

**ENSURING EFFECTIVE PREPAREDNESS RESPONSES
AND RECOVERY FOR EVENTS IMPACTING
HEALTH SECURITY**

HEARING

BEFORE THE

**SUBCOMMITTEE ON EMERGENCY
PREPAREDNESS, RESPONSE,
AND COMMUNICATIONS**

OF THE

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**ENSURING EFFECTIVE PREPAREDNESS
RESPONSES AND RECOVERY FOR EVENTS
IMPACTING HEALTH SECURITY**

Thursday, March 17, 2011

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

The subcommittee met, pursuant to call, at 2:07 p.m., in Room 311, Cannon House Office Building, Hon. Gus M. Bilirakis [Chairman of the subcommittee] presiding.

Present: Representatives Bilirakis, Richardson, and Clarke.

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

The subcommittee is meeting today to receive testimony from Dr. Alexander Garza on how the Department of Homeland Security's Office of Health Affairs is working to provide health security for our Nation.

I now recognize myself for an opening statement.

Last week the subcommittee held a hearing to examine FEMA's capacity to ensure effective preparedness and response to terrorist attacks, natural disasters, and other emergencies. I now look forward to having a similar conversation with the Assistant Secretary to ensure that the Office of Health Affairs is meeting its mandates with respect to preparedness, response, and recovery and thereby doing its part to meet the Nation's health security challenges.

While this hearing has been scheduled for some time, it is particularly timely in light of the recent catastrophe in Japan. Our thoughts are with the Japanese people as they continue to respond to this tragedy and begin to recover. Of course, the United States stands ready to assist our ally in this difficult time.

As we work to assist Japan, we must also reflect on our own level of preparedness and learn from Japan's experience so we can be better prepared here in the United States.

The Office of Health Affairs' mission is to provide health and medical expertise in support of the Department's mission to prepare for, respond to, and recover from all hazards impacting the Nation's security; that is, to protect our health in the case of a National incident with health consequences.

This is a valid mission that I think is not always well understood, but OHA's accomplishments are real. For example, during the 2009 H1N1 influenza outbreak, the Assistant Secretary briefed

the Secretary and other DHS leaders on matters such as where the flu was spreading, whether closing the border with Mexico could slow its progression, and how DHS could mobilize resources to assist in the response.

Staff in the workforce division are working to ensure that emergency medical personnel, such as EMTs with the Border Patrol, are adequately credentialed when they cross State lines in the course of their duties. OHA operates the BioWatch program, a deployment of detectors in more than 30 metropolitan areas designed to detect aerosolized agents of bioterrorism.

The subcommittee looks forward to learning more about these successes, as well as on-going challenges. I would particularly like to hear more about OHA's work with interagency partners on the development, procurement, and distribution of medical countermeasures. This is a topic that this subcommittee will consider more specifically in the future, but I would like to begin our conversation today.

The President's fiscal year 2012 budget request includes \$161 million for OHA's affairs, a \$21 million increase over fiscal year 2011, the continuing resolution. The BioWatch program accounts for the vast majority of this spending.

While BioWatch is not the only activity for which your office is responsible, it is however the most expensive. The request includes \$115 million for BioWatch, \$25 million of which will go towards operational testing of Next Generation technology. If successful, this new system would enable a drastic decrease in detection time from the current 12–36 hours to 4–6 hours. It would also provide detectors that could function reliably indoors. Such milestones would be important advances, but I and other Members are concerned that the timeline for deployment has been repeatedly delayed.

I am also concerned that the testing phase includes only one type of technology. There have been two viable competitors going through the process, and now you are down to one before you have even gotten to the field and operational testing and evaluation.

I look forward to hearing from you about why this is the case and how we can increase competition to ensure that at the end of the day we have a robust BioWatch program with the best technology, CONOPS, and buy-in from the communities in which it is deployed.

Finally, I would like to discuss the National Biosurveillance and Integration System, NBIC, which seeks to achieve the important goal of fusing many inputs of biosurveillance data to provide early detection of an Event of National Significance, such as an anthrax outbreak.

The President's budget requests \$7 million for NBIC, an amount consistent with historical funding levels for this program. While an effective National biosurveillance capability is an important component of preparedness and response, the necessary cooperation from other Federal agencies remains lacking and has led to an ineffective NBIC that has not met its statutory mandates.

Continued funding at this level under the current operating scheme will be money wasted. While we are pleased that DHS has recognized the shortcomings of NBIC and has developed a plan to

confront its challenges, I believe we really need to see a demonstrable increase in value prior to supporting on-going appropriations.

With that, I look forward to hearing from Dr. Garza on his budget request and all the activities and challenges of his office.

I now recognize the Ranking Minority Member, Ms. Richardson from California, for any statement she may have. You are recognized.

Ms. RICHARDSON. Thank you, Mr. Chairman. Good afternoon. I would like to thank Dr. Garza for appearing before this committee today and expressing this committee's deep gratitude for your current and previous service to our country.

But let me start by saying that our thoughts and of course our prayers, and I join with the Chairman, as we continue to be thoughtful of our friends in Japan as they search for survivors, or continue I should say, and recover from one of the greatest disasters that was certainly known in Japan and maybe in the world.

I supported the President's decision to work in an expeditious way to assist with the relief and efforts by deploying U.S. military and FEMA's urban search and rescue teams and any other assets that might be required in the region.

This disaster has caused damage to areas in Hawaii and in my own home State of California, and it demonstrates how one emergency can spiral into others. The effects of the earthquake and the subsequent tsunami are now prompting a public health emergency, including concerns regarding the radiation seeping from nuclear reactors. It is a truly a tragedy of historic proportions, and one that we all must learn from in order to prepare in our own home bases.

As a representative of the 37th Congressional district, I understand the potential effects of earthquakes and tsunamis that could have on cities, neighboring areas, and our infrastructure. In my district alone, we have various oil refineries that produce more than 1 billion barrels per day. We are home to a number of gas treatment facilities, petrochemical facilities, all that abut against the Nation's largest ports, which aside from all of that going on, when you consider the fact that we are in due proximity to the Pacific ocean and the San Andreas fault, preparations still needs to be in order.

