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Public Health
Prevent. Promote. Protect.

**Statement of Rex Archer, MD, MPH
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Before the Committee on Oversight and Government Reform
U.S. House of Representatives
May 20, 2009**

Good afternoon, Mr. Chairman and Members of the Committee. Thank you for the opportunity to speak with you today. I am Dr. Rex Archer, Director of the Kansas City, Missouri Health Department. I applaud this Committee's efforts to scrutinize our preparedness efforts. Let me start with a phrase often used in public health, and I'm sure in other venues. "The only thing harder than preparing for a disaster is trying to explain why you didn't." There are two overarching issues to consider in viewing the state of preparedness in America today; 1) Knowing what to do; and 2) Being able to do it. Considerable time and funding resources have been expended to help us know what to do. Unfortunately, we are severely under resourced for our needed capacity to do it and have been losing ground the last two to three years.

There's an old adage, "Don't chase a fire." You might ask, how does that apply to preparedness for and response to an influenza pandemic? One of the things that we learned from other public safety partners, fire fighters, is that you don't chase a fire when you are responding to a fire call. If you send the minimum number of trucks you think you'll need, or even less than you think you'll need, then you're more than likely going to constantly be asking for more trucks. By the time each arrives at the scene, the fire would have spread so that you're chasing the fire. It's not a safe or prudent way to fight a fire.

Influenza is like a fire, except instead of burning through dwellings, it burns through people. If, as with the example above, we underestimate the severity of the influenza outbreak, it may be too late to control it. My remarks today are pertinent to a Category 3 level influenza pandemic. A lower level pandemic would require fewer resources, but a pandemic level such as in 1918-19 would take considerably more resources.

What types of resources (e.g., human resources, monetary resources, supplies, etc.) and preparedness plans should a State and/or locality have in order to be appropriately prepared to respond to a pandemic?

Staffing and Surge Capacity. CDC's leadership, communications, and support have been critical during this outbreak of novel H1N1 influenza. I do question whether they could have sustained their quality of service at a Category 3 or higher pandemic. At the local level, the analogy to a fire department is once again helpful. Unlike public health departments, urban fire departments have more substantial staffing and resources so that 99.99% of the time they have substantial surge capacity. They are able to handle an individual fire event, respond to multiple fires in their jurisdiction, and can bring substantial resources to a major emergency within that jurisdiction without drawing on external assistance. Their resources are not already maxed out before the alarm sounds and the entire department's resources are rarely called on to reply to one alarm. Public health staffs across the country, on the other hand, are typically fully engaged on a daily basis and have little or no surge capacity. It isn't even included in their budgets. There are rarely dedicated funds that apply or substantial budgeted overtime. In fact, many key staff are not even overtime eligible. The only readiness staff are usually those who assist in the community with creating plans.

Attachment 1 graphically reflects the increasing resource demands as levels of severity and response increase. There are few recurring dollars for readiness planning, either internally or to truly reach our community partners. Our department has zero (0) local funds for this purpose. This creates a real challenge during threats, outbreaks, or epidemics. Although under a threat right now, we must maintain a daily work load of TB contact tracing & treatment, STD management, maternal & child health, food, air quality, nuisance abatement, and multiple other tasks with the same staff who must also transition to the National Incident Management System (NIMS) to manage the public health event. Attachment 2 reflects staffing and staffing availability to address emergencies.

Activation of an Incident Command System (ICS) requires setting up an organizational structure with an incident commander, operations function, planning, logistics, finance/administration, and public information officer (to name a few) components to manage the emergency, as we did in Kansas City on April 27, 2009. The functions and staffing needs differ based on the nature and magnitude of that emergency. Most functions typically utilizes two or more staff times. Public health can rarely do this so they tend to work single 12⁺ hour shifts, with 24/7 pagers for contact outside the 7am to 7pm time window. That can work, but only for one to two weeks at most and for a low-level event that does not include rapid and sustained transmission between humans or a high mortality rate. For each position that is needed during an emergency, the position should be at least three people deep to be able to rotate in that function even if it is a short-term event, meaning the matter of a few days to a week. If it is a longer term event, at least five deep staffing is really needed in each position in order to rotate people out to preserve safety and effectiveness. This also assumes that people can stop doing the daily activities which they regularly manage. Without adequate staffing, event managers can't run 12-hrs on/12- hrs off (but still on call) for extended periods of time and still manage an event well. If an event is not only potentially long-term but is also an infectious disease, closer to seven people may be needed in each position.

