuticals for biological and chemical toxins, maintaining a rapid response team for radiological events, and training public and private National Disaster Medical System (NDMS) medical center personnel in responding to biological, chemical or radiological events. Among the Emergency Support Functions (ESF) assigned to the VA, which relate directly to the mission of the VA, are ESF #6, which includes mass care, emergency assistance, housing, and human services; and ESF #8, which includes public health and medical services. I am interested in discovering today what VA has learned from the events of 9/11, Katrina and Hurricane Isabel, and how their role relates to the overall emergency response mechanisms.

Following Hurricane Katrina in September 2005, the Speaker of the House called together a Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina. The report, *A Failure of Initiative*, was issued on February 15, 2006. I understand that Ranking Member Buyer had been selected as part of the Committee that worked on the report, and one of our own Subcommittee staff, Mr. Wu, had been detailed to work on the Bipartisan Investigative Committee. I expect that we will hear from the Department that improvements have been made following this report, as well as on the recommendations made by the report from the Office of Inspector General issued in January 2006. I am also curious as to what VA's commitment is to emergency management in both dollars and manpower.

Again, Mr. Chairman, I appreciate you holding this important hearing. It is my hope that this will be a good news hearing, and that the VA is much better prepared to handle emergencies that come up in the future. I yield back my time.

**Prepared Statement of John N. Hennigan,
President and Chief Executive Officer, bt Marketing, The Woodlands, TX**

Opening Statement to Committee:

Chairman Mitchell and Members of the Committee, I would like to thank you for the opportunity to come to you today as a citizen who's been involved with not just the medical industry here and abroad, but as an elected official in Montgomery County, Texas.

I have been fortunate enough to travel extensively throughout South America, Europe and here in the States in the health care arena. I have witnessed firsthand differences between government facilities and those in the private sector, and can state without question the improvements I've seen in our VA facilities. A perfect example is the Michael E. DeBakey VA Medical Center in Houston, Texas. Prior to this health care system being built, in my opinion, our facilities were old and less than adequate for the veterans in our area.

Before going into my testimony I would like to give this Committee a brief background of myself for you to have a better understanding of why I feel privileged to be able to speak to future needs of our veterans and to offer a fresh pair of eyes to the emergency preparedness and planning within the VA Department going forward.

I mentioned earlier that I am an elected official in Montgomery County, Texas. I am a board member of the Montgomery County Hospital District and have been since 2006. I am currently serving as Vice Chair of this Board for my third consecutive year and in addition Chair our Legislative Committee.

The Montgomery County Hospital District is the sole provider of emergency ambulance service for Montgomery County, Texas. Serving a rapidly growing population of 460,000, MCHD responds to 42,000 calls for service each year.

MCHD serves a pivotal role during disaster response. The agency and its staff have taken a lead role in developing the tools to coordinate EMS mass response for coastal community evacuation and post-landfall response. MCHD's dispatch center was the coordination point for the mass EMS response into East Texas following Hurricane Rita. The lessons learned from that incident contributed greatly to the

statewide success during Hurricane Ike—the largest EMS deployment in United States history.

MCHD coordinates public health preparedness and medical branch operations in Montgomery County during large-scale operations, including the 2009 H1N1 pandemic. Currently, MCHD is coordinating a regional effort to develop EMS mass response to no-notice catastrophic situations as part of the Regional Catastrophic Planning Grant program.

Our Hospital District CEO serves as the Chairman of the Southeast Texas Regional Advisory Council. This organization is the grant recipient and administrative entity overseeing hospital preparedness using funding for the nine counties in the Houston region.

Mr. Chairman, Committee Members, my company has been involved with several startup organizations or corporations that are attempting to rise to another level. These companies have asked me to come in and assess current status, where they have been, and set goals to achieve where they would like to get. Through this process I have had clients who have benefited by programs that were well intended but lacked long-range planning.

The reason I'm here today is that I believe that I can plant the seed for new ideas in the hope that this Committee, and our Veterans Affairs Department, can nurture these ideas to benefit our veterans.

Finally, I want to once again thank you for this opportunity to testify before this Committee.

Testimony:

Mr. Chairman, Committee Members, in evaluating the request to speak to you today concerning emergency preparedness of the VA system along with my company's involvement in both private and public sector, I drew from our lessons learned in Montgomery County, Texas. Those lessons taught us that there are key topics necessary to address in preparation of such catastrophes. Those areas include **Communications, Action** and review of **New Programs** available.

Communications:

In our case (Gulf Coast) hurricane season repeats itself every year so that preparation becomes a fine-tuning issue versus starting from the unknown. In my review of the VA Web site I found it easy to find information and locate facilities. This is a large part of the success we've had in Montgomery County with the abilities to communicate with our residents and it falls under the communications necessary to serve the people the VA is charged with caring for.

The need for our veterans to be able to communicate to the VA is essential and in scrolling through the Web site there are several toll-free numbers to do this. My question to this Committee, and I do not know the answer, is: Are we doing enough for them in communicating using other forms of contact?

In addition, since every area of the country has known weather disasters (fires, mudslides and earthquakes in the west, tornadoes in the mid-section of our country, hurricanes and flooding in the Southwest and Northeast, these include 8 zones of the 21 listed: Questions 7, 8, 15, 16, 17, 19, 21 and 22), are there plans in place through the Veterans Administration that educate our veterans where to go and what to do to prepare?

Since the Veterans Administration has divided the country into 21 separate zones would it be beneficial for each zone with known potential catastrophic issues to communicate to their constituency what to do and where to go if such an issue occurs?

Action:

Are our (VA) facilities prepared in case of a catastrophic event in each zone?

Example:

What we did after Rita was to identify what went wrong (and there was plenty) to determine how best to resolve that problem.

A few problems MCHD incurred during Rita that were addressed and solutions found:

1. Power outage
 - a. No fuel
 - b. No refrigeration
 - c. Not enough generators for those homebound
2. Evacuation of population
 - a. Freeways and city streets were at a standstill
 - b. No electricity, no communications (i.e.: phones, television, radios, computers)

Again, I believe advance solutions can be found with our knowledge of weather-related issues in geographic areas of the United States.

New Programs:

Public:

Does the VA integrate new communication programs to benefit our veterans on an ongoing basis? Is it working with local officials for this communication?

Is there a method that rewards staff members when they create a program to better serve our veterans?

What is the mission of the VA and is it communicated with those who have to achieve it?

Private Sector:

There are always entrepreneurs who can identify problems and create solutions. Are we making an opportunity available to them to introduce themselves and become a supplier to the VA? I was pleased to see the VA supported bill H.R. 114 in assisting our veterans who have been “inside the ropes,” understand the problems, and have creative solutions. Are we listening to them?

Currently, my company has been involved with a program that was specifically geared for the benefit of the medical needs in Haiti. There, medical needs include requiring operating rooms that are not under tents. The company I’m working with is owned by a veteran who developed and patented a mobile hospital that in fact has the highest medical standard (Joint Commission Inspected) we live by here in America. This is a private sector opportunity that could very well be integrated into the VA system. It’s cost effective and mobile in case of catastrophic events.

My question again is: If I have a company who’s created solutions to problems, imagine how many other veteran-owned companies or simply private entities are out there with solutions to problems.

No different from our current disaster in the Gulf, when the private sector is given the opportunity to create solutions it will. My message to this Committee is to assure our veterans the best care possible and in order to do that we need to listen to the private sector and develop internal solutions through our public entities.

Finally I want to again express my gratitude for the opportunity to speak before this Committee today. It’s my hope that my testimony today will inspire thoughts for solutions.

I’ll be happy to answer any questions you have.

**Prepared Statement of Darrell Henry, Executive Director,
Healthcare Coalition for Emergency Preparedness, Washington, DC**

Introduction

The Healthcare Coalition for Emergency Preparedness was formed in an effort to raise awareness and educate people where two of the most relevant issues facing health care providers today intersect—what health care facilities have to do to maintain operations during a crisis, such as a pandemic, and develop efficient methods to reduce health care costs. We call it operational sustainability.

The Coalition consists of health care facilities, equipment providers, and industry experts stationed across the country.

The Coalition believes that a key component of hospital readiness lies in the ability of medical centers to maintain sustainable operations to meet public health needs and a patient surge on health care facilities in all circumstances. Surge capacity is defined as the ability of a health care system to adequately care for increased numbers of patients while also having the ability to treat the unusual or highly specialized medical needs produced as a result of surge capacity.

A lot of work has been done on the topic of emergency preparedness and what hospitals and medical centers can and should do. The Coalition is looking at questions like, “What isn’t occurring?” “What are the systemic weaknesses?” “Where are the vulnerabilities?”

The Coalition is committed to achieving the following goals for its members:

- Highlight vulnerabilities in operational sustainability during a crisis or emergency, including medical waste treatment.
- Promote new best practices to help sustain hospital operations during a pandemic or other crisis situation.

- Provide expertise and education on hospital preparedness and operational sustainability.

With looming threats of pandemic/epidemic, bioterrorism and everyday disease exposure, it is imperative that we utilize today's technology to ensure that our hospitals and health care centers have the ability to sustain operations in the event of such a crisis or emergency.

One of the largest hindrances to operational security revolves around transportation constraints to the hospital itself or such impacts on key suppliers and vendors that a hospital relies upon. Transportation constraints not only involve passable road conditions to access the health care facilities and vendor facilities, but they are just as likely to be vendor staffing issues, quarantined facilities, availability of transportation fuels, and other nonroad related issues. One of the issues we've found that is most often overlooked when dealing with transportation constraints, and emergency preparedness over all, are adequate provisions and planning relating to regulated medical waste.