I am committed to ensuring that we are doing everything we can to learn from and assist in what has occurred in Japan. Therefore, today's hearing can provide us with a better understanding on how well DHS is prepared to respond to the health effects of both natural and man-made disasters.

As you know, the previous administration's reorganization efforts created the Office of Health Affairs. Since its founding, there have been concerns, though, however, on how well OHA fits within the Department's enterprise.

Dr. Garza, during your confirmation hearing, you stated that OHA is a young entity and in many ways a work in progress. In these tough economic climate times, it is important that each homeland security investment is dedicated to programs that are effective, efficient, and not duplicative. Unfortunately, there have been many programs within OHA's responsibilities that have not always met those standards.

The BioWatch program, which is vital to our preparedness effort, has suffered from some management issues in the past as well as not having the ability of upgrades and the developmental delays of the Gen-3 technologies. A more glaring demonstration of some of our growing pains has been the inability to fully establish the National Biosurveillance and Integration Center. The GAO found that the NBIC relied upon publicly available internet information. This is completely opposite to the vision and intention of the Congress.

Finally OHA's workforce protection efforts appears to mimic those designated for the DHS Office of Safety and Environmental Programs. We must do all that we can to protect DHS staff to ensure that they can protect the Nation, but duplicating efforts are not effective.

Dr. Garza, I look forward to hearing your plans today, your plans to address the concerns that we have laid out in this committee, and also hopefully to share with us OHA's mission and how you plan on expanding that further.

With that, I look forward to your testimony. Thank you for being here.

Mr. BILIRAKIS. Thank you, Ms. Richardson. Appreciate it very much. Other Members of the subcommittee are reminded that opening statements may be submitted for the record.

I am pleased to welcome Dr. Garza before the subcommittee. Dr. Garza is the Assistant Secretary for Health Affairs and Chief Medical Officer for the Department of Homeland Security. He manages the Department's medical and health security matters, oversees the health aspects of contingency planning for all chemical, biological, radiological, and nuclear hazards, and leads a coordinated effort to ensure that the Department is prepared to respond to biological and chemical weapons of mass destruction.

Prior to joining the Department in August 2009, Dr. Garza spent 13 years as a practicing physician and medical educator. He most recently served as Director of Military Programs at the ER One Institute at Washington Hospital Center and has served as the Associate Medical Director of the Emergency Medical Services for the State of New Mexico and Director of the EMS for the Kansas City, Missouri Health Department.

Dr. Garza holds a medical degree from the University of Missouri, Columbia School of Medicine, a Master's of Public Health from the St. Louis School of Public Health, and a Bachelor of Science in biology from the University of Missouri, Kansas City.

Prior to earning his medical degree, he served as a paramedic and an emergency medical technician. He is a fellow in the American College of Emergency Physicians and a member of the American Public Health Association.

Welcome, Dr. Garza. Your entire written statement will appear in the record. I ask you to summarize your testimony. You are now recognized, sir.

**STATEMENT OF ALEXANDER G. GARZA, MD, MPH, ASSISTANT
SECRETARY FOR HEALTH AFFAIRS, CHIEF MEDICAL OFFI-
CER, DEPARTMENT OF HOMELAND SECURITY**

Dr. GARZA. Thank you and good afternoon, Chairman Bilirakis, Ranking Member Richardson, and distinguished Members of the committee. Thank you for inviting me to testify before you today.

It is a privilege to be here to discuss the Office of Health Affairs and my strategic priorities. OHA serves as the principal authority for all medical and health issues for the Department of Homeland Security. We look at health through the prism of National security, providing medical, public health, and scientific expertise in support of the Department's mission to prepare for, respond to, and recover from all threats.

Our responsibilities include serving as the principal adviser to Secretary Napolitano and FEMA Administrator Fugate on medical and public health issues. We lead and coordinate biological and chemical defense programs. We provide medical and scientific expertise to support DHS preparedness and response efforts, and we lead the Department's workforce, health protection, and medical support activities. OHA, furthermore, serves as the point of contact for State and local governments on medical and public health issues for the Department.

Our role is indeed unique within the Federal Government. We are the only health office broadly tasked to bridge the divide between security threats and risks and health issues. We focus on how the health impacts of disasters and catastrophic events will affect our homeland security operations and our workforce health protection measures. We also work across multiple disciplines. We take a one-health approach in order to fully understand how health issues affect the security of the homeland.

Almost all issues involving health and catastrophic events are multi-factorial and complex. They do not fit cleanly into a single ownership model. This is where DHS and OHA bridge the different disciplines needed to develop a complete picture.

We don't have to look far to see the significance of how having a robust and effective preparedness and response system protects the Nation. Look at the headlines over the past year and what dominated the news cycle. A year and a half ago, everyone was concerned with the H1N1 pandemic. After that came Haiti. After that came Deepwater Horizon. As both of you have mentioned today, the unfolding disaster in Japan.

Each threat, whether it is overt or covert, intentional or accidental, man-made or naturally occurring, brings with it its own health and homeland security challenges, and it is my mission to make sure that the homeland security is able to meet its mission of a safe and secure homeland where the American way of life can thrive.

I want to thank this committee for the opportunity to testify. I look forward to answering any questions you may have.

Thank you.

[The statement of Dr. Garza follows:]

PREPARED STATEMENT OF ALEXANDER G. GARZA

MARCH 17, 2011

Chairman Bilirakis, Ranking Member Richardson, and distinguished Members of the committee: Thank you for inviting me to testify before you today. It is a privilege to be here to discuss my strategic priorities and the fiscal year 2012 budget for the Office of Health Affairs.

I would like to begin by providing an overview of the mission of the DHS Office of Health Affairs (OHA) and our role within the Homeland Security Enterprise. OHA serves as DHS's principal authority for all medical and health issues. We look at health "through the prism of National security," providing medical, public health, and scientific expertise in support of the DHS mission to prepare for, respond to, and recover from all threats.

