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Statement of the

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Submitted by Terry Allan, MPH, Health Commissioner
to the
Committee on Oversight and Government Reform
United States House of Representatives

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Opening Statement

Mr. Chairman and members of the committee, I very much appreciate the opportunity to testify today, along with my public health colleagues, on the resource constraints affecting the readiness of States and localities to respond to future pandemics. My name is Terry Allan, and I'm the Health Commissioner at the Cuyahoga County Board of Health. We serve as the public health authority for over 886,000 Greater Cleveland residents in 57 communities. I have been with the Board for 20 years and have served as the health commissioner since 2004. From 2002 to 2004, I was the Regional Coordinator for Public Health Preparedness for five counties in the Northeast Region of Ohio, occupied by about 2 million residents.

There are many lessons to be learned with the emergence of the 2009 H1N1 Influenza A virus in Mexico and the United States. It presents a critical opportunity to evaluate local public health preparedness and response capacity, illuminating our obvious strengths and clear challenges that face us as we prepare for the coming flu season and beyond. I'd like to briefly share some of our local progress and quantify the impact of funding cuts on meeting our preparedness goals and rightful public expectations.

Prior to 9/11, public health in many locales had only intermittent involvement with the emergency response community and might assist in the response to extreme heat or cold events, flooding, or other natural disasters. Since that time, public health has become an integral partner in all-hazards community preparedness, actively preparing and/or responding to emerging issues like anthrax, smallpox, avian influenza and now H1N1. We have developed strong relationships with safety forces like police and fire departments and have advanced existing relationships with hospitals, EMS, and our local emergency management agencies. We have bolstered our 24/7 response capabilities, built valuable epidemiologic capacity to understand the distribution and determinants of disease outbreaks, worked on a regional basis to advance our response and exercise plans, established mutual aid agreements across multiple political subdivisions and developed a functional understanding of incident command and our role in the National Response Framework.

Much work is left to be done. We need to substantially augment and in some cases, initiate and integrate local plans for 1) volunteer recruitment, training and retention; 2) alternate care sites and surge capacity to assist people outside of the hospital setting if their resources are exceeded; 3)specific provisions for vulnerable populations like the indigent or disabled; 4) antiviral distribution; 5) social distancing strategies to limit how we interact with one another to reduce influenza transmission and 6) local biosurveillance for early detection of outbreaks.

Unfortunately, all of these important advances and identified needs are at risk of being lost or never addressed because of serial funding cuts. Since 2005, community funding for public health preparedness in Cuyahoga County, including the City of Cleveland, has dropped from a high of $2.2 million to the current level of $1.3 million as the public's concern about a potential influenza pandemic has waned. Notably, funds for pandemic preparedness have been zeroed out in the coming grant year, which begins in August of 2009. This amounts to a 36% cut, with the likelihood of further cuts on the horizon. Over time, this trend is eroding our existing capacity and preventing us from developing the ability to meet our required target capabilities for local public health response. A compounding disadvantage emerges in the increasing list of local expectations in the face of these losses. Reversing this trend and sustaining funding levels for public health emergency preparedness must become a national priority.

In order to meet our obligations to the public, state and local health departments need an adequate and stable funding source to assure that we can prepare, detect and respond to a future pandemic. Without this assurance, the collective response capacity of the local public health system will be fractured and widely variable in urban areas and may be particularly pronounced in rural areas in Ohio and elsewhere. About 5 years ago, through national preparedness funding, the local public health system in Ohio proudly established a benchmark of one epidemiologist per 200,000 population. Given our funding trends, this is clearly an unsustainable benchmark. These resources were built over time and have created a well of talent and experience that will be lost, given the current course.