According to Walter Reed Army Medical Center (WRAMC) regulation, medical waste (aka infectious waste) is any waste that is potentially capable of causing disease in man. Such waste would likely contain pathogens in sufficient quantity to result in disease, including microbiological wastes; blood and blood products; surgical and autopsy wastes; and sharps (i.e. needles). Pathological waste is also a regulated medical waste, but it is treated differently than infectious waste.

After recognizing that so many medical centers, including VA facilities, did not have appropriate processes set up to address the disposal of waste during a crisis and that Federal, State and local entities do not adequately address the issue, infectious waste disposal became one of the first issues identified and addressed by the Coalition. In addition, the Coalition is also looking at supply chain management and other issues, which are all inter-related.

Background

The H1N1 swine flu and previous issues, such as SARS, have highlighted the vulnerability our health care system faces from serious tests of preparedness in the area of operational sustainability in the time of a crisis. The ability for our private and government run health care facilities to maintain operations during times of crisis is a matter of interest for every American and should be a priority for Federal and State policymakers.

Paramount to emergency preparedness and pandemic containment is the need for full hospital operational sustainability of hospitals and treatment centers. Creating medical centers that can sustain a surge in the event of a crisis and continue operations must become a priority during a pandemic or other crisis (such as a natural disaster or bio-terrorism incident).

The bipartisan Pandemic and All-Hazards Preparedness Act of 2006 has helped us prepare for the current crisis and deal with future crises. There are many sectors of hospital operational sustainability that desperately need experienced solution management, but we have found the disposal of infectious waste is not being addressed adequately by health care emergency preparedness planning, best practices and guidance, or resources, and have focused our initial efforts on it.

A 2003 GAO study concluded that many hospitals lack the capacity to respond to large-scale infectious disease outbreaks and most hospitals lack adequate equipment for a patient surge on a medical facility. Further, many reports cite the challenges of medical supply chains, both inbound and outbound, to deal with waste products that will accumulate in a pandemic or natural disaster.

In the mid-90's, new regulations made onsite hospital incinerators uneconomic due to the restrictions placed on them because of the harmful emissions they released in the air. Most hospitals could not afford to keep up with the new standards and thus, out of convenience for a temporary fix, they resorted to hiring contracted service providers who gather waste and truck it offsite to be discarded elsewhere. Unfortunately, this temporary solution is still the way most hospitals discard their infectious medical waste today.

With real threats of pandemics, transporting infectious and contagious medical waste is no longer prudent. There are modern, affordable technologies that can cleanly, safely, and economically sterilize infectious and contagious waste on the premises of health care facilities. Treating hazardous materials on site is also a cleaner, greener, less costly, and, most importantly, safer option.

Since the mid-90's, 90 percent of our hospitals have chosen to export their infectious waste through their local communities and over our roads and highways. However, during an outbreak, infectious waste should not be allowed to leave the realm of the clinical experts of disease control at our Nation's hospitals.

Various reports by the Center for Disease Control staff, Federal health officials, and other experts have recognized the practice of inactivating amplified cultures and stocks of microorganisms onsite (as a medical waste treatment) is the best practice for emergency preparedness and pandemic response. Taking an onsite sustainability approach helps address this looming issue of hospital preparedness in the case of a pandemic or other crisis. Under such a scenario, the volume of hazardous materials would dramatically increase when a large population suddenly contracted a contagious disease or incurred a disaster and surged a hospital's capacity. Further, because the primary method of controlling the spread of infection and avoiding a pandemic is quarantining, the development of an onsite approach to waste disposal appears to be the most appropriate one.

Our country has begun to apply stringent actions to avoid some catastrophic health threats. The United States Department of Agriculture demands that food waste is sterilized at ports of entry to avoid agriculture contamination. A logical next step in our efforts to polarize waste and keep our country healthy would argue that we should sterilize medical waste at the point of generation as well.

Clearly the operational sustainability advantage is to sterilize the infectious waste onsite, but there are other notable benefits with regards to treating infectious waste onsite—namely, disease prevention, economics, and an environmentally green alternative (including reduced truck traffic, no incineration, and clean energy power). It also provides a safer option than the current practice of hauling medical waste many miles through our neighborhoods and over our Nation's roads to be treated offsite, which is particularly dangerous in the instance of a pandemic or other dangerous and exotic disease outbreak, such as H1N1 or the Ebola virus.

Expenditures for onsite treatment of infectious waste are perhaps the only preparedness tool that would begin to pay for itself from the day of installation. Waste treatment systems are custom designed and manufactured for each application. Users range from small clinics, hospitals, to large commercial processing centers. Prices for these systems range from about \$150,000 to \$1M+. Average health care clients, 300–400 bed hospitals, will purchase a system that is about \$450,000. This equipment often produces a return on investment (ROI/payback) between 18 and 36 months.

We have also identified that the development of mobile units can give the Federal Government the tools to eliminate infections or disease at the source and provide the necessary containment to help eliminate pandemic threat and improve public health and safety.

We remain vulnerable in the area of contagious waste management and the threat of pandemics, bioterrorism, and natural disasters are very real. There appears to be no rational logic for hospitals not to sterilize their infectious waste onsite during a pandemic crisis other than the lack of equipment and a lack of incentive to install such equipment. However, we must ensure the burden to implement safer and greener waste disposal options doesn't fall solely on the hospitals.

Pandemic and Medical Waste Issues

Last year, the Coalition developed a comprehensive pandemic preparedness plan, and has developed a six point action plan for medical waste sustainability during a pandemic. The Coalition urged the Department of Health and Human Services to consider this plan as a part of its response to the recent H1N1 swine flu outbreak.

We called for the newly confirmed Secretary Kathleen Sebelius to adopt onsite sterilization capacity as a best practice as a part of health care facility operational sustainability in a crisis and dedicate the resources necessary to improve onsite infectious waste treatment capacity.

We have learned a lot from the SARS outbreak on how hospitals adopt Universal Precautions regarding infectious waste classification at hospitals. Studies showed that during the SARS outbreak infectious waste volumes increase by as much as 500 percent due to the reclassification of "infectious" waste.

Joint Commission's new mandate for hospitals to be free-standing entities for a minimum of 96 hours does not address a pandemic, which could last up to 18 months. The only viable solution is to treat infectious waste onsite with equipment that has the surge capacity to function in a Universal Precautions work environment.

During the last pandemic in 1968, medical waste management was not an issue since nearly all hospitals were treating onsite (incineration) and were already commingling the medical and solid waste streams. It is a shame to think that this is one area (infectious waste management) of hospital preparedness where we have actually made our hospitals more vulnerable compared to just 15 years ago.

If the scope of the pandemic threat is truly global, an outbreak would dwarf our already strained resources, which is why it should be a priority for the Federal Gov-

ernment to address commonsense solutions and resources for onsite infectious waste treatment now in order to help ensure the health and safety of every community throughout the Nation.

Federal Support for Health Care Emergency Preparedness

In particular, the Coalition stresses the vital role of Federal funding. We are trying to make sure Congress continues to allocate funding to support hospital preparedness programs.

For the private sector, the current Hospital Preparedness Program (HPP), which was funded at \$375 million in FY09, provides a ready-made avenue to offer the financial incentive for medical facilities to transition over to onsite methods of infectious medical waste treatment. The HPP awards competitive grants or cooperative agreements to the States to enable eligible entities to improve surge capacity and enhance community and hospital preparedness for public health emergencies.

Currently disaster relief operations lack efficient means to dispose of infectious medical waste, including most VA facilities. The Federal Government should look at research, development, and deployment of mobile sterilization units capable of being deployed to areas affected by a pandemic, natural disaster or bio-terrorism attacks.

The recently released FY10 Hospital Preparedness Program Funding Opportunity Announcement clarified onsite waste treatment as an appropriate project for HPP funding, which was prompted in part by the House Appropriations Committee's FY-10 report language to mandate U.S. Department of Health and Human Services (HSS) look at onsite medical waste treatment procedures. This guidance is a major victory for hospitals that would like to use this grant to help fund this type of capital equipment.

VA Emergency Preparedness

We know that the VA has worked to be in compliance with the Homeland Security Presidential Directive, The Joint Commission, the National Incident Management System, National Fire Protection Association, and other recognized standards, guidance and procedures as well as Federal laws such as the Pandemic and All-Hazards Preparedness Act (PAHPA). The VA's progress and plans can be reviewed in the VA's updated emergency management guidebook.

While our testimony highlight's our findings and work with private hospitals, the principles and findings we've discuss in this testimony must also be considered for VA facilities. One of the VA's missions is to serve as a safety net when DoD, public health facilities, and private hospitals fail or are overburdened. The impacts to private hospitals and critical supplies due to such events would likely spillover to the VA—especially if we are talking about a serious medical surge event or transportation constraint. In such an event, it is easy to assume that VA facilities would experience similar disruptions in medical waste removal and other services whether or not it is providing mutual aid.

We believe it is important that the VA evaluate each facilities management of medical waste and what plans and procedures are in place for a crisis and any accompanied disruption in waste management services. A simple review of the VA's Pandemic Influenza Plan shows that hospitals should plan for transportation difficulties and be prepared for alternative routes for additional staff and supplies. In regard to supplies, they should have alternative vendors or have established agreements in case of emergency, but it does not address their supplier's transportation issues. The plans says to handle medical waste as it normally would (via the WRAMC policy), but they don't deal with contingencies of increased volumes of medical waste, the costs of such an increase, staffing shortages, and the many other vulnerabilities we've identified in this testimony. We are merely using this example to point out that there are a few key points missed in this plan and pandemic preparedness could easily be improved by adding onsite sterilization equipment.