OHA's responsibilities include serving as the principal advisor to the Secretary and FEMA Administrator on medical and public health issues; leading and coordinating biological and chemical defense programs; providing medical and scientific expertise to support DHS preparedness and response efforts; and leading the Department's workforce health protection and medical support activities. OHA also serves as the primary DHS point of contact for State and local governments on medical and public health issues.

To execute these responsibilities, we developed a Strategic Framework that outlines our mission space within the Department, and enumerates four overarching goals: (1) To provide expert health and medical advice to DHS leadership; (2) to build National resilience against health incidents; (3) to enhance National and DHS medical first responder capabilities; and (4) to protect the DHS workforce against health threats.

Today I will discuss a number of initiatives that help us achieve our goals and contribute to the health security of the Nation. I will also highlight how our fiscal year 2012 budget request supports these efforts.

BIODEFENSE

OHA operates, manages, and supports the Department's biological defense and surveillance programs. Our work is primarily focused on the operational areas of detection and surveillance, as well as helping to build preparedness at the State and local level.

Detection

One of our primary responsibilities is to mitigate the consequences of biological incidents through early detection. OHA uses early detection as a tool to make the Nation more resilient against health events. Prompt identification of a biological event has the potential to improve the delivery of medical countermeasures and save lives.

OHA's BioWatch program is a Federally-managed, locally-operated, Nation-wide bio-surveillance system designed to detect the intentional release of aerosolized biological agents. This program deploys collection devices and analytical capability in more than 30 high-risk metropolitan areas throughout the Nation. BioWatch provides public health experts with a warning of the presence of a biological agent before exposed individuals develop symptoms of illness. This "detect-to-treat" approach provides public health officials with an opportunity to respond to the release of a biological agent as quickly as possible in order to mitigate the potentially catastrophic impact on the population.

In addition to providing critical early detection capabilities, the BioWatch program has built a collaborative capacity that did not previously exist among the Federal Government, State and local public health, and emergency management. This partnership provides a model of interaction for future endeavors.

OHA is committed to providing cutting-edge, technically robust early detection solutions. The fiscal year 2012 budget request supports continued operations for our deployed detection systems and includes an increase from current services to fund the start of operational testing and evaluation of the Generation-3 automated detection system. The Gen-3 system will advance current detection technology by providing an automated detection capability that is expected to significantly reduce the time between a release of a biothreat agent and confirmation of that release by BioWatch technology. Current detection capabilities, termed Gen-1/2, consist of outdoor aerosol collectors whose filters are manually retrieved for transport to and subsequent analysis in a Laboratory Response Network (LRN) facility. This system, while extremely beneficial, is labor-intensive and the results may not be available until 12-36 hours after the release of a biological agent has occurred. The transition

to an automated detection system (Gen-3) will improve the time to detect to 4–6 hours, increase population coverage, and provide greater overall cost effectiveness.

Biosurveillance

Another key element to an overarching biodefense framework is biosurveillance. OHA is focused on developing and maintaining an integrated, real-time, multidiscipline surveillance picture.

To that end, OHA manages the National Biosurveillance Integration System (NBIS)—a consortium of Federal partners that was established to rapidly identify and monitor biological events of National concern. NBIS collaborates among Federal and State partners to collect, analyze, and share human, animal, plant, food, and environmental biosurveillance information. The National Biosurveillance Integration Center (NBIC) integrates this information from Federal agencies and State, local, private sector, and international sources to provide early warnings of a possible biological attack or pandemic. By identifying those bio-events that have reached reporting thresholds and publishing reports using the Biosurveillance Common Operating Picture (BCOP)—which is currently being piloted in four States—the NBIC and NBIS enhance recognition of biological events of National concern, reduce response time, and promote effective response.

While the NBIC and NBIS have been successful in helping us to achieve our biosurveillance mission, there is still much more work to do in order to achieve a true National capability. OHA is currently working with our partners and stakeholders to continue to enhance and improve the NBIC while successfully meeting the statutory requirements and Congressional intent. We will continue to work with our stakeholders to increase collaboration and data integration, improve analysis, and ensure high-quality and timely reporting. The fiscal year 2012 budget request supports our ability to maintain current efforts, and enhance the system in this manner.

CHEMICAL DEFENSE

OHA leads the Department's coordinated efforts to protect against high-consequence chemical events. OHA integrates chemical defense expertise into National planning and partners with State and local jurisdictions to build capabilities and develop resilience for high-consequence chemical events.

OHA's Chemical Defense Program (CDP) provides health and medical expertise related to chemical preparedness, detection, response, and resilience—all critical to a comprehensive approach to protect against a chemical attack. Technologies and operations already employed at the Federal, State, and local level are being leveraged to create a comprehensive chemical defense framework. The chemical defense framework will create synergies and efficiencies among the many on-going, but currently separate, chemical defense efforts. This framework will integrate DHS's current capabilities as well as strengthen relationships both horizontally and vertically amongst all Federal, State, local, and Tribal chemical defense stakeholders.

The Baltimore Demonstration Project is an example of a current CDP project that is focused on enhancing chemical defense preparedness and response by emphasizing partnerships with Federal, State, and local stakeholders. The fiscal year 2012 budget request will allow OHA to continue to provide health and medical expertise related to chemical preparedness, response, and resilience in support of an integrated chemical defense framework to protect against high-consequence events.

BUILDING RESILIENCE

OHA provides health and medical expertise to planning and exercise efforts that advance National preparedness and response capabilities for threats that have potential health consequences. The Anthrax Response Exercise Series (ARES), which we completed in partnership with FEMA last fall, is an example of this work. The workshops included Federal, State, regional, and local public health and emergency management professionals and were designed to help coordinate roles, responsibilities, and critical response actions following a wide-area anthrax attack. This year, as well as in fiscal year 2012, we plan to continue to build on the success of ARES by conducting workshops in additional high-threat cities.