Existing pandemic influenza plans at the Federal, state and local levels should be built on the assumption that up to forty percent of the public health staff will be unable or unwilling to respond due to illness, family members' illness or fear of infection. In a pandemic, we could not

rely on a mutual aid agreement with another health department because a public health event would affect most jurisdictions at relatively the same time. Public health is a people-to-people profession, wherein technology provides major assistance but cannot manage a pandemic event. Nor can technology maintain relationships with essential partners, businesses, restaurants, schools, nonprofit associations, health care providers, etc. It is still a face to face activity.

Communications and Community Liaison. Ability to respond to public health events is based on solid planning, training, communications, and relationships with community partners. Much of the work we do is based on relationships with community partners such as health related nonprofit organizations, faith based community, and business coalitions. Using the business community as an example, for a larger metropolitan area, at least one full-time position is needed whose main role and responsibility is liaison to the business community for partnering, to assist in preparation for pandemics and other public health challenges. Without this ongoing liaison, private industry has little incentive to provide information or lend technical assistance and resources during an event. This function would also work to have communications systems put in place for rapid communications in an event. This is necessary to reinforce communications through the media, and to create a methodology for providing tailored information to the community group. Businesses need different specific assistance and information during an event, from information we would provide to skilled nursing facilities, restaurants, or to schools.

One of the best ways to manage rumor control in an event is for people to hear a consistent message through the media, through one-on-one individual interactions, discussions with their doctors and medical community, through communication channels at work and their faith community, etc. and through the schools (if they have kids that are involved with school activity); if all those messages are consistent and timely, people are more likely to respond without under or over reacting to the event.

As we all seek to increase capacity and stretch scarce tax dollars, we must consider where we look to obtain necessary resources at least cost. I would suggest we consider variations of the use of outreach workers. Outreach workers embedded or in close association with health departments are a potential gold mine of staffing and assistance during a public health event. Having adequate community outreach workers to be able to work with neighborhood associations for multiple public health purposes can improve health outreach on a daily basis, and can be invaluable in a public health emergency.

A principle of emergency planning is the fact you don't attempt to build credibility and trust during an emergency, because it is pretty risky to expect that. You must have trust and communication developed before an emergency. If the first time a health department interacts with a community agency or association is during an emergency, there is a substantial credibility issue that can inhibit or slow our ability to contain or stop the event in its tracks. Those interactions must occur on a daily and regular, often weekly basis. Staffing levels in health departments must include time for interaction with schools, churches, businesses, and nonprofit agencies. No one bemoans the fire protector seen sitting outside the fire station or just cleaning the truck because we know they may be called at any minute to respond. Yet we do not consider public health professional staffing patterns with the same relative possibility in mind to plan for and respond to a public health emergency. We can get full use of these staff during non-

emergency circumstances and have full use during new emergencies. Attachment 3 provides a graphic image analogy between limited and full use of resources.

Faith communities provide a challenging and potentially huge resource during emergencies. In a public health emergency, faith communities have a closely aligned mission purpose and offer yet another means of communications and an irreplaceable volunteer base. While individuals are often reluctant to sign on as public health volunteers, congregations are anxious to fulfill a mission as a whole. Liaising with faith leaders in the community is crucial to responding to public health emergencies, especially to fill the void that dedicated public health staff are no longer funded to address. Most importantly, routine contact and interface with faith leaders provides a platform to draw on resources to deal with an emergency. Having an adequate number of liaison positions to also include coordination with parish nurses and other lay leaders and various congregations creates shared vision, facilitates trust and partnership. Routine contact in non-emergent times, working together on community health issues, cements communication and trust, leading to access to a valuable resource to gear up rapidly under a pandemic. If we have not done pre-planning and worked with those communities, the diseases may spread as much or more through those channels as any others.

Volunteers. One of the biggest values in use of monetary resources is having the actual trained staff to respond. Unfortunately, it is also an area that I believe is a real challenge from the monetary resources standpoint because of inadequate funding for the recruiting and training of “volunteers.” This is an area that I think has been doing amazing work on the cheap, but that’s also very dangerous. Medical Reserve Corp (MRC) is an important program, but I feel that ultimately in many communities is likely to, if not fail, at least not meet anywhere near the challenge that’s required. MRC can move professionals from one location to another to meet a localized or regional emergency. In a pandemic, those resources will be needed right at home.

The model needs to be re-considered. We don’t expect our National Guard or military reserves to be all-volunteers, with no pay and with no pay for training or time away from their jobs to obtain that training. Many response agencies pay for staff to cross train to increase versatility in an emergency. There are no such funds in public health to encourage this process. In Kansas City, nearly 55% of our positions are grant funded. That means most of those individuals are paid by a specific grant – that’s what they’re funded to be working on. Our ability to take them away from the grant functions to cross-train them on emergencies is limited. We will use them in an emergency, but with the knowledge there are no funds to pay for their specific functions and it is possible that the granting agency could deny their costs.