We'd also like to point out that installing onsite sterilization of medical waste at VA facilities would also provide ancillary and immediate benefits for the VA beyond emergency preparedness, including cost savings and carbon emission reductions. In regard to cost saving, we estimate that onsite waste treatment using sterilization equipment can provide an average cost savings of \$1.63 million per hospital, which would equate to \$190.71 million if installed at all 117 VA Medical Center hospitals that are currently relying upon offsite vendors to haul and treat their waste. Further, regarding the VA's ability to comply with Executive Order #13514, the Coalition has developed a carbon footprint calculator that can calculate the savings, in real numbers of reductions in x pounds of CO₂ emissions each year, for those facilities with onsite waste processing and estimate the savings for those facilities who switch from off-site to onsite processing.

We have constructively urged that onsite sterilization capabilities should be added to the VA's list of best standards and practices as well as a mission critical component to their emergency management plan. Currently, twenty four VA facilities process their waste onsite. We know that other facilities would like to add this component to their capital budgets, but have thus far not done so.

We do not intend to be critical of the VA in this testimony, as we haven't audited individual hospital preparedness plans. We do know that there are groups within the VA looking at this very issue and recognize that onsite medical waste treatment could benefit VA facilities from an everyday operational aspect as well as for emergency preparedness.

Additional VA Emergency Preparedness Considerations

As the one of the missions of the VA is to provide assistance to other Federal, State, and local agencies as outlined in the Department of Homeland Security's National Response Plan, issues that affect private hospitals may also impact the VA. In addition to the medical waste issues we've discussed in this testimony, here are other several areas of concerns of health care emergency preparedness that have been identified by the Coalition.

Vaccines—currently only one of the five companies producing vaccines used in the U.S. for the H1N1 virus are domestically located. The majority of vaccines used are produced overseas and then shipped to the U.S. The H1N1 virus has helped to unveil severe issues with vaccination production and distribution issues inherent with needing to ship in vaccines. The Issue of production and distribution of vaccines has drawn attention at the Federal level, prompting a hearing in the House Energy and Commerce, Subcommittee for Oversight and Investigation. While the issues facing the production and supply of the H1N1 are important, they only serve to highlight an even more severe unpreparedness for a greater virus requiring even more vaccine.

Surge Capacity—In March of 2008 the House Oversight Committee performed a survey of surge capacity in the event of a terrorist attack like the commuter train attacks in Madrid, Spain in 2004 that injured over 2000 people. The survey was conducted for a similar event in seven cities most likely to experience a terrorist attack: New York City, Los Angeles, Washington DC, Houston, Chicago, Denver and Minneapolis. Results of these surveys demonstrated that none of the hospitals surveyed had sufficient emergency capacity to absorb a surge of that magnitude. The survey results showed that the average emergency room in each hospital was operating at 115% capacity. Surge sustainability is a key component of emergency preparedness, terrorist attacks and epidemics are examples of an unexpected surge in emergency room need.

The tragedy that took place in New York on September 11, 2001, the collapsing of the overpass in Minnesota, the flooding in North Dakota, the hurricanes in Louisiana and Mississippi, and now, the current H1N1 pandemic are realities of unexpected events we must always be expecting. None of the areas surrounding these events were logistically prepared to handle the surge capacity or long term sustainability needed. These are the sort of unpredictable event that we must prepare our health care community to be able to withstand in all areas of the country. Protections must be instituted to be able to respond to any event in a moment's notice or be equipped to handle long term sustainability needs if needed.

Supply and Services—a key component of maintaining emergency preparedness at all times is ensuring that hospitals have enough supply capability on hand to withstand a major surge and also sustain an extended lapse in re-supply availability. Most hospitals and medical centers across the country lack sufficient supplies or systems to enable them to handle a sustained surge in patients like would be seen in the event of a crisis. A shocking example of hospitals dependence on offsite aid can be seen in the fact that most hospitals do not even treat their own laundry on the hospital grounds. It is a common practice for hospitals to outsource laundry services creating an unnecessary vulnerability.

Gap Analysis—one of the most common suggestions for health care organizations is to perform a complete "Gap Analysis" as part of their Emergency Management Program (EMP). There are four major components to a thorough Gap Analysis: (1) Identification of planning scenarios along with the number of anticipated casualties for each planning scenario; (2) Requirements development; (3) A listing of current resources and capabilities; and (4) Identification and forwarding to the next higher support agency, the gap between current resources and capabilities and the total requirements needed for each planning scenario.

With a well-defined Gap Analyses, VA can then analyze, plan, program, budget, procure and pre-position additional resources and capabilities needed to close Gaps and sustain and fortify the VAMC's hospitals during future emergencies and disas-

ters requiring Federal support. Further, gap analysis at the VA should consider needs and planning done with DoD, and *local and State Emergency Management Agencies* so it can program for the entire array of “unmet requirements” including mobile medical units, as well as a full complement of staffing by facilities and vendors, medical and nonmedical supplies, equipment and services required to support State/territory and local governments during future disasters and public health emergencies.

We encourage VA emergency managers work extraordinarily closely in identification of all gaps in resources and capabilities and forward the appropriate unmet requirement gaps up the support chain in order to ensure the health care and public health needs of veterans and communities reliant on VA support are met.

Conclusions

Our Nation remains vulnerable in the area of contagious waste management during a pandemic or crisis and we need to highlight the benefits of prudent alternatives, such as onsite sterilization capacity, as a best practice for emergency preparedness and health care facility operational sustainability and be considered a mission critical system for VA hospitals.

The Coalition believes that it is imperative that we use technology to ensure dangerous medical waste is disposed of in a safe and sanitary way, and that the VA is prepared to do so in an emergency. We encourage the VA implement appropriate programs that address onsite waste disposal for both emergency/crisis, which is important as the most hectic periods for health care providers are also the periods that typically produce the most waste, and during every day operations where it can show cost saving and other benefits.

Congress should dedicate some of the current Federal funding to help cover the initial installation costs of implementing onsite technology at VA facilities, which will save the government money in the long term. Offering such Federal funding for the implementation of a more common sense and cost effective approach for government owned health care facilities to deal with infectious waste, and it will set a precedent for private hospitals to adopt and deploy such technologies. Only scarce funds within the HPP are eligible to hospitals or medical facilities transitioning to onsite medical waste treatment in preparation for pandemic or other emergency preparedness.

Furthermore, congress shall appropriate sufficient funding for the research, development, and deployment of mobile sterilization units capable of being deployed to areas affected by a pandemic, natural disaster or bio-terrorism attacks that could be used by multiple jurisdictions, including the VA and the National Guard. Currently, our Nation’s disaster relief operations lack efficient means to dispose of infectious medical waste.

The Coalition believes that a few simple changes in policy, including legislative and appropriation efforts by Congress, would help improve the methods and best practices by which infectious medical waste is handled by VA in this country every day and, as we are discussing today, in emergency situations.

Prepared Statement of Barry A. Searle, Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee.

Thank you for the opportunity to present the views of the American Legion concerning this extremely important, but sometimes neglected topic. The American Legion applauds the foresight of this Committee in bringing this topic back to a place of importance. As we discuss this issue today, I am reminded that on the morning of September 11, 2001, then-National Commander of the American Legion, Rick Santos, was preparing to deliver the Legislative Priorities of the American Legion for FY 2002 in this very room. How quickly the priorities of our Nation changed that fateful morning. Today, after almost 10 years, we, as veterans’ advocates still have priorities that affect the lives of America’s veterans and their families. Perhaps lulled into a sense of security since September 11, 2001, we are now focused on the extreme disability claims back log, increased employment opportunities for veterans, and better access to quality health care for veterans. While these concerns are of great importance, it is equally important that we do not lose sight of the fact that our world, and priorities, could once again change just as quickly.

As was seen during Hurricane Katrina in 2005, the recent flooding in Oklahoma City and Nashville this year as well as Iowa and the Dakotas last year, the earthquake in Haiti, and tornadoes across the southern U.S., a natural disaster can be

only days, hours, or minutes away. Additionally, a weapon of mass destruction can turn an urban area into a mass casualty area, crippling communications and overwhelming traditional emergency services. Prior planning and coordination are the difference between managing a disaster effectively or adding to the chaos and suffering.

The Department of Veterans Affairs (VA) has published policies and given guidance concerning emergency preparedness. There is no question that VA's Central Office understands and accepts its responsibility to prepare for and execute its "Fourth Mission" in support of National Emergency Preparedness. In VA's 2009 *Performance and Accountability Report*, "Strategic Goal 4, Contributing to the Nation's Well-Being," the strategic goal for emergency preparedness addresses Continuity of Operations (COOP) at the Under Secretary and Assistant Secretary levels as 100 percent prepared.

While the American Legion applauds VA for its approach to preparedness, we are concerned that there may be a lack of oversight and feedback concerning preparedness at the Regional Office, VISN and facility levels. The American Legion is concerned that the participation and preparedness at the Regional Office, VISN and facility may be overshadowed by primary day-to-day operations. This would potentially lead to confusion and delay in a disaster situation in the attempt to organize a response.

In a January 2006 VA Office of Inspector General (VAOIG) report on *Emergency Preparedness in Veterans Health Administration Facilities*, it was reported that "At the national level, VHA had developed comprehensive initiatives and directives to address emergency preparedness training, community participation, and decontamination activities. However, at the facility level, VA employees did not consistently receive emergency preparedness training, and emergency plans did not always include some critical training elements as required."

VA's Emergency Management Strategic Health Care Group (EMSHG) has as part of its mission statement an approach that "... assures the execution of VA's Fourth Mission to improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans, as well as to support national, State, and local emergency management, public health, safety and homeland security efforts."

The EMSHG publication, "Legal Authorities of the Veterans Health Administration Emergency Management Program" states, in support of Emergency Mobilization Preparedness, "VA participates in emergency medical response measures with other Federal, State, and local agencies by providing assistance in seven support functions outlined in the Department of Homeland Security's National Response Plan. For example, if requested, the types of support VA would provide include public health and medical services, emergency management, and public safety and security."