OHA works directly with State and local leaders to develop capabilities to respond to health threats. We have done this by expanding local public health participation in, and coordination with, the National network of fusion centers; and by developing guidance for health and medical experts to better access Federal grant and training programs to improve public health preparedness capability.

Additionally, OHA works to provide Department leaders with appropriate subject matter expertise both in steady state and during events which encompass public

health, medicine, food defense, agricultural security, veterinary defense, pandemic influenza preparedness, and other threats. Our Food, Agriculture, and Veterinary Defense (FAVD) Branch initiative leads the coordination of the Department's programs to ensure the security of our Nation's food, agriculture, human and animal health. FAVD experts support the Department's efforts to enhance preparedness through capabilities development and facilitate the integration of the emergency management services community into Federal, State, local, territorial, and Tribal food and agriculture sector disaster preparedness activities.

EMERGENCY MEDICAL SERVICES

OHA coordinates the Department's medical first responder activities. This includes providing support to DHS personnel who perform operational medicine, including emergency medical services (EMS). DHS has thousands of medical personnel deployed throughout the country who provide care for wide-ranging and often remotely deployed personnel, from Border Patrol agents in the Southwest desert to personnel engaged in counternarcotics and counter-smuggling operations. OHA supports these personnel by developing health guidance and policy; providing medical countermeasures; collaborating with the DHS Management Directorate to provide occupational health protection for use in dangerous work environments; and facilitating health screening programs to help ensure that responders are able to support the Department's missions while minimizing health threats.

WORKFORCE HEALTH PROTECTION

Finally, OHA works each day to build resilience within the Department and protect the DHS workforce against health threats by implementing activities that promote employee resilience. Initiatives include the development of medical guidance for DHS personnel, the provision of standards and guidelines to DHS medical care providers, and the oversight of DHS quality improvement and medical training. Additionally, we provide guidance, protocols, and support to DHS components and offices for medical countermeasure storage and dispensing.

The fiscal year 2012 budget request includes additional funding to support the DHS Together employee and organizational resilience initiative to ensure that DHS employees have the tools and resources necessary to manage the stresses inherent in their occupations. DHS Together was introduced to employees a little over a year ago. During the initial training effort, approximately 190,000 employees received training about resilience and participated in a dialogue about methods to improve the workplace. Moving forward, OHA will utilize an overarching resilience framework that will unify existing activities and provide a platform for leadership to build a culture of support. This initiative will have a direct impact on the resiliency and wellness of the DHS workforce and provide the resources and information necessary to effectively manage the stress associated with work. The annual planning, production, and distribution of resilience training and information on a Department-wide scale will maximize participation and increase the program's ability to effectively improve the resilience of the workforce.

CONCLUSION

Thank you again for the opportunity to testify today regarding the strategic objectives of the Office of Health Affairs and the fiscal year 2012 budget request. I look forward to your questions.

Mr. BILIRAKIS. Thank you, Dr. Garza.

I recognize myself for 5 minutes for questions.

As the Chief Medical Officer for DHS and adviser to FEMA, which is responsible for guiding State and local preparedness and response, what would your message to the public be about the appropriate use of potassium iodide in any nuclear event?

Dr. GARZA. Yes, sir. FEMA has worked diligently on addressing the nuclear issues surrounding homeland security, and that involves whether it is an accidental release, a man-made release, or an intentional release of nuclear material. We focus on the whole-picture consequence management, of which potassium iodide is part of that. But what we would truly like to focus on, and I think Administrator Fugate has said this well, is developing a whole-of-community response, of which potassium iodide would be part of,

but really developing the community aspect of how we deal with disasters since we all know that all disasters are local.

Mr. BILIRAKIS. FEMA has a formal role in regulating off-site emergency plans and preparedness in support of nuclear power plants to ensure appropriate protective measures can be taken in the event of a radiological emergency to protect the health and safety of the public. Is OHA working to advise FEMA's guidance and review of State and local response plans from a health perspective? If not, why? What entity is providing the expertise to FEMA, if not OHA?

Dr. GARZA. As I mentioned in my opening statement, we are the principal health adviser for FEMA. So in that respect I do have two physicians that work with FEMA on exactly these issues, amongst a multitude of issues, as well as a public health service officer who works with their day-to-day operations.

So we are involved in every aspect of what FEMA does, whether it is exercising, whether it is planning, whether it is going out into the communities and exercising as well. So we are very much involved with the aspects of what they do.

Beyond that, the rest of the office is also included in the development of planning for responses such as this.

If I can shift a little bit and use for example our biological planning programs, we really view it as a whole-of-DHS approach where it is not just FEMA, but it also involves our office and it involves our policy offices as well as our operational components. But we really view it as a whole-of-DHS approach to planning as well.

Mr. BILIRAKIS. Thank you. My next question, and I mentioned this to Administrator Fugate last week, I am concerned that the President's budget proposes to eliminate the Metropolitan Medical Response System Grant Program as a stand-alone program, and to instead roll it into the State Homeland Security Grant Program. MMRS provides funding to enhance the ability to respond to mass casualty incidents. While grants are not your personal responsibility, I know that OHA has an interest in ensuring that States and localities have the tools they need to prioritize medical response capabilities. Do you feel that consolidation is the right approach?

Second, if the grants were to be consolidated, how will your office work with FEMA to ensure that the medical preparedness remains a priority within the larger grant program and that States and localities do not lose the capacity they have gained to date under the program?

Dr. GARZA. Yes, sir. So we do work with them on the grants program, providing the advice on how grant money should be spent for public health infrastructure, for improving public health response to natural disasters. We do have natural allies over there in Mr. Serino and Mr. Fugate because I truly do believe they understand the public health aspects of disasters. I can say that because Mr. Serino comes from the Public Health Department in Boston.