In many departments, a substantial number of staff that respond in an emergency are not overtime pay eligible. Their job descriptions emphasize their routine expectations. So, to train them and/or utilize them outside of the normal 8-5 work day means they are truly volunteering. It is also important to remember that all public health staff are already semi-volunteers. They are paid considerably less than the private sector, but choose public health at a lower salary because of their passion for prevention. We should not expect them to “volunteer” even further.

I believe we should be paying our people to train and work in public health emergencies the same way we pay our National Guard members to train for emergencies. Moreover, public

health staffs should be paid to train and work in public health emergencies in the same way we pay our firefighters and law enforcement.

Public Information. Another critical emergency response resource is the public information function. As with community credibility and trust, rapport with the public media must be in place during normal working conditions. You must be a credible source, make yourself available to the media, acknowledge the vital role they play in public communications, and have a professional relationship that allows for give and take to keep the public informed.

In smaller jurisdictions, staff performs multiple roles that are not part of their daily routine and for which they are therefore far less prepared or connected to manage media needs in an emergency. Failure to have media connectivity can make things go sour pretty fast in an emergency. In a larger metropolitan area, that takes several FTE's working full-time with the media, with 24/7 availability with 90% response in less than ten minutes. During daily operations, the media will have interest in restaurant closures, air quality notices of violations, facts on the effects of smoking, and a myriad of other health topics of interest or concern to readers/listeners. Availability provides a means for health education; and ultimately provides a rapport that when an emergency occurs you have the credibility to take the leadership role necessary to assure the story is accurate with the correct tone in communicating with the public.

There also needs to be surge capacity because the number of media contacts goes up exponentially during an event. Smaller communities may not have much experience with the media. When the first case or two occurs, or maybe when the first death is announced, they can basically be crippled or nearly taken off line in their operations because of the number of media that will show up and camp out at their door step. That's where we need **mutual aid agreements** for regional coverage or ways for federal funding to pay for these public information officers (PIO) to allow us to redeploy public information officer assets to other locations.

This has happened during the current H1N1 experience in the Kansas City area. The media descended on a smaller neighboring health department which did not have a full-time PIO. Their PIO was also their deputy director, who has other operational responsibilities as well during an emergency. We provided assistance in preparation and execution of the news conferences. In the metro area, the initial tone and the way an event is handled with the media from the very beginning, regardless of the jurisdiction, can have major consequences for all jurisdictions in that area as an event unfolds.

Continuous Planning. Kansas City Health Department plans include cross pollination with other regional health departments for continuity, consistency, and inter-dependability. Those plans should also relate to plans that other institutions, whether businesses or faith communities, have thought through in regards to a pandemic response.

It's important to remind people that no plan survives intact the first engagement with the enemy. As a senior military leader, the late President Eisenhower once said, "A plan is nothing, but planning is everything." A plan is only a blueprint for what you think you will do. Reality dictates potentially multiple paths and you cannot predict which path you will follow, nor can

you predict each scenario you may face. A plan is a consistently changing document that must be revised at least annually based on the factors at hand. A response plan is a living document requiring input and buy-in from the very people who will be there to carry it out when a public health response is needed. The people who developed the plan should be the people who drill the plan, do the "hot washes" after various drills or actual live incidents, and then adjust and correct the plan. In an event, they should be the ones that frequently end up in the boxes of the organizational incident command structure either in the planning function or the logistics function. They frequently perform more than one incident command function. In many areas, particularly in metro areas, there needs to be multiple people who can perform those functions during an event. Sometimes we have only one or two people performing critical, longer term functions, which dooms their part of the emergency support to failure. This doesn't happen when the plan are made by outside consultants who are not required to respond to the emergency.

National Progress in Preparedness. When I started raising these issues and concerns 10 years ago, there was really no voice talking about this so the National Association of County and City Health Officials launched a committee, that I chaired, to look at bioterrorism and other emergency response issues. That summer of 1998, the CDC shared its first draft strategic plan to look at bioterrorism and chemical terrorism. We've come a long way since then. If I had to say where we were in pandemic-like influenza preparedness 10 years ago, I would say that we were probably at 5 percent of needed capacity to deal with a pandemic. In the last 10 years we may have expanded our capacity roughly 500%, so that we're now at a 25% overall figure in regards to what we need. Attachment 4 provides a visual image of surge capacity (what public health needs) versus knowledge versus preparedness (what public health has). Then again, that's in reference to a Category 3 level pandemic. With the exception of vaccine production capacity we're probably pretty close to what we need for a Category 1 pandemic. A few communities are close to what they may need for a Category 2 pandemic, **but most have lost capacity since 2006**. Unfortunately, many local health departments have lost substantial funding over the last 5-6 years. As an example, we no longer have any general fund support for our department, whereas, we had almost \$11M of general fund for health purposes 10 years ago. We believe as a general rule we should have approximately 1 epidemiologist, or disease detective, for every 700 disease reports that come into local health departments if we're going to do adequate tracing of those reports (particularly if a lot of those reports need follow-up information).