The American Legion has also studied VA's 2009 Emergency Management Guidebook, a well organized framework identifying duties and responsibilities. The Guidebook goes into great detail concerning training, to include sample scenarios which cover a wide range of incidents including hurricanes, earthquakes, and relatively small incidents such as a multiple bus accident involving numerous injuries. What we were not able to determine is a feedback mechanism to confirm implementation at the Regional Office, VISN, or facility level. The American Legion believes that disaster preparedness and response cannot be trained and implemented in a short period of time. Effective communication networks and routine relationships are critical to efficient response. For this reason we feel a greater emphasis on requiring reporting for annual exercises and training at the local level is necessary to insure the proper networks are in place to ensure a quick and effective response.

The American Legion's System Worth Saving Task Force annually conducts site visits at VA Medical Centers nationwide to assess the quality and timeliness of VA health care. In follow-up conversations we have found there is a wide range of actual response preparedness across VHA. We believe that this range is symptomatic of the decentralized nature of VA. As with other programs there appears to be limited follow-up on compliance by Central Office.

For example, the American Legion and other VSOs have been briefed on VHA's pandemic preparedness efforts; in particular, the District of Columbia VA Medical Center's preparations for a forecasted H1N1 flu epidemic last fall. The facility should be complimented on its proactive approach to stockpiling vaccine and its preparedness for the potential epidemic. Also during various briefings VSO's were advised of the existence of 50 vehicles, 6 of which are specifically allocated to VHA, the remainder controlled by VBA. These 38-foot vans are primarily tasked with providing veteran counseling outreach, but were specifically designed to be adapted for medical purposes during disaster relief efforts. In particular, each has satellite com-

munications capability critical in a disaster situation. This is an excellent program that shows how a specific component can be utilized to fulfill multiple roles when the demand exists.

During 2009, massive flooding overwhelmed portions of the Midwest. In Fargo, North Dakota, where regular VA Medical Center operations were impacted by the flooding, VA dispatched three mobile Vet Centers for use as triage clinics to help bridge the gap for the community until regular operations could be restored. The use of these vehicles in a successful manner demonstrates that VA's mission as a Support Agency as part of Emergency Support Function #8 in the National Incident Management System (NIMS) works. However, on the other end of the spectrum, during recent discussions with a group of facility directors it was found that some had no knowledge of the mobile clinics' existence. Such a valuable resource must be part of the ingrained knowledge of any facility director or the value of these tools will be lost.

Another demonstration of how advanced preparation can be invaluable was pointed out during a recent American Legion staff visit to the Atlanta VAMC. Legion staff was briefed about how the facility coordinated with local hospitals and DoD personnel to provide medical services for individuals injured in the Haiti earthquake under the National Management Disaster Assistance program. Several VAMC staff members worked at local hospitals to provide assistance as needed for the situation. Atlanta VAMC emergency management personnel were the team lead for the disaster assistance.

Unfortunately, we have also found during our followup to our System Worth Saving facility visits that at the local level there is in some cases a lack of awareness of the responsibility of facilities to prepare for non-veteran casualty assistance. The primary focus is on mutual support of VA facilities for assisting veterans in a disaster. Additionally it was discovered that turnover and shortage of personnel at most facilities require renewed emphasis on standardized procedures, quality review and individual training, as well as documentation of that training. The American Legion has concerns that if not properly prepared and trained to respond, these facilities will be quickly overwhelmed and unable to support the "4th mission" as effectively as needed in a time of emergency.

To further examine the specific, local level of disaster preparedness, it is important to go out into the field to assess exactly what those levels are, and how they differ from the expected and dictated policies.

The American Legion conducts Quality Review audits of Regional Offices across the country to identify issues relating to veterans claims. During the 2009 visit to the VA Regional Office (VARO) in New Orleans 4 years after the hurricane it was found that the VARO was only just starting to approach a sense of normalcy. Interviews with the workforce who had been present through the entire ordeal revealed two important facts. Every employee felt that the office did the best that they possibly could under unimaginable circumstances. However, they also felt that there were many failures and there was a hope that the lessons learned would be captured. The number one complaint with the response to the disaster of Katrina was the poorly defined lines of communication. The lesson that must be captured is that a clear-cut disaster protocol, with clear lines of communication, must be second nature in its actual application.

Some areas of concern regarding the VA's emergency response mission are actually being addressed indirectly by the day-to-day improvements VA is implementing in assisting veterans. For example, cited in the Department of Health and Human Services (HHS) Medical Surge Capacity and Capability Handbook when discussing disaster assistance is, "many of the tenets of the MSCC Management System are not easily achieved." For example, garnering support and participation from medical clinics and private physician offices, while laudable, is by no means a simple task to accomplish. Because the private medical community is so diverse and disconnected, there is wide variation in motivation and constraints to implementing these processes. There is an effort to develop Lifetime Virtual Electronic Records (LVER), which will cover an individual from "the day you raise your hand till after you are laid to rest." This system will not only involve DoD/VA participation but in an effort to assist with VHA's responsibilities it will also entail establishing networks with private physicians to share information. This network will, we believe, assist in the communications issues raised in the HHS handbook by establishing the Internet connections and bridging firewalls between VA/DoD and civilian practices and developing mutual understanding of required information.

Additionally, the emphasis on rural health care clinics and telehealth in order to assist veterans will continue to expand the VA's outreach and disburse critical assets and make them available in case of emergency. For example, should a VAMC's operations in a relatively urban area be degraded due to a natural disaster, a rel-

actively close rural clinic or clinics with functional telecommunications could be developed as staging areas for directing resources and, to some degree, triage areas for evacuating casualties until the VAMC could resume full operation.

In conclusion, the American Legion fully realizes the importance of VA's Fourth Mission, not only to the veterans that VA serves, but to our Nation as a whole. In a resolution approved in 2008 we urged the Secretary of Veterans Affairs to take an active role in the development and implementation of plans to enhance Federal homeland security initiatives and that Congress provide VA with the funding necessary to further enhance its capacity to act as a back-up to DoD and FEMA. We believe that at the national level VA is serious in this mission. However, we feel additional follow-up and reporting on activities on the local level is essential to ensure that the Central Office policies actually reach the ground level.

Thank you again for the opportunity to provide insight and analysis on this issue on behalf of the American Legion and its more than 2.5 million members.

**Prepared Statement of Neal Denton, Senior Vice President,
Government Relations and Strategic Partnerships, American Red Cross,
Washington, DC**

Good morning Chairman Mitchell, Ranking Member Roe and distinguished Members of the Subcommittee. My name is Neal Denton and I serve as the Senior Vice President for Government Relations and Strategic Partnerships at the American Red Cross. We salute your attention to emergency preparedness and appreciate the opportunity to join with our partners to share our work when preparing for and responding to large-scale disasters. Particularly, I am grateful for this opportunity to speak to the partnership between the American Red Cross and the Department of Veterans Affairs when it comes to disaster response.

For more than 125 years, the American Red Cross has provided relief to victims of disaster and helped families and individuals prevent, prepare for, and respond to emergencies. Our Congressional Charter mandates that the Red Cross carry out a system of national and international relief. We meet our mission through a national network of nearly 700 chapters that respond to approximately 70,000 disasters annually—about 200 disasters each day. From single family house and apartment fires to large scale disasters such as hurricanes and floods, the Red Cross works to provide essential lifesaving and sustaining services to those in need. We shelter, feed, and provide critical supplies and emotional support to those impacted by disasters in communities across our country. The Red Cross also provides support to members of the military, veterans and their families, supplies nearly half of the Nation's blood supply, and teaches lifesaving skills in communities across the country. As you know, the Red Cross is a charitable organization—not a government agency—and depends on volunteers and the generosity of the American public to perform its mission, including donations of time, money and blood.

Whether it is a hurricane or a heart attack; a call for blood or a call for help, the American Red Cross is there.

Red Cross volunteers and staff are on the frontlines when emergencies occur in their communities. Our national system builds upon our local chapter presence to supplement staff and to provide additional resources when necessary. Together, we offer immediate emergency assistance to those in need during disasters of all sizes. The Red Cross is committed to delivering the best possible response, and we strive to continuously improve our operations and services.

Our organization operates in a constant cycle of responding to disasters and preparing for the future. The Red Cross—at the local and national levels—regularly participates in activities to build capacity, partner, plan, prepare, exercise, and evaluate our capabilities. We periodically review and, when necessary, refine our roles and responsibilities. This is a critical time of the year, as the Red Cross is currently responding to tornadoes, floods and wildfires at the same time that we are preparing for the potential demands of what is predicted to be a very active hurricane season.

In preparation for disasters large and small, we carefully analyze data and project potential needs for shelters, food, personnel, and other operational functions. To meet expected needs, material resources have been pre-positioned in warehouses across the country for easy access and prompt mobilization. We also have completed a detailed assessment of our communication equipment inventory and have verified and pre-positioned our Nationwide disaster fleet of more than 300 vehicles. This fleet includes emergency response vehicles, communication vehicles, tractor trailers, and utility vehicles.

In addition, the National Shelter System (NSS), which tracks potential shelter locations and capacities, is populated with up-to-date data. It now contains location and capacity information for over 55,000 buildings that could potentially be used as shelters across the country. The system, used for both planning and operational decisions, records all shelter openings, closings and overnight populations on a daily basis. The NSS is available to FEMA and to all States free of charge and it is currently being used by 12 additional national nongovernment partners. I also am happy to report that the American Red Cross features a link to the NSS and shelter locations on the home page of our Web site, www.redcross.org.