Furthermore, the grant alignment has always been an issue between HHS and DHS and how the money is divided up and spent on public health measures. I can only speak from my experience in working with both of those entities that there is a renewed focus and I think a very active effort to make sure that those programs,

those grant programs between DHS and HHS are becoming more aligned, and so we can identify where the gaps and seams are in order to support public health and emergency responders with grant dollars.

Mr. BILIRAKIS. Thank you very much.

I yield to the Ranking Member, Ms. Richardson, for 5 minutes.

Ms. RICHARDSON. Thank you, Mr. Chairman.

My first question, Dr. Garza, is the Government Accountability Office noted that the public health response involved Federal shared responsibilities, and yet it is unclear how these roles would really work in practice. It was recommended that DHS and HHS conduct training and exercises to ensure that the Federal leadership roles are clearly defined and understood. Has that happened as of yet?

Dr. GARZA. It has happened, and it has happened on a couple of different platforms. As you may know, our office in conjunction with FEMA did conduct a number of exercises around the country, discussing biological release incidents. Those were mostly geared towards the State and locals, but we did have Federal partners there as well. The culmination of those events were a Federal workshop, which was here in Washington, DC, and it involved multiple different partners across the Federal Government. So it wasn't just DHS and HHS; it also involved our partners within DHS such as TSA, but also partners outside such as EPA and other people that we know are going to play a significant role in any large-scale response.

Ms. RICHARDSON. Who would ultimately be the final decision-maker?

Dr. GARZA. The decision-maker for?

Ms. RICHARDSON. If an incident occurred and all these groups are together.

Dr. GARZA. I think it really depends on what the event is. So as we saw a couple of years ago with the H1N1 pandemic, clearly that was a public health issue. The President was correct in putting HHS at the lead for that.

So I think it very much depends on the situation at hand. Clearly if there is a large event in the country that involves multiple disciplines, it would have to be argued one way or the other which department was going to be the lead agency.

Ms. RICHARDSON. So have we argued that?

Dr. GARZA. There are different Homeland Security Presidential Directives that direct who is in charge of large events. So HSP-5 states that the Secretary of Homeland Security would be in charge of coordinating a large-scale Federal event.

Ms. RICHARDSON. Is that clear to everyone?

Dr. GARZA. As I discuss it with other people, I haven't heard any arguments one way or the other.

Ms. RICHARDSON. I am not trying to be difficult. I have been in several circumstances where you have got multiple people who have their various competing interests, and it is important to ultimately have a final who is in charge here. Because we have had that problem before.

Dr. GARZA. Yes, ma'am.

Ms. RICHARDSON. I did want to associate myself with the remarks of the Chairman of my concerns of consolidating the Metropolitan Medical Response System Grant Program, and I know what your answer was, but I do want to express that I am concerned about the consolidation of that program. When Mr. Fugate was here, I suggested if we were going to go into the sort of consolidated idea, that there would have to be some sort of commitments in writing from the State and local agencies that if they chose to then direct the majority of their funds to another area than this area, that they would have to be able to document that the concerns and the needs of this particular section had in fact been met. He agreed to work on some sort of language to that effect. So we look forward to those issues.

In terms of the development of OHA, over the past few years your existence, roles, and responsibilities have shifted and expanded. As a result, the office has become reorganized and kind of fits into several different priorities, as we have seen them, being biosurveillance and workforce resilience.

What is your overall mission for OHA and how does OHA assert your authority despite its statutory limits and its position within the Department? Are DHS agencies compelled to consult with you regarding health-related issues before implementing policies related to the medical and public health issues?

Dr. GARZA. The missions within our office fit into what I feel are one of four different sets. One is of course to support the Secretary on public health issues. You have already mentioned biosurveillance, but that would fit into a broader picture of biodefense. But we really view that as an all-hazards, so we include chemical and other issues as well.

You correctly pointed out workforce health protection as one of our main tenets. Then the fourth would be working with our first responders around the country as well as within DHS.

I do feel that the Department does look towards us to get public health opinions and medical opinions on issues that are on-going for DHS. So, for instance, with the incident unfolding in Japan, we recently issued guidance for our workers who are deploying there, specifically our USAR teams, as well as guidance for some of our workers that will be working back here in the continental United States for questions that may come up about contamination and other issues.

Ms. RICHARDSON. I yield back the balance of my time.

Mr. BILIRAKIS. Thank you. Now I recognize the gentleman from Michigan, Mr. Clarke, for 5 minutes.

Mr. CLARKE. Thank you, Mr. Chairman.

Mr. Garza, thank you for being here. I am going to ask a couple of questions, but let me give you the context. I represent a metro Detroit area, the Detroit border sector. It is a pretty large area. Only 4 miles of it, though, is under operational control. Our State is surrounded by the Great Lakes, one of the largest bodies of fresh water in the world. Our Detroit border, much of it, is right in the middle of the water. We also have a large water and sewage treatment plant.

Now, for all of these reasons, I am concerned that our border sectors are vulnerable to an attack on a mass scale with chemicals or

biological or radiological or nuclear weapons. No. 1, we don't have enough trained health professionals to be able to respond to such an attack, to help people recover from it, and to prevent mass casualties and to prevent people from being sick as a result of the attack.

To give you an example, in Detroit, our hospitals have to hire nurses from Canada and they have got to come from Canada to Detroit every day to work because we don't have enough trained nurses in the city of Detroit.

How do you think that we could best have the staffing capacity to respond to such an attack in the event that it could happen? That is one question.

My other question has to deal with the Homeland Security Presidential Directive No. 18. There I had questions on how we can make sure that we have the adequate inventory of medical countermeasures needed to respond to such a widespread attack.

I might as well just give you all of my sub-questions related to that. For example, how do we stockpile the antibiotics that we would need for anthrax? The last point related to that Presidential Directive, this relates to jobs, very important to metro Detroit and very important to our country. Do you have any thoughts on how the Department can work more effectively with the biotech and pharmaceutical sectors to help develop those new countermeasures that are referred to in Tier II of that Presidential Directive?