Vaccine Availability. The biggest resource that has not been adequately addressed that we need and every local health department needs to fight a pandemic is **getting vaccine on board as quickly as possible**. We need expanded vaccine production capacity. When everyone in the mall or grocery has been flu vaccinated, then the risk goes down; but even if you received vaccine, but no one else did in the places you go, your risk goes up. If you vaccinate people in schools, universities, and day care settings, the elderly are at less risk from exposure from others. Many individuals whose immune systems are not as strong really rely not just on getting the vaccine themselves but also on others in their community being immunized.

Does Kansas City, Missouri have adequate resources to respond to a public health emergency such as a pandemic?

The answer is yes! But, only to a Category 1 event. As with all other governmental entities, the City of Kansas City, Missouri is challenged with a myriad of fiscally demanding requirements in an environment of scarce resources. Attachment 5 depicts that the specific public health response can not be effective if the foundation under it is crumbling. There has been inadequate recognition at any governmental level of what public health requires to fulfill its role in emergency response in a pandemic. Public health must have adequate numbers of trained staff and staff training. We must have sustained readiness education resources (funds) to reach out to the public, other government agencies, nonprofit groups, businesses, and the faith community so they know what we provide, can provide, and in an emergency, where we fit in managing the event on their behalf. Training of volunteers, equipage, periodic re-training, and orientation is a low cost source of support to help address transportation, traffic control, entry control, and other non-professional staffing needs during a pandemic but there are no funds.

The following describes how my department managed the recent H1N1 outbreak.

Assumption: A Category 1 event will require a different level of resources than a Category 2 or 3 event. Although Kansas City Health Department eventually lowered its classification of the 2009 H1N1 event to a Category 1, the beginning early deaths reported in Mexico had us concerned that this outbreak might rise to a Category 3.

Situation: Most public health services were still offered to the citizens of Kansas City during the event, but even with only 3 confirmed cases, 5 epi linked suspect cases and numerous disease investigations, the Department felt the impact. The numbers alone do not drive response. Nationwide as well as worldwide events now directly impact response preparation and level of effort much sooner.

- Incident Command Staff, Public Health Preparedness Staff and Communicable Disease Staff worked extended hours (10-14 hours/ day) and weekends for two weeks.
- Numerous events and activities were cancelled due to:
 - i. Diversion of staff to Emergency Response duties
 - ii. Public Information requests/demands
 - iii. Epidemiological Investigations
 - iv. Disease Surveillance specific to H1N1
 - v. Increased local, regional and statewide meetings and conference calls
 - vi. Warehousing and distribution operations for Strategic National Stockpile (SNS) materials
 - vii. Security requirements for transporting, distributing and storing SNS materials became necessary
- 75% of duties scheduled to be performed by at least 20 of the Department's lead staff had to be suspended for the two-week period.
- When daily public health activities are suspended, diseases will continue to occur. The longer the delay in public health interventions, the greater the potential for disease outbreak.
- Tuberculosis treatment must continue during even the most severe pandemic influenza.

Does Kansas City, Missouri have a detailed preparedness plan for handling such activities as lab testing, epidemiological investigations, treatment, medical surge, and antiviral and vaccination storage and distribution in order to respond to an outbreak?

The Kansas City Health Department has developed a comprehensive plan that addresses Communicable Diseases with an appendix dedicated entirely to Pandemic Influenza. The plan is incorporated into the City's all-hazard Local Emergency Operations Plan as Annex M – Health and Medical Plan and is revised annually based on lessons learned from exercises and real events as well as annual reviews of the Basic Plan, each Appendix and Attachments. We ratcheted up our response level through to Phase 4 during the first week, and slowed activity to sustain operations at Phase I. The Kansas City, Missouri staff is capable of and currently is engaged in epidemiological investigations and could sustain a Category 1 pandemic response, albeit with an ever increasing negative impact to daily functions. Staffing levels in a Category Two pandemic event, however, would be inadequate to the task.

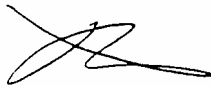
How has the economic downturn affected pandemic preparedness in Kansas City, Missouri? While the Department has developed a comprehensive response plan and laid the foundation for critical partnerships in carrying out the plan, the funding that made this possible was discontinued in 2008. As the Department has needed to increase its capacity for operations (e.g., inventory control of antivirals obtained from the SNS), the demands on existing staff has significantly increased. Simultaneously, funding for pandemic influenza response was cut from the budget altogether and the Department anticipates a 20% cut in the funding for the Cities Readiness Initiative in the next contract year when it should receive a 100% increase.