Staffing of relief operations is a critical function that requires advance planning. We focus on the use of local volunteers whenever possible, and also have more than 50,000 trained volunteers who are available to travel outside of their home communities. These disaster workers are trained for specific jobs, and we are assessing their availability for disaster assignments during this hurricane season. Including locally available disaster-trained volunteers, the Red Cross has more than 90,000 volunteers—a considerable increase from the 23,000 that were available prior to Hurricane Katrina nearly 5 years ago.

Working With Partners—U.S. Department of Veterans Affairs

While service delivery happens at the local level, it is supported by a national system. Our disaster field structure is aligned by State and provides a point of contact and integration of plans with Federal, State and local officials across the nation. In recent years, the American Red Cross has focused more resources on coordination with Federal, State, and local government. This increased presence has improved coordination and is strengthening key relationships with our Federal partners like the Department of Veterans Affairs (VA).

With support from FEMA, we have full-time Red Cross employees to staff each of the ten FEMA regional offices and the two area offices in the Caribbean and Pacific. We also have one full-time representative to the National Disaster Housing Taskforce and two additional full-time staff positions to represent our organization at FEMA National Headquarters. We continue to be closely aligned with FEMA and are currently collaborating on how to ensure even more information sharing and situational awareness during operations as we prepare for what is predicted to be a higher-than-average hurricane season.

In a disaster response capacity, the American Red Cross sits at the same table with the Department of Veterans Affairs during planning, exercises and operations. With FEMA as the lead agency for synchronizing the Federal support to tribal, State and local partners, we coordinate closely before, during and after a disaster. Both the VA and the Red Cross work in close coordination to identify assets, capabilities, and plans with the Federal interagency community. The Red Cross and the VA both serve as a support agency for the National Response Framework and work closely together on Emergency Support Function #6 (ESF #6), providing technical support for Federal mass care activities, emergency assistance, housing and human services. During a Weapons of Mass Destruction (WMD) incident, both agencies work within the ESF #15 External Affairs coordination structure to ensure unity of effort on public communication and guidance.

The VA and the Red Cross also are collaborating with the Department of Defense, the Department of Health and Human Services and FEMA as we develop a reliable patient and evacuee tracking system. While this long term project is in its initial phases, VA hospitals have participated in patient evacuation as receivers of medical transferees. Red Cross tries to help nonmedical evacuees co-locate in shelters near their loved ones and assists in connecting families by using the Safe & Well notification system, which is an effective online communication tool that helps those affected by the disaster alert family and friends outside the immediate area that they are “safe and well.”

The American Red Cross is also excited about a possible opportunity that will allow us to train and provide resources to the families of veterans. In partnership with the VA, the Red Cross can assist families through the delivery of Red Cross Family Caregiving and Nursing Assistant programs, which will enable them to address the challenges of caring for their loved ones. These programs will help participants develop skills in personal care, nutrition, home safety and legal and financial issues. We believe this information is vital to those caring for loved ones who suffer from chronic illness and temporary or permanent disabilities. Training builds confidence and instills knowledge a caregiver will need when providing support to a veteran.

Identifying new partners and strengthening existing partnerships is a key priority for our organization. We strive to be an effective leader and valuable partner before, during and after a disaster. Our outreach, however, extends beyond traditional dis-

aster response agencies. We continually seek and engage organizations that possess a particular critical expertise, community trust, or credibility that can greatly expand and improve a community's response. Organization-wide, we are committed to fostering a culture of collaboration, diversity and inclusion in our partnering efforts.

On the local level, chapters partner with local community, faith-based and civic organizations. We also have stepped up efforts to ensure that community 2-1-1 organizations have current disaster information. On a national level, we continue to rely on our long standing partners in disaster, such as Southern Baptist Disaster Relief, The Salvation Army, and Catholic Charities. In addition, we are cultivating and strengthening more diverse partnerships with groups like HOPE worldwide, the NAACP, Legal Services Corporation, National Baptist Convention and Tzu Chi Buddhist Foundation. We work closely with disability rights groups, immigration rights groups, and language interpretation and translation groups such as the National Association of Judiciary Interpreters and Translators, the National Virtual Translation Center, the National Council of La Raza, National Disability Rights Network, Save the Children, and tribal organizations. Our work with pet rights groups such as the U.S. Humane Society has also been important. All of these groups provide invaluable expertise to help clients, in particular diverse clients and those with unique needs.

Together with our partners, we can continue to strengthen the country's capacity to better meet the needs of the diverse communities we serve.

Encouraging Community and Citizen Preparedness

Individuals and families across this nation rely upon the American Red Cross to deliver on our promise—provide for emergency needs in times of disaster. However, the system of relief will not work well without continued emphasis on community and personal preparedness. One Red Cross national survey last summer showed that approximately 68 percent of individuals and families have not made an emergency communications plan and 79 percent have not identified a meeting place should family members become separated during a disaster.

In August 2009, the American Red Cross Emergency Preparedness Survey indicated that approximately half of Americans (51 percent) have experienced at least one significant emergency where they have lost utilities for at least three days, had to evacuate, could not return home, were unable to communicate with family members or had to provide first aid to others. More than a third (37 percent) lost utilities for at least 3 days. Although 89 percent of those surveyed believe it's important to be prepared, far fewer are ready for an emergency.

American Red Cross preparedness programs and tools help to save lives and empower people to prepare for and respond to disasters and other life-threatening emergencies. Just as every disaster is ultimately an intensely personal experience; the American Red Cross has found that a commitment to making our homes and communities safer also must be personal. Therefore, preparedness staff members work closely with local, State and national partners to help people personalize their risk to natural hazards and make preparedness and mitigation a personal priority. The overall goal is to build a "culture of preparedness" by encouraging Americans to understand their individual risk and geographical threats and then take action to adopt specific preparedness behaviors. The American Red Cross is playing a leadership role in hundreds of communities across the nation that has made a commitment to be more disaster resistant.

Conveying a single national message of preparedness is critical. Our "Be Red Cross Ready" campaign, which parallels the Department of Homeland Security's Ready Campaign, offers three important steps: (1) Get a Kit; (2) Make a Plan; and (3) Be Informed. This message serves as our public call to action for citizen preparedness.

The valuable partnership among the American Red Cross, FEMA, Ready.gov and others was showcased at the Military Family Preparedness Event hosted at Fort Belvoir earlier this month. Together, on June 5, we distributed approximately 1,500 preparedness kits to military families including active duty, retired and reserve soldiers. This September, as part of National Preparedness Month, we are planning to conduct similar events at four military installations across the United States and two locations overseas in order to raise awareness of being prepared and to help many families be better prepared for emergencies. The locations for the September Military Family Preparedness Events are: Fort Drum (Jefferson County, NY); Joint Base Lewis-McChord (Pierce & Thurston County, WA); Fort Polk (Vernon Parish, LA); Garrison Grafenwoeher (Vilseck, Germany); and Garrison Yongsan (Seoul, South Korea). While this is a promising start, there is much more we can do to help military families prepare for emergencies.

Conclusion

Thank you again for this opportunity to be before you today. As we enter the 2010 hurricane season and communities across our country are already dealing with floods, wildfires and tornadoes, the American Red Cross stands ready to help those in need. We are working hard to improve efficiencies, and to increase individual and community preparedness. Our work would not be possible without a powerful corps of volunteers supported by thoughtful and effective partnerships.

We are especially pleased to be working with FEMA's strong leadership team, with Administrator Fugate, and with the leadership in the executive branch. The American Red Cross is our Nation's largest mass care provider, and we stand ready to work with our partners in government, in the nonprofit sector, and in the private sector to ensure that the country is as prepared as possible to respond to disaster of any kind.

And finally, a crucial part of our mission at the American Red Cross is to create a culture of preparedness prior to a disaster to ensure communities are better prepared to take care of themselves, their families and their neighbors in the wake of a disaster. We simply cannot fail in this mission.

I am happy to address any questions you may have.

**Prepared Statement of Kevin Yeskey, M.D.,
Director, Office of Preparedness and Emergency Operations,
Deputy Assistant Secretary, Office of Preparedness and Emergency
Response, U.S. Department of Health and Human Services**

Thank you, Mr. Chairman and Members of the Subcommittee. My name is Dr. Kevin Yeskey, and I am the Deputy Assistant Secretary for Preparedness and Response, in the Office of the Assistant Secretary for Preparedness and Response (ASPR), at the Department of Health and Human Services (HHS). I direct ASPR's Office of Preparedness and Emergency Operations, which oversees the medical planning and operations for the Department. I appreciate the opportunity to comment on the Department's role in the National Response Framework, and specifically about how we coordinate with and utilize the U.S. Department of Veterans Affairs in our response efforts.

HHS adheres to the National Response Framework which establishes a comprehensive, national, all-hazards approach to domestic incident response. Within the NRF are 16 Emergency Support Functions. The Secretary of Health and Human Services leads all Federal public health and medical response to emergencies and incidents covered by the NRF, known as Emergency Support Function or ESF #8. Within HHS, and on behalf of the Secretary, ASPR coordinates national ESF #8 preparedness and response actions.

Among the ESF #8 functions are medical care, public health surveillance, patient movement, and fatalities management. In carrying out this responsibility, HHS depends on public health and medical resources from within HHS, including the National Disaster Medical System (NDMS), the Commissioned Corps of the U.S. Public Health Service, and civilians from our component agencies, such as the Centers for Disease Control and Prevention and the U.S. Food and Drug Administration. Additionally, we request assistance and support from our interagency partners, including the Department of Veterans Affairs (VA).

As we develop our plans and execute our response to disasters, HHS and the VA work closely together. In my remaining testimony, I would like to discuss areas where HHS and VA collaborate in support of our common goal of providing high quality public health and medical care to those in their time of greatest need.