I know that is a lot. But, No. 1, we need the people to be able to help respond to an attack in case it happens. In order to prevent one, and to prepare us for it, we need to have the medical countermeasures available; and then how do we build a capacity to produce the new ones that we need to be effective in the future?

Dr. GARZA. Thank you. Let me try to tackle the staffing question first. Of course I am not going to be able to come up with nurses and doctors overnight, but recognizing that the health care system in the United States is very stressed, as it is right now across the country, but I think this gets back to your original point, which is preparedness, and preparedness doesn't merely just involve the health care sector, it involves multiple different public services as well as private industries in the community.

This brings me back to my whole-of-community point where if there is a disaster, it really is going to take a whole-of-community effort because, as you adequately stated, the health care sector is already under tremendous strains. If you threw a catastrophic event on top of that, it is going to need help. The help is going to have to come from the community.

As far as the medical countermeasures go, that is under the purview of the CDC through the Strategic National Stockpile on making sure that there are doses adequate for the American public. There are many different programs for storing countermeasures. The Strategic National Stockpile is National, but there are also State and local programs spread throughout the country.

As far as procuring items that go into the stockpile, DHS has the responsibility to develop the threat and risk assessment for the country and give that to HHS, to BARDA, and say these are the things that we are worried about and we would like for you to develop countermeasures for these. BARDA then takes that request

and then develops the countermeasures, interacting with just the people you are talking about, the pharmaceutical and the biotechnology industry.

Above and beyond that, our Science and Technology Director does work with a lot of universities in developing technologies and other things for biological and chemical defense as well.

Mr. CLARKE. Thank you.

Mr. BILIRAKIS. It looks like we have time for one more round, Doctor. So I am going to begin and recognize myself for another 5 minutes, and then we will go around.

My question has to do with EMS credentialing. It has come to our attention that some of the DHS components that employ medical personnel, such as the Border Patrol, occasionally run into problems with State credentialing when they cross State borders in the course of their daily duties.

How can the committee be helpful to ensure that the 3,000-plus medical personnel within the Department have the credentialing coverage they need?

I know this is so very important, so we are very interested. I am going to talk with the Ranking Member about this, too, on how we can be helpful, but we need some guidance from you.

Dr. GARZA. Yes, Mr. Chairman. That is an important question. As you mentioned, we have around 3,500 EMTs and paramedics who work in very difficult environments. The majority of our population of EMTs and paramedics work in very austere environments where health care is 4 hours away. A lot of times these are on the Southwest border where we have to move assets very quickly in order to accomplish the mission.

Recognizing that medical licensure is a State's authority, we have had some issues of being able to move our assets quickly. To that end, we have tried to develop a system for EMS services throughout DHS, so not just focusing on Customs and Border Protection, but also our medics at Secret Service, with any of our other organizations, to develop a system where we can do training, education, licensuring, and credentialing, which you talked about, as well as addressing the issues of cross-border.

We have also done an outreach to those States where this is mostly affected, which are mostly border States, to bring them to the table to say this is what we would like to do and are you comfortable with this, tell us what your concerns are because we would much rather have them feeling comfortable with what we need to do as an organization in moving our assets around. To date we have been very successful in discussing these issues with them, and a lot of them are very supportive.

Now whether the solution comes from an agreement between the States or whether it comes from legislation at the Federal level to allow DHS medics to operate, much like Federal gun carriers do, from State to State, I think is open to discussion.

Mr. BILIRAKIS. All right. What are the three most important components of the chemical, biological, radiological, and nuclear defense endeavor that OHA provides? How is this reflected in your budget request?

Dr. GARZA. Of course as you mentioned, our BioWatch program is a large part of our budget. It is a Nation-wide program, and I

know a lot of people get fixated on the machinery of the BioWatch, but what I do want to impress upon the committee is that BioWatch is much more than a machine. It is a community of people that operate within the program. The real beauty I believe of BioWatch is bringing those different people together, and I think it exemplifies what DHS is, which is a community of people that are there for security. So of course BioWatch is a big part of what we do. We are committed to pushing the technology because we know that decreasing the amount of time for detection gives us more time to decide and to treat.

In addition to that is our chemical defense program which we recently empowered to take a much more appropriate role, which is looking at more end-to-end strategies instead of just focusing on detection. Chemical is much different than bio, which is different than rad, and they each deserve their own attention.

Last, I would focus on the biosurveillance picture. As you mentioned before, the National Biosurveillance Integration Center has had some challenges, and we understand that and we appreciate that. But what we have done is we have gone back and we have gone back to our customers that we integrate with within the system, and it is a system. It is not merely just a DHS-centric place. It really does have to involve the system. Recognizing that a system can only be built on trust, we have taken a step back and gone to our partners and said, what can we do to improve the trust between our organizations and what can we do to improve the analysis of data, to improve the flow of information, and what sort of value can DHS bring to you? So bringing it down from very DHS-centric and focusing more on the system is very important to us.

Mr. BILIRAKIS. Thank you. My last question has to do with BioWatch, and I mentioned this in my opening statement, and I think you referred to it as well, Ms. Richardson.

Your budget calls for an additional \$25 million to support testing the next generation of BioWatch sensors, known as Generation-3. Considerable resources have gone into BioWatch, as you know, the development since President Bush announced the rapid stand-up of this capability in his 2003 State of the Union Address. Now more than 30 cities have these sensors deployed, and we wait for the faster and more efficient Generation-3 machines that will significantly reduce the time it takes to detect a bioterror attack. Of course, that is so very important. It will theoretically save lives, as I said, to have this rapid and automated capability.

Will the Office of Health Affairs use the fiscal year 2012 funds to work with State and local stakeholders to develop response protocols and comprehensive concepts of operation plans? These are critical elements, of course, of a successful BioWatch program that have been criticized for being absent from the architecture. That is my first question.

Then why has it taken so long to get this new automated detection equipment developed and on-line? Does your acquisition strategy allow for spiral or incremental development; that is, getting technology out there, gain experience with it, and make upgrades and improvements?

I know it is a long question.

Dr. GARZA. Thank you. Let me tackle the second question first.