The result is that management staff continue to take on more and more responsibilities because there is no one else to do so. We rely on fewer staff to carry our increasing burden. Due to the economic downturn, open positions have not been filled and many have been cut city-wide. With every City department experiencing increased work load with fewer employees, KCHD can depend on less support from those agencies during public health emergencies. In area businesses, if employees are not engaged in direct operations in some way, their jobs are vulnerable. Added management risks are accepted hoping better times return before an emergency occurs. This means planning positions are eliminated or left vacant, funds are not set aside for planning time, coordination with external partners, training, or exercising of plans has mostly ceased. Businesses in the area have shown less enthusiasm for participation in readiness processes. Business survival is priority one. "Administrative" functions such as readiness planning which do not directly help make the assembly line run today, are temporarily expendable. On the other hand, during the recent outbreak, local businesses and business coalitions have been eager for information and receptive to CDC and other related templates that will help them take short term steps to sustain operations. Unfortunately, we have provided very limited response due to our own staffing shortage.

What solutions are available to increase pandemic preparedness at the state and local level that are not dependent on funding?

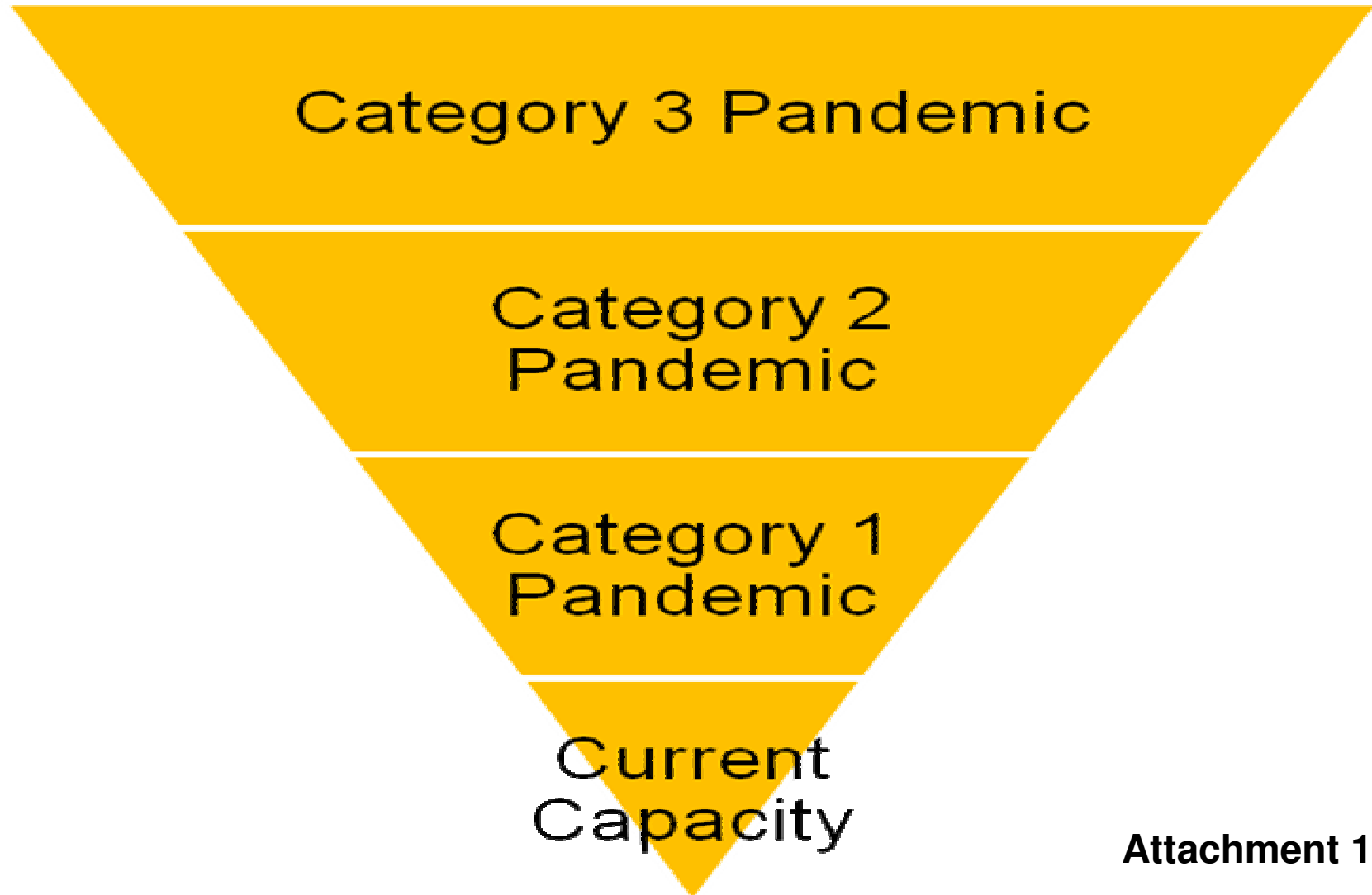
There is no free lunch. One time funds are not enough. We must maintain progress or lose ground. The two-year pandemic preparedness initiative that recently ended began the process of forming partnerships with the faith community, federal agencies, volunteer agencies, businesses, hospitals, and schools. That process brought us a long way toward preparedness with minimal cost. Gaps were identified in planning and resources and many of those gaps were resolved. There are many more that cannot be resolved without monetary investments. Someone must fill the liaison roles to maintain the contact and coordinate execution of those plans. These organizations already have structure and hierarchical organization. They are located in all areas of our jurisdictions. Emphasis should continue with education, training, cooperative planning, table top exercises, and other related minimal investment opportunities.