I believe that our initial local response was robust and decisive in combating H1N1, but the network of local public health agencies would have been severely outgunned had H1N1 exhibited the severity characteristics of the 1918 pandemic. The local public health system must be considered part of our national defense system; a valuable asset in the prevention of disease, promotion of good health and protection of our citizens. Ultimately, we need to have adequate staffing in place to prepare and reliably respond to meet national expectations at the state and local level. This will require a long term investment in states and in the existing network of approximately 3,000 local public health agencies across the United States.

Activating Our Response to H1N1

Many local health departments were formally alerted about the H1N1 outbreak the late evening of Friday, April 24th . On Saturday, April 25th, we immediately alerted our community preparedness partners through our Northeast Ohio Health Alert Network and became aware of a suspect case of H1N1 in the City of Elyria, Ohio, located in Lorain County, about 15 miles from downtown Cleveland. By 8:30 a.m. on Sunday, April 26th, we were informed that the Elyria case was confirmed for H1N1 prior to Secretary Napolitano declaring a public health emergency at the White House that same day. Consequently, we prepared a press release (to be released first thing Monday morning) on the situation in Elyria and provided further educational guidance for the public.

On Monday, April 27th, we met with the Health and Medical Subcommittee of the Urban Area Working Group, a group of local preparedness leaders including police and fire department leadership, emergency coordinators from our area hospitals, infectious disease physicians, the Cuyahoga County Coroner, the Cuyahoga County Emergency Manager and local public health leadership. A decision was made to activate a 24/7 City of Cleveland/Cuyahoga County combined Emergency Operations Center (EOC) housed at the City of Cleveland EOC to begin assuring clear and unified messaging and to track the progress of and response to the outbreak. Additionally, our public information officer developed fact sheets and informational links to CDC on our website. Myself and Matt Carroll, the Director of the Cleveland Department of Public Health, began rotating in the role of incident commander. Twice daily conference calls were held with community partners from hospitals, nursing homes, safety forces, schools and universities, daycares, and businesses. A regular email briefing was established for local elected officials.

In short order, we had activated our response plans, mobilized staff for surge capacity, assured continuity of normal daily operations at the health department, and established our link to the media and the public to provide trusted information. These actions were evidence that public health had formally integrated as an essential partner in our community emergency response system.

Dispelling Public Fears and Addressing School Closures

Multiple media briefings were held to assure that the most current and reliable information on the outbreak was coming from public health through the EOC. We worked to dispel unfounded fears, identified and tracked suspect and probable cases and their close contacts and dispelled a wide range of false rumors that were circulating throughout many communities. We found that public health became the trusted source for providing clear and current information on the status of the outbreak. With some schools in the area unilaterally closing because of fears about ill students or faculty, we advised and immediately corrected false information and assured that CDC school closure guidelines would be followed. The public quickly came to rely on the local health departments to gauge how serious the developing outbreak was and we continuously recited the mantra that the situation was cause for concern, but not alarm. I

believe that these extensive efforts had an important effect of reducing panic and anxiety in the community; knowledge became a source of power for the community.

Funding Cuts Impede and/or Prohibit the Completion of Preparedness Plans

As we reflect on the last several weeks, we are also looking ahead to the Fall of 2009 and beyond, not knowing if the virus will shift or drift, to continue the essential work of preparedness to protect the public. However, our "To Do" list is still long and the resource outlook is currently not commensurate. If funding levels continue to drop as anticipated, we will be unable to advance our detection, preparedness and response capacity to the level that will be necessary if a more severe virus were to emerge in the United States or elsewhere in the world. Advancing the volunteer recruitment, training and retention, planning for alternate care sites and addressing surge capacity to serve people outside of the hospital setting, protecting our most vulnerable citizens, advancing antiviral distribution and social distancing plans and augmenting early outbreak detection systems are all important capabilities that public health must accomplish. A relatively modest and sustained increase in funding at the state and local level can reap huge public health preparedness dividends now and into the future.

Now is time to recognize and honor the role of the public health system as an integral component to our national defense system. In the face of a virulent pandemic, the consequences might otherwise be quite severe.

Thank you