With regard to our relationship with the U.S. Department of Veterans Affairs, there is a long standing tradition of collaboration between the staffs of the two Departments. Consequently, we have shared a lengthy history in health related efforts, including emergency preparedness activities, beginning with extensive collaboration on the creation and management of the National Disaster Medical System. HHS has developed "playbooks" for 14 of the 15 national planning scenarios. These playbooks serve as a guide to our response to disasters, such as earthquakes and hurricanes. The VA and other ESF #8 partners provide significant input into each of the playbooks as they are developed and revised. Additionally, at the request of the VA, HHS has placed a liaison in the VA's Office of Public Health and Environmental Hazards. This liaison provides continuity of communications between the two Departments in the area of preparedness and response.

When HHS responds to an event, the VA provides liaison officers to the HHS operations center. When HHS deploys public health and medical assets to an affected

area, we use personnel from the NDMS, a partnership between the VA, Department of Defense, Department of Homeland Security, and HHS. Disaster Medical Assistance Teams provide acute care for victims, often at or near the area of the disaster. When these teams need to be augmented with additional clinicians, we have turned to the VA for them and they have provided appropriate personnel. Most recently, the VA provided three surgeons and two anesthesiologists for our medical teams deployed in response to the earthquake disaster in Haiti. These clinicians immediately integrated into the teams and provided outstanding care. In the hurricane season of 2008, VA provided personnel to completely staff two of our Federal Medical Stations and, in past hurricane seasons, the VA has provided VA hospital sites for us to set up Federal Medical Stations. They have willingly provided staff and space when HHS has had the need for such support.

Through the NDMS, HHS has responsibility for transporting patients from disaster sites. HHS, DoD, and VA have key functions in moving patients. One of their key functions in patient movement is managing the Federal Coordination Centers (FCCs). These FCCs are critical to our role in both patient movement and the provision of definitive care to patients evacuated during a public health emergency. FCCs recruit hospitals to participate in the NDMS and coordinate the receipt of patients in host cities. Nationwide, we have 62 FCCs, two-thirds of them are managed by the VA. DoD manages the other one-third. NDMS has over 1600 participating hospitals nation-wide. In the 2008 hurricane season, VA-managed FCCs coordinated the receipt of medically evacuated patients in Arkansas and Oklahoma. When NDMS was activated for the Haiti earthquake, VA personnel coordinated the receipt and distribution of patients evacuated to Florida and Georgia to receive life-saving definitive care.

HHS regards the VA as an integral partner in our preparedness and response activities. The VA has provided expertise in the development of our preparedness plans. The clinical support provided by VA has provided HHS with crucial medical care to victims of disasters.

We greatly respect the work the VA does in its support to veterans on a daily basis. We also appreciate the breadth and depth of clinical expertise the VA provides our medical response teams.

During emergencies, whenever HHS has asked for assistance, VA has reliably stepped up to the plate and provided the requested support. I believe that HHS's partnership with VA is a strong and extremely cooperative one that enables both Departments to serve our Nation in times of emergency.

Again, thank you for the opportunity to be here today. At this time, I will be happy to answer any questions you may have.

**Prepared Statement of Steven C. Woodard,
Director of Operations Division, and Response Directorate, Federal
Emergency Management Agency, U.S. Department of Homeland Security**

Good afternoon, Chairman Mitchell, Ranking Member Roe and Members of the Subcommittee. Thank you for inviting me to appear before you today.

I am Steven Woodard, Director of Response Operations within the Response Directorate at the Federal Emergency Management Agency (FEMA). We look forward to working with Congress to ensure that our Nation is prepared for all disasters. It is often difficult to know if an event might be the initial phase of a larger, rapidly growing threat. Response must be quickly scalable, flexible and adaptable. To meet the challenge of that uncertainty, we have developed the National Response Framework (*Framework*) with our Federal partners. The *Framework* is a guide for how the Federal, State, local, and tribal governments, along with nongovernment organizations (NGOs) and private sector entities, will collectively respond to and recover from all disasters, particularly catastrophic disasters, regardless of their cause. The *Framework* details a dynamic and flexible response—one that can evolve to address new challenges we may face in the future.

Incidents begin and end locally, and most are wholly managed at the local level. Cognizant of this, we must manage these events at the lowest possible jurisdiction, supported by additional capabilities when needed. State and local governments are closest to those impacted by incidents, and have always had the lead in response and recovery. During response, States play a key role coordinating resources and capabilities throughout the State and obtaining resources and capabilities from other States. Many incidents require unified response from local agencies, NGOs, and the private sector, and some require additional involvement from neighboring jurisdictions or the State. A small number require Federal support.

National response protocols recognize this and are structured to provide additional, tiered levels of support when there is a need for more resources or capabilities to aid and sustain the response and initial recovery. All levels should be prepared to respond, as well as have the capacity to anticipate resources that may be required. The number, source, and type of resources must be able to expand rapidly to meet the needs of a given incident. Layered, mutually supporting capabilities at Federal, State, tribal, and local levels allow for strategic collaboration during times of calm, as well as an effective and efficient response in times of need.

The *Framework* recognizes the need for collaboration among the myriad of entities and personnel involved in response efforts at all levels of government, nonprofit organizations, and the private sector. The Department of Veterans Affairs (VA), which is the second largest of all Federal departments, is one of many agencies serving as cooperating/support for the *Framework*. Specifically, the VA is a Support Agency for five ESFs: ESF 3 (Public Works and Engineering), ESF 5 (Emergency Management), ESF 6 (Mass Care, Emergency Assistance, and Housing & Human Services), ESF 7 (Logistics Management and Resource Support) and ESF 8 (Public Health and Medical Services). In my testimony, I will outline the different mechanisms available in order to create the most effective, cohesive, and efficient response capability to mitigate the damage caused by disasters.

Coordination of Federal Responsibilities

The President leads the Federal Government response effort to ensure that the necessary coordinating structures, leadership, and resources are applied quickly and efficiently to large-scale catastrophic incidents. The President's National Security Staff, which brings together Cabinet officers and other department or agency heads as necessary, provides strategic policy advice to the President during large-scale incidents that affect the nation.

Federal disaster assistance is often thought of as synonymous with Presidential declarations and the Stafford Act; however, Federal assistance can also be provided to State, tribal, and local jurisdictions, as well as to other Federal departments and agencies, through various mechanisms and authorities. Often, Federal assistance does not require coordination by the Department of Homeland Security (DHS) and can be provided without a Presidential major disaster or emergency declaration. Examples of these types of assistance include those described in the National Oil and Hazardous Substances Pollution Contingency Plan, the Mass Migration Emergency Plan, the National Search and Rescue Plan, and the National Maritime Security Plan. These and other supplemental agency or interagency plans, compacts, and agreements may be implemented concurrently with the *Framework*, but are subordinated to its overarching coordinating structures, processes, and protocols.

When the overall coordination of Federal response activities is required, it is implemented through DHS, consistent with Homeland Security Presidential Directive (HSPD) 5. Other Federal departments and agencies carry out their response authorities and responsibilities within this overarching construct. Nothing in the *Framework* alters or impedes the ability of Federal, State, tribal, or local departments and agencies to carry out their specific authorities or perform their responsibilities under all applicable laws, executive orders, and directives. Additionally, it does not impact or impede the ability of any Federal department or agency to take an issue of concern directly to the President or any member of the President's staff.

Robert T. Stafford Disaster Relief and Emergency Assistance Act

When it is clear that State capabilities will be exceeded, the Governor can request Federal assistance, including assistance under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). The Stafford Act authorizes the President to provide financial and other forms of assistance to State and local governments, certain private nonprofit organizations, and individuals to support response, recovery, and mitigation efforts following presidential emergency or major disaster declarations.

The Stafford Act is invoked when an event causes damage of sufficient severity and magnitude to warrant Federal disaster assistance to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating damage, loss, hardship, or suffering.

Other Federal Departments and Agencies

Under the *Framework*, various Federal departments or agencies may play primary, coordinating and support roles based on their authorities and resources, and on the nature of the threat or incident.

In situations where a Federal department or agency is responsible for directing or managing a major aspect of a response coordinated by DHS, that organization is part of the national leadership for the incident. In addition, several Federal de-

partments and agencies have their own authorities to declare disasters or emergencies. For example, the Secretary of Health and Human Services can declare a public health emergency. When those declarations are part of an incident requiring a coordinated Federal response, departments or agencies act within the overall coordination structure outlined in the *Framework*.

Federal Actions

FEMA and DHS engage the Federal interagency on a daily basis through numerous channels. Formally, we do so through a Disaster Resilience Group (DRG), which is composed of cabinet level departments and agencies, including the Department of Veterans' Affairs, and is hosted by the National Security Staff. The DRG serves as a forum for interagency planning, discussion and policy formation with respect to disaster preparedness.

In the event of, or in anticipation of, an incident requiring a coordinated Federal response, the FEMA National Response Coordination Center (NRCC) notifies other Federal departments and agencies of the situation and specifies the level of activation required. After being notified, departments and agencies:

- Identify and mobilize staff to fulfill their department's or agency's responsibilities, including identifying appropriate subject matter experts and other staff to support department operations centers.
- Identify staff for deployment to the DHS National Operations Center (NOC), the NRCC, FEMA Regional Response Coordination Centers (RRCCs), or other operations centers as needed, such as the FBI's Joint Operations Center. These organizations have standard procedures and call-down lists, and will notify department or agency points of contact if deployment is necessary.
- Identify staff that can be dispatched to the incident Joint Field Office (JFO), including Federal officials representing those departments and agencies with specific authorities. They must also identify lead personnel for the JFO sections (Operations, Planning, Logistics, and Administration and Finance) and the *Framework* Emergency Support Functions (ESF).
- Begin activating and staging Federal teams and other resources in support of the Federal response as requested by DHS or in accordance with department or agency authorities.
- Execute pre-scripted mission assignments and readiness contracts, as directed by DHS.