In closing, I would like to thank you for the opportunity to share our experience and insight today. You asked me to shine some light on challenges we face, and I have tried to do so, however, I would be remiss not to include some positive input as well. In addition to the outstanding efforts of local and state health departments across the nation during the current H1N1 event, the Center for Disease Control and the National Public Health Information Coalition have been vital components in providing valuable information and support for state and local use. Their coordination and partnership helped provide tools and messages needed to communicate timely, accurate, and consistent information to the public.



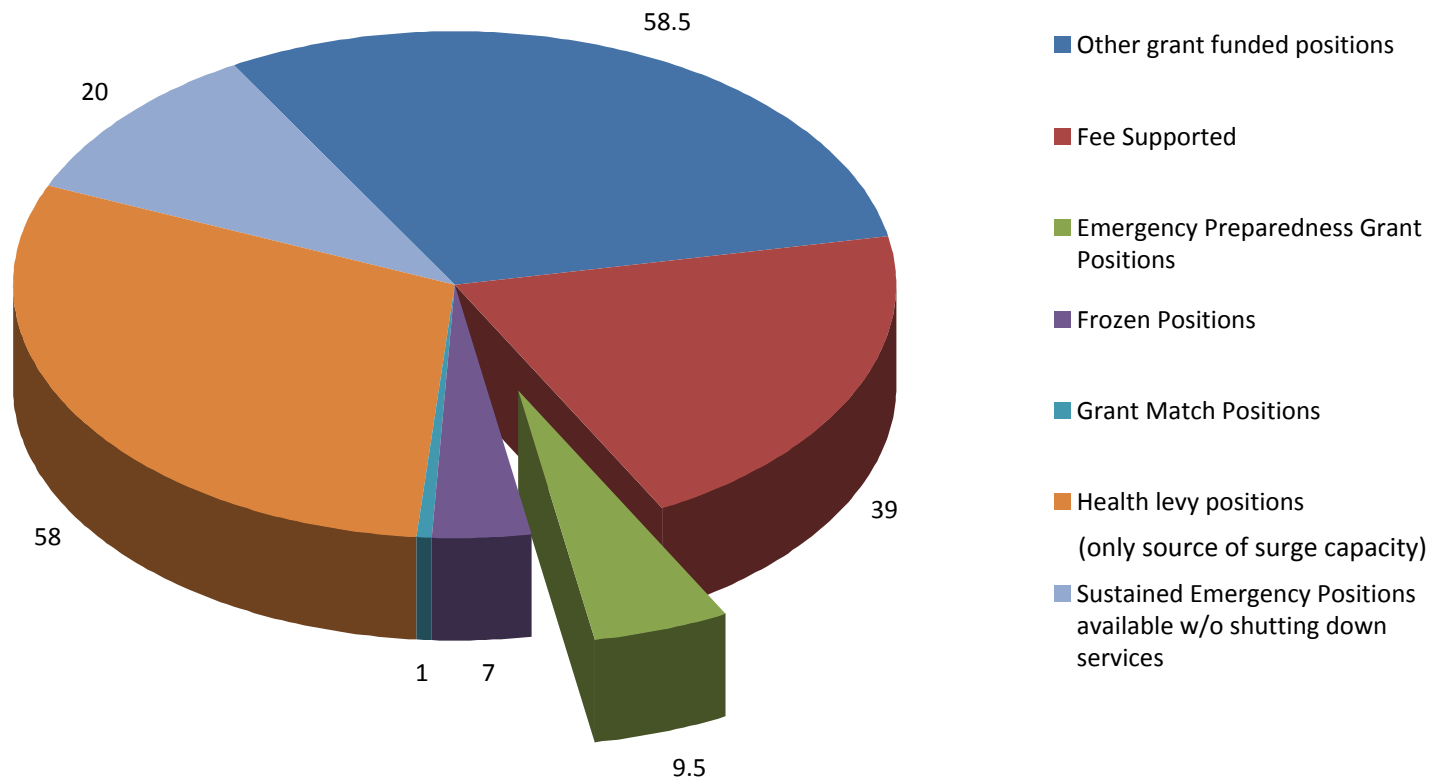
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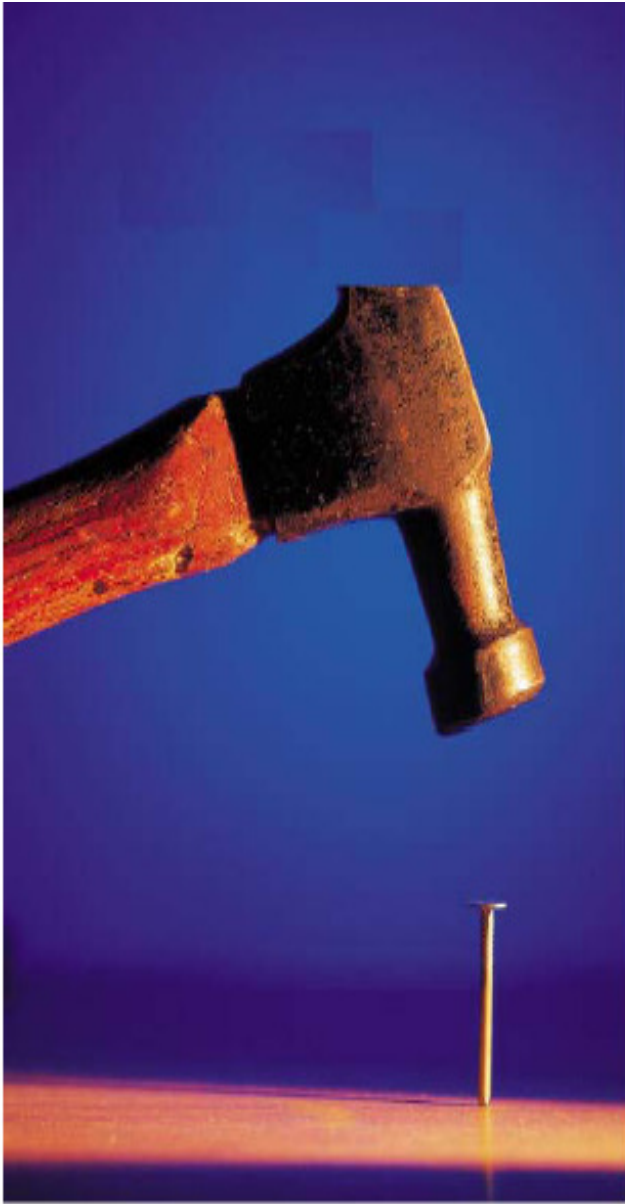
Demand vs. Capacity