The acquisition strategy, I think, is very solid. There have been slips in getting it through the testing and evaluation, but I think the big picture to focus on here is what a tremendous leap in technology that we are talking about.

This is first-in-world technology. No other industry, no other country, not DOD, is not doing what we are attempting to do with biological detection. We are basically taking something that is very technically concentrated and really scrunching it down into a box. We are talking about amplifying DNA of bacteria and looking for it, and this is not an easy project.

With that being said, the testing and evaluation has done exactly what it is supposed to do, which is make sure that we are spending tax dollars wisely, that we are not going to spend money on a machine that doesn't work.

The other side of that, and as you mentioned in your concept of operation side for the communities, is we have to make sure that this new technology is going to be right all the time. We cannot be wrong on either side of the coin. What that means is we can never miss a detection. So we can never miss an anthrax spore. We can never go off when there is no anthrax spore there because the ramifications of that are huge. You have seen how difficult it is to evacuate a city when 6 inches of snow fall. You can imagine how complicated it would be if we had a large-scale incident.

So we take that very seriously and we are being very methodical in working through testing and evaluation. This is a first-in-kind technology. So yes, there is going to be some hiccups along the way, and we expect that. But overall, the testing and evaluation is going very well.

The second part of your question on working with the communities, absolutely you are right. I tried to emphasize that previously by saying BioWatch is so much more than a machine. It is a community of people that understand biodefense. It is not just your public health people, but it is also law enforcement, it is your emergency responders. It is your EPA people, it is your public affairs people because, quite frankly, messaging is going to be huge in a bioevent.

So we go out into these communities and we develop these concept of operations, and we are developing them now before we even consider deploying Gen-3 because we know what a huge issue this is going to be, and we want to make sure that the communities are comfortable with what we are doing, and, that we can take care of whatever concerns or questions they have, and make sure that this technology, as well as people that surround it, are able to do their job.

Mr. BILIRAKIS. Thank you, sir. I appreciate those answers.

Now I recognize Ms. Richardson for 5 minutes or so, since I took a little longer. You are recognized.

Ms. RICHARDSON. You are the Chairman. You can take as much time as you want.

Mr. BILIRAKIS. I am going to hold you to that.

Ms. RICHARDSON. Absolutely.

Dr. Garza, the budget request for the National Biosurveillance Integration Center at the Office of Health Affairs was cut from \$13 million down to \$7 million. This program has been what some

would say almost a complete failure to date. We estimate that it would take a substantial investment to upgrade the subpar facilities at the Nebraska Avenue complex where the NBIC currently resides and to make it a viable program. Instead you are cutting the program nearly in half.

Would you first of all please explain the reason for the cut?

Dr. GARZA. Of course we support the President's budget as proposed. Let me get back though to what NBIC should really focus on, and it really, I do not believe, should focus on infrastructure and buildings. I think that was part of the reason why it hasn't been successful so far, is that there was a lot of focus on technology. Of course technology can only get you so far. At the end of the day, what it really takes is interpersonal and trusted relationships. I know this from serving in the military. I know this from being a paramedic, I know this from being a medical adviser, that you have to know the person that is on the other end.

So when we took a step back, what is it going—and the other reason is because data, although we would like to say we have a lot of real-time data, when it comes to bio, the data is very slow in coming because, if you remember, it has to come from that local provider to the State to any of different Federal agencies, and it has to be vetted all the way along. So data is very slow in moving. We cannot afford to wait. So what it really takes is a trusted environment where when people recognize these anomalies that are going on amongst the data, within a trusted environment, are able to talk to each other and say I am seeing this, what does it mean to you, and bringing that from multiple different points of view. They have to be able to trust that DHS is not going to take their data and display it somewhere without their okay, without them vetting their own data.

Ms. RICHARDSON. Dr. Garza, I am sorry. I only have—you have taken now 2 minutes and 15 seconds. My question is pretty specific. It originally had a budget of \$13 million, you are suggesting to cut it to \$7 million. Why? You danced around the idea it is buildings and now we are switching to talking to one another. If you can more specifically answer the question, and briefer because now I have used 2 minutes and 22 seconds.

Dr. GARZA. I apologize. The majority of that was an appropriation for a project that was working in the State of North Carolina which has been stripped out of the budget.

Ms. RICHARDSON. So what is happening in Nebraska?

Dr. GARZA. The Nebraska Avenue complex?

Ms. RICHARDSON. Yes.

Dr. GARZA. Current operations are going on in the Nebraska Avenue complex. It currently occupies real estate which is somewhat valuable to DHS because it is in a secure environment. So there are options going on on where we are going to move that center. But the budget cut was specifically for the North Carolina project.

Ms. RICHARDSON. Why do you feel that is not necessary anymore?

Dr. GARZA. I do feel that it is necessary to be reaching out with States and locals.

Ms. RICHARDSON. So why are we stripping it out?

Dr. GARZA. It was stripped out, I believe, through the CR. It was in the original 2011 budget, if I remember correctly. I can get back with you on that, ma'am, just to be sure we are not confusing numbers.

Ms. RICHARDSON. Okay. Then my last question, you started to get into people talking to each other, which I guess gets to the point of the inadequate participation that we know have occurred between the agencies. Would it be just a better solution to go ahead and zero out all of the funding and direct it to more viable programs?

Dr. GARZA. I do not believe that that would be a good option.

Ms. RICHARDSON. Why?

Dr. GARZA. The reason for that is because it would solidify the silos where data live right now. It would not cure the problem of integrated biosurveillance.

Ms. RICHARDSON. So I would say to you, Dr. Garza, because now they are just ringing for votes, clearly due to the cuts that are being involved, whether it is CR or whether within the administration, there seems to be a perception of the viability and the effectiveness of the program. So if you could more in writing provide to us why this really needs to exist and what are you going to do to fix it, and what are we losing by cutting down to this point.

Dr. GARZA. Yes, ma'am.

Ms. RICHARDSON. Thank you. I yield back.