Some Federal departments or agencies may deploy to an incident under their own authorities. In these circumstances, Federal departments or agencies will notify the appropriate entities such as the NOC, JFO, State Emergency Operation Centers (EOC), and the local Incident Command.

Federal-to-Federal Support

Federal departments and agencies execute interagency or intra-agency reimbursable agreements, in accordance with the Economy Act or other applicable authorities. The *Framework's* Financial Management Support Annex outlines this process. Additionally, a Federal department or agency responding to an incident under its own jurisdictional authorities may request DHS coordination to obtain further Federal assistance.

In such cases, DHS may activate one or more ESF to coordinate required support. Federal departments and agencies must plan for Federal-to-Federal support missions, identify additional issues that may arise when providing assistance to other Federal departments and agencies, and address those issues in the planning process. When providing Federal-to-Federal support, DHS may designate a Federal Resource Coordinator.

National Response Coordination Center (NRCC)

The NRCC is FEMA's primary operations management center, as well as the focal point for national resource coordination. As a 24/7 operations center, the NRCC monitors potential or developing incidents and supports the efforts of regional and field components.

The NRCC also has the capacity to increase staffing immediately in anticipation of or in response to an incident by activating the full range of ESFs and personnel as needed to supply resources and policy guidance to a JFO or other local incident management structures. The NRCC provides overall emergency management coordination, conducts operational planning, deploys national-level entities, and collects and disseminates incident information as it builds and maintains a common operating picture. Representatives of nonprofit organizations may also participate in the NRCC to enhance information exchange and cooperation between these entities and the Federal Government.

Emergency Support Functions (ESFs)

FEMA coordinates response support from across the Federal Government and certain NGOs by activating, as needed, one or more of the 15 ESFs. The ESFs are coordinated by FEMA through its NRCC. During a response, ESFs are a critical mechanism to coordinate functional capabilities and resources provided by Federal departments and agencies, along with certain private-sector and NGOs. They represent an effective way to bundle and funnel resources and capabilities to local, tribal, State and other responders. While these functions are coordinated by a single agency, they may rely on several agencies to supply resources for each functional area. The mission of the ESFs is to create an efficient, interagency channel to access the vast disaster response capabilities of the Federal Government. During large disasters, FEMA hosts video teleconferences with over 200 departments and agencies to synchronize response efforts between Federal responders, States impacted by the disasters, the JFO, the NRCC and the RRCCs. During these video teleconferences, approximately 30–40 agencies, including the VA, provide updates on the situation.

The ESFs serve as the primary operational-level mechanism to provide assistance in functional areas such as transportation, communications, public works and engineering, firefighting, mass care, housing, human services, public health and medical services, search and rescue, agriculture and natural resources, and energy.

Each ESF is comprised of an overall coordinator as well as primary and support agencies. The *Framework* identifies primary agencies on the basis of authorities, resources and capabilities. Support agencies are assigned based on resources and capabilities in a given functional area. The resources provided by the ESFs are consistent with resource-typing categories identified in the National Incident Management System (NIMS).

As stated earlier, the VA is a Support Agency for five ESFs: 3, 5, 6, 7 and 8. The VA can provide available resources requested directly by FEMA or by the primary agencies in charge of the ESFs—most frequently from the Department of Health and Human Services, the primary agency for ESF 8. During a presidentially declared disaster, the VA assists the Secretary of HHS with numerous ESF 8 responsibilities. These include coordinating available hospital beds, additional personnel and supplies, and providing technical assistance. In addition, FEMA has a Pre-Scripted Mission Assignment for the VA to provide technical assistance to FEMA in support of Housing Task Forces established in response to a disaster. Other resources the VA has provided during recent disasters include staffing assistance to call centers.

ESFs may be selectively activated for both Stafford Act and non-Stafford Act incidents under circumstances as defined in HSPD–5. Not all incidents requiring Federal support result in the activation of ESFs. FEMA can deploy assets and capabilities through ESFs into an area in anticipation of an approaching storm or other event that is expected to cause significant harm. The coordination between ESFs allows FEMA to position Federal support for a quick response, though actual assistance cannot normally be provided until the Governor requests and receives a Presidential major disaster or emergency declaration. Many States have also organized an ESF structure along this approach.

When ESFs are activated, they may have a headquarters, regional, and field presence. At FEMA headquarters, the ESFs support the strategy and coordination of field operations within the NRCC. The ESFs deliver a broad range of technical support and other services at the regional level in the RRCCs, and in the JFO and Incident Command Posts, as required by the incident. At all levels, FEMA issues mission assignments to obtain resources and capabilities from across the ESFs.

The ESFs also plan and support response activities. At the headquarters, regional, and field levels, ESFs provide staff to support the incident command sections for operations, planning, logistics, and finance/administration, as requested. The incident command structure enables the ESFs to work collaboratively. For example, if a State requests assistance with a mass evacuation, the JFO would request personnel from ESF 1 (Transportation), ESF 6 (Mass Care, Emergency Assistance, Housing, and Human Services), and ESF 8 (Public Health and Medical Services). These would then be integrated into a single branch or group within the Operations section to ensure effective coordination of evacuation services. The same structures are used to organize ESF response at the field, regional, and headquarters levels.

To support an effective response, all ESFs are required to have strategic and highly detailed operational plans that include all participating organizations, and engage both the private sector and NGOs as appropriate. The ongoing support, coordination, and integration of ESFs and their work are some of FEMA's core responsibilities in its response leadership role for DHS.

NRF Support and Incident Annexes

In addition to the ESFs, support is harnessed among Federal, private sector and NGO partners in the NRF Support and Incident Annexes. By serving as coordinating or cooperating agencies for various Support or Incident Annexes, Federal departments and agencies conduct a variety of activities to include managing specific functions and missions or providing overarching Federal support within their functional areas. For example, the Department of Veterans Affairs serves as a Cooperating Agency for the Critical Infrastructure and Key Resources Support Function.

Conclusion

Our Nation must be prepared to meet all challenges. FEMA recognizes that disaster events, regardless of magnitude, can be devastating to the people and communities affected. The *Framework* establishes a comprehensive, national all-hazards approach to domestic incident response that brings together all levels of government and private-sector businesses and organizations. The *Framework* integrates our Nation's response plans, capabilities, and preparedness activities around common principles, and allows FEMA and its Federal colleagues to be more agile and responsive partners with the States and the public following a disaster. Thank you for the opportunity to testify and I look forward to any questions the Committee may have.

Prepared Statement of Hon. José D. Riojas, Assistant Secretary for Operations, Security, and Preparedness, U.S. Department of Veterans Affairs

Mr. Chairman, Members of the Subcommittee, I appreciate the opportunity to appear before you today and provide an overview of the Department of Veterans Affairs' (VA) state of preparedness. In carrying out its "Fourth Mission," VA supports national efforts to prepare for, respond to, and recover from natural disasters, acts of terrorism, and man-made catastrophes. While serving in this capacity, VA must continue to maximize its service to Veterans. Today, I will describe for you the strategic planning, preparation, and exercises that take place across the Department, enabling VA to be a national asset while at the same time keeping our promise to our Nation's Veterans. I also will share specific examples of VA preparedness efforts, how VA applies lessons learned, how VA planned for the H1N1 influenza pandemic, how it responded after the earthquake in Haiti, and how we have prepared for the upcoming hurricane season.

I am accompanied today by Mr. Kevin Hanretta, Deputy Assistant Secretary for Emergency Management, and Dr. Gregg Parker, Chief Medical Officer for Veterans Integrated Service Network (VISN) 16, Veterans Health Administration (VHA), which includes the parish of New Orleans. Both VA officials served during Hurricane Katrina—Mr. Hanretta in Headquarters operations and Dr. Parker on the ground in New Orleans. Together they can provide a firsthand account of VA's performance during that crisis from a Department-wide and local perspective. More importantly, each can attest to the knowledge gained through that experience and the ways in which VA has applied those lessons learned to enhance its preparedness.

Since joining the VA team just over a year ago, I have been increasingly impressed with the quality of our dedicated professionals who work to ensure that VA's preparedness is continuously improved. The team within the Office of Operations, Security, and Preparedness (OSP) provides an excellent example. OSP's mission is to coordinate the Department's emergency management, preparedness, security, and law enforcement activities to ensure VA can continue to perform its mission-essential functions under all circumstances across the spectrum of threats. OSP's success in fulfilling these responsibilities enhances the Department's capabilities to support our Veterans and the Nation. President Obama has charged Secretary Shinseki to transform VA into a 21st century organization that is "people-centric, results-driven, and forward-looking." Enhancing VA's preparedness is essential to this task.

Preparedness involves using VA's capability to maximize our ability to prevent, protect against, mitigate the effects of, respond to, and recover from natural disasters, acts of terrorism, and man-made disasters. VA's ability to assist, in case of a national emergency or act of terrorism, depends on how well we anticipate needs, plan for evolving scenarios, and respond with agility to the disaster or threat. This means positioning personnel and equipment in anticipation that routine modes of transport and communications may be compromised, as well as having contingency plans and mapping out next steps. It also is important to practice emergency response procedures. Through training exercises, senior leaders and other responsible

personnel gain confidence in knowing what is required to support the mission and to continue operations.