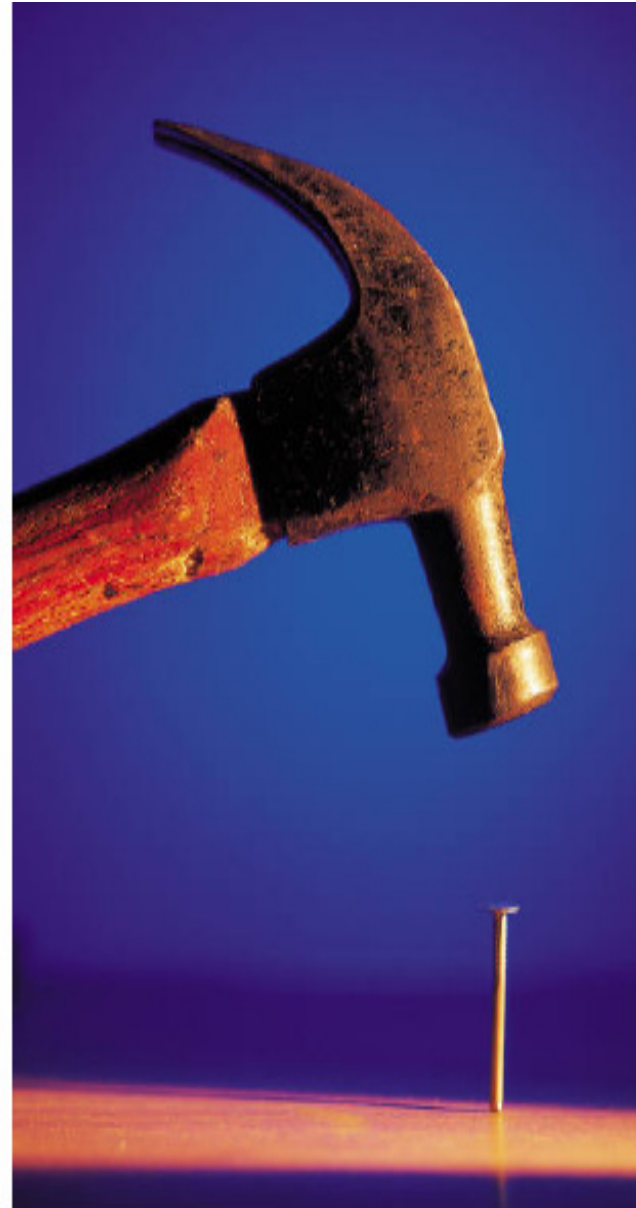
Attachment 1

Public Health Preparedness Staffing Kansas City Health Department (shown as actual number of funded positions)





Limited Use



Full Use

Attachment 3

How Public Health Has Prepared for a Pandemic

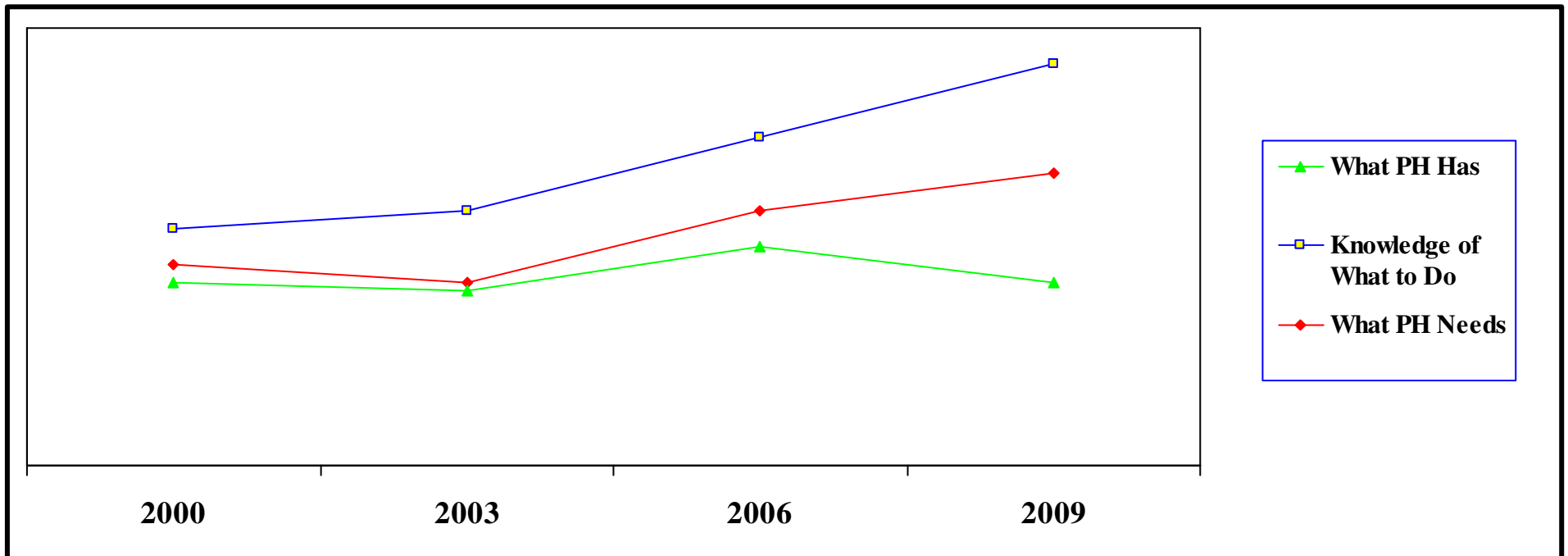
What Public Health Has

- Fewer** Staff
- Plans
- Some** Equipment
- Training
- Some** Partnerships
- Warehouse Capability, in infancy stages
- Meds|Pod system
(medical or non-medical automated medical screening and dispensing system)
- Personal Protective Equipment

What Public Health Still Needs

- Funding
- CRI funding - Losing 20% in FY 2010
- Lost Pan Flu funding - 2008
- PHP funding level for last 3 years (costs continue to rise)
- Equipment Maintenance
- Continued education for staff
- Partnerships Maintained
- Outreach to
faith communities, businesses and schools
- Volunteers
- Phone banks
- Auxiliary staff

Public Health continues to plan for the unknown



Assuring Public Health Infrastructure