Mr. BILIRAKIS. Thank you very much. Dr. Garza, thank you for the valuable testimony, and Members for their questions. The Members of the subcommittee may have some additional questions for you, and we ask you to respond to in writing. The hearing record will be held open for 10 days.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 2:55 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS FROM CHAIRMAN GUS M. BILIRAKIS OF FLORIDA

BIOWATCH

Question 1a. The subcommittee is concerned to hear that OHA is down to only one viable competitor for Generation-3 BioWatch technology, after discontinuing testing of a second vendor's candidate technology. The problem appears to be a difference in interpretation of test results. This decision comes after the Science and Technology (S&T) Directorate invested over \$35 million developing this vendor's technology.

Why was this vendor discontinued, and were formal, written processes in place to determine that discontinuation was reasonable?

Answer. The Department discontinued funding for one of two vendors competing in the BioWatch Generation-3 (Gen-3) Test, Evaluation, and Acquisition Program due to its failure to meet the acceptance criteria on a key performance parameter. Specifically, the Department's decision to not provide further funding was due to the vendor system exhibiting false positives when challenged with biological agents of concern based on the clearly stated requirements for automated performance. OHA as the Program Executive made the decision to not continue funding HSSSI through Phase I. This decision was briefed to and concurred with by Office of General Counsel (OGC), Office of Procurement Operations (OPO), Science and Technology (S&T) Testing and Evaluation/Standards and Acquisition Program Management Division (APMD) as well as the Under Secretary for Management. Given that a response to a bioterrorism event will result in significant disruption to society, any response must be predicated on the extremely accurate detection of a biological agent of concern.

Question 1b. Was the decision validated by S&T or an independent assessment team?

Answer. The Independent Test Activity (Los Alamos National Laboratory) conducted the test and provided the data. The data and analysis were reviewed by the BioWatch Program as well as the Operational Test Agent (the National Assessment Group, Office of Secretary of Defense, Under Secretary for Acquisition, Technology & Logistics). The summary of results was provided to members of the BioWatch Coordinating Committee. The BioWatch Coordinating Committee includes OHA, DHS Office of Procurement Operations, DHS Office of the General Counsel, the S&T Directorate Chemical/Biological Division, the S&T Test and Evaluation/Standards (T&E/Standards) Division, the DHS Office of Policy, and the DHS Acquisition Program Management Division within the Management Directorate.

Question 1c. Do you believe that, now with only one competitor proceeding to operational testing, this is a capability we can reasonably expect to procure?

Answer. According to industry responses to the Request for Information that was recently issued to support the Phase II Gen-3 Acquisition, it appears that potentially two vendors may be capable of submitting a compliant proposal. We believe the Phase II procurement to be of low risk because of the technology maturity required to be accepted.

Question 1d. How are you maximizing opportunities for competition in the procurement process?

Answer. The Department stresses the importance of establishing and maintaining competition through a number of different venues, including requirements definition, data rights, market research, acquisition planning, and a strong competition advocate program. DHS defines requirements at a level that is not vendor-specific, but instead is defined in terms of salient characteristics/generic specifications. The Department also emphasizes the importance of negotiating sufficient data rights for each procurement (with consideration of price a key factor) to facilitate future competitions. Strong market research and adequate acquisition planning are two addi-

tional keys to maximizing competition. In this regard, DHS has issued a comprehensive market research guide and an expanded Acquisition Planning Guide that have both been widely embraced by DHS components.

The Gen-3 test, evaluation, and acquisition program is flexible and promotes industry involvement by providing an initial operational capability with the explicit intent of delivering additional improved capability incrementally over time. With a sensor and component open architecture arrangement, this will allow the Department to consider technology insertion appropriately in a cost-effective manner.

This strategy affords the Department two major benefits—first, the ability to deploy a proven Gen-3 capability now to meet current threats and risk, while second, encouraging industry to continue improving autonomous technology for later insertion into the Gen-3 system.

DHS also maintains a robust competition advocate program. The DHS Competition Advocate, who is a Senior Executive, is responsible for ensuring the Department maximizes competition. The DHS Competition Advocate works with each component to establish annual competition goals, encourages components to attain competition goals, and identifies and resolves barriers to competition. As part of this effort, the DHS Competition Advocate monitors competition data as reported to the Federal Procurement Data System—Next Generation on a monthly basis. Quarterly reports are prepared for Competition Advocate review, and action, as appropriate. Mid-year reports are provided to the Chief Procurement Officer and to the Heads of the Contracting Activities regarding year-to-date competitive accomplishments versus established goals. Corrective action plans are requested if mid-year goals/achievements gaps are greater than 10 percentage points.

Question 1e. Can you provide a performance rating or other documentation of MFSI/Hamilton Sundstrand's performance as a vendor?

Answer. The answer has been retained in committee files.

Question 2. When can we expect a cost-benefit analysis to strategically justify the Generation 3 acquisition against an analysis of a broad set of alternatives?

Answer. The BioWatch Program, the Department, and outside entities have previously conducted analyses of options to provide appropriate protection to the U.S. public against the highest-risk biological pathogens as determined by the Biological Terrorism Risk Assessment. An important conclusion of these analyses has been confirming the importance of early detection.

Because of the inherent characteristics of certain biological pathogens and their effects on humans, providing medical countermeasures prior to the presence of symptomatic conditions is critical to saving lives. Studies have shown this is most effectively done through deployment of an early detection system. Other than the current BioWatch system and potential BioWatch Generation-3 system, there are no other technically mature approaches available for alternative consideration and deployment in the foreseeable future.

This was the same conclusion expressed in the National Academy of Sciences (NAS) Report, *BioWatch and Public Health Surveillance: Evaluating Systems for the Early Detection of Biological Threat*. The NAS analysis considered the current risk environment, options to protect the public, current, and near-term technical capabilities and solutions, and appropriate response protocols that would be used.

NATIONAL BIOSURVEILLANCE AND INTEGRATION CENTER

Question 3. Your