Leadership Attention

Maximizing preparedness requires the attention of leadership. VA's Secretary, Deputy Secretary, and senior leaders take preparedness very seriously and are committed to investing the time, training, and resources necessary to ensure that VA can step up when called to action. Through his personal participation in national training exercises, Eagle Horizon 2009 and 2010, Secretary Shinseki set the example. Secretary Shinseki has established three "Fourth Mission" priorities for VA: personnel accountability, improved communications, and increased capability to serve as a national resource. These priorities are reinforced with senior leadership on a regular basis during briefings and meetings about operations and have been communicated to every level of the Department. Additionally, I am pleased to report that, "Ensure Preparedness to meet emergent national needs" is one of the 13 Department-Level Initiatives within VA's Strategic Plan for FY 2010–2014.

Increased Capabilities

The Integrated Operations Center (IOC), established in June 2009, continues to evolve and will allow for more comprehensive and active participation by internal VA stakeholders.

The IOC is the cornerstone of VA's preparedness effort and serves as the Department's fusion point for unified command, integrated planning, data collection, and predictive analysis. OSP Watch Officers staff the VA IOC 24/7. Each of the administrations—Veterans Health Administration, Veterans Benefits Administration and National Cemetery Administration—along with the Office of Information and Technology provide 24-hour coverage as well. The Office of Human Resources and Administration and the Office of Public and Intergovernmental Affairs provide coverage to the IOC on a daily basis during business hours. All other VA staff offices and organizations are available on-call. The IOC is the focal point within VA for the receipt, analysis, and dissemination of information related to developing and ongoing events that potentially affect VA. It forms a nexus that allows for situational awareness, coordinated recommendations, and feedback to VA senior leaders in real time so that they can make timely and proactive decisions. The IOC also serves as the central point for coordination with interagency stakeholders at the Federal, State, and local levels.

Planning

VA is an active member of the Federal planning community and has senior representatives on a variety of interagency planning initiatives. VA plays a key role in national level training exercises and serves as a ready resource for interagency partners.

The Exercise, Training and Evaluation team in OSP coordinates VA participation in all national level exercises. In addition, this group conducts monthly preparedness and planning meetings with all Departmental Emergency Coordinators, maintains an ongoing comprehensive National Incident Management System (NIMS) training initiative, conducts quarterly Line of Succession Training, and provides real time guidance on all Emergency Management issues to the IOC.

VA recently implemented WebEOC, which is an emergency management National Incident Management System-based collaborative operating platform. WebEOC further enhances intra- and interagency communications and information sharing and provides VA, through the VA IOC, with real time situational awareness of the Department's operational status.

Furthermore, in the past year OSP has developed, coordinated, and published Department policy and plans that address VA Continuity, the IOC, VA Serious Incident Reports, VA Devolution, and VA Reconstitution. Having such plans in place allows for more efficient and effective coordination within the Department. It also can facilitate communications with external agencies and stakeholders.

Training/Exercises

I am proud to report that the involvement of VA senior leaders in training and exercises is comprehensive and thorough. Our training and exercise planning includes full-scale participation and after action reviews that involve all Under Secretaries, Assistant Secretaries, and other Key Officials. Continuity of Operations and Continuity of government are fundamental objectives of these planning and exercise programs. The focus is employee accountability, communications, and increasing our capability to provide services to Veterans as we support national efforts.

In the past 12 months, VA has participated in two national exercises: Eagle Horizon '09 and Eagle Horizon '10. We deployed more than 200 people during each exer-

cise to our alternate and reconstitution locations. VA personnel deployed to these sites represent our Emergency Relocation Group, whose components are the Crisis Response Team, the Continuity of Operations Team, and the IOC.

VA participation in this year's Eagle Horizon exercise was evaluated by the Department of Homeland Security (DHS). DHS has not published the results of that review. However, I am confident that the VA team effectively demonstrated our capability to continue operations, and carry out the Department's primary and supporting mission essential functions.

In January 2010, we conducted a comprehensive devolution exercise ensuring that when needed, Department-level command and control could be transferred. This exercise was important to validate our procedures and led to publication of the first VA Devolution Plan.

Practical Application

Some of the strategies written into OSP policy and practiced during VA and national training exercises are the direct application of lessons learned from our experience with Hurricane Katrina. Although VHA did not suffer any loss of life resulting from the 2005 hurricane season, and all inpatients affected by the storm were accounted for, VA did have to close two major medical centers (Gulf Port and New Orleans) and evacuate hundreds of patients, staff and family members from them.

Katrina caused significant disruption to health care operations throughout the entire Gulf Coast region. Yet, through alternate venues, we were able to continue providing care to Veterans. For example, VA deployed a system of 12 "mobile clinics" to various sites across the region in coordination with local authorities and expanded the capacity of our Community-Based Outpatient Clinic in Baton Rouge, Louisiana. A key element of our success in this regard was VA's electronic health record, which enabled VA clinicians across the U.S. to access the medical records of VA patients displaced by Hurricane Katrina. VHA also took on a significant role in providing care to non-VA beneficiaries in keeping with VA's "Fourth Mission."

In the aftermath of Katrina, VHA deployed 1,300 volunteers and staff in a series of 14-day rotations to:

- Operate two Federal Medical Stations (FMS) providing medical services to hundreds of non-VA beneficiaries under the National Response Plan's Emergency Support Function 8.
- Operate VHA mobile medical clinics.
- Deliver food, water, fuel and supplies to affected medical facilities.
- Augment command and control internal and external to VHA.

Medical Emergency Preparedness

Important lessons learned from Katrina that VHA applies today include:

- Conduct a comprehensive assessment of all VA Medical Centers (VAMC) preparedness to operate independently.
- Provide equipment and supplies, as well as funds to train and exercise Federal Coordinating Centers (FCC).
- Train and prepare cadres to support future FMS operations.
- Provide an internal VHA patient evacuation system that does not rely on external resources.
- Procure deployable command and control, medical, pharmacy, housing and hygiene units.
- Enhance the registry and abilities of the Disaster Emergency Medical Personnel System (DEMPs).

Since 2005, VA has taken a number of steps to improve our medical emergency preparedness. After Katrina, VA conducted a business impact analysis and is now nearing completion of a comprehensive 3-year assessment of the readiness of all 153 VA Medical Centers. We provided \$2 million for FCC patient reception team caches that can be used to support receipt of patients under the Department of Defense (DoD)-VA Contingency Plan as well as the National Disaster Medical System (NDMS). In addition, VA has procured and tested prototype Dual-Use Passenger/Patient Vehicles capable of transporting various configurations of ambulatory, wheelchair and litter-borne patients. We have an agreement with the General Services Administration to procure over 130 of these vehicles, beginning this year. Finally, VHA procured 25 mobile command and control, medical, pharmacy, housing and hygiene units to support internal continuity operations, as well as external taskings under the National Response Framework. We also have recruited additional DEMPS volunteers and are working on enhancing VA's ability to identify and deploy volunteers more efficiently in support of both internal and external taskings.

Beyond Katrina

Returning to Secretary Shinseki's three "Fourth Mission" priorities of accountability, improved communications and increased capability, I would like to highlight certain other accomplishments and emphasize VA's preparedness should we be called upon to act.

Personnel Accountability

In 2009, the Assistant Secretary for Human Resources and Administration, John Sepúlveda, convened a Departmentwide Employee Accountability Task Force. Recommendations from that Task Force have resulted in development of the Emergency Employee Information Database (EEIDB). The EEIDB is a new tool for identifying employee status during an emergency. Mr. Sepúlveda continues to lead the effort to test and refine this important tool that facilitates employee accountability.

H1N1 Influenza Pandemic

From the onset, VA carefully monitored the progression of the H1N1 influenza virus. VHA tracked patient information in order to forecast where and when we would need vaccines. The receipt and movement of vaccines was carefully managed. Fortunately, the virus did not manifest as predicted. Nonetheless, VA continuously responded to the needs of our veterans and employees, and was prepared to respond as a national asset, if we had been called upon to do so.

Haiti Earthquake Relief

In preparation to provide support during the Haiti earthquake relief effort, VA quickly validated the list of individuals registered within the DEMPS. In support of the Department of Health and Human Services (HHS), five VA medical personnel were deployed to Haiti. VA had a list of available volunteers and was prepared to provide more support.

VA has the responsibility to operate up to 57 FCCs located throughout the United States to transfer civilian patients to civilian hospitals. At the request of HHS, which is responsible for the NDMS, VA operated two FCCs; one in Tampa, Florida, and one in Atlanta, Georgia. VA processed more than 100 patients from Haiti. We used this experience as another opportunity to refine our policies, plans, and procedures.

Hurricane Season

This hurricane season, VA again will focus on serving Veterans, saving lives, protecting property, and ensuring public health and safety. VA has performed admirably during previous hurricane seasons. In 2005, following Hurricane Katrina, VA operated 17 of the 18 FCCs activated by HHS; supported 89 military aero-medical missions and processed 2,830 displaced non-VA beneficiary patients to 220 non-Federal hospitals in support of the NDMS. Additionally, in 2008, following Hurricanes Gustav and Ike, VA operated three FCCs and two HHS Federal Medical Stations.

The National Oceanic and Atmospheric Administration has forecast increased hurricane activity this year in the Atlantic. We believe we are well positioned and prepared to continue to serve Veterans and execute our "Fourth Mission" should we be called upon to perform.

Conclusion

Secretary Shinseki is committed to transforming VA into a "People-centric, Results-driven, and Forward-looking" Department. Maximizing our preparedness to execute our "Fourth Mission" priorities is a significant element of this transformation. The Secretary and all senior VA leaders continue to give close attention to preparedness as we continue to invest, plan, train and exercise.

VA will continue assessing and improving its preparedness procedures. Nonetheless, I am confident that we have the capability to respond to our Nation's call as needed during this hurricane season or in response to any other threat or national emergency.

Thank you for your support, time, and interest in providing the best for our Nation's Veterans who deserve nothing less. I look forward to your questions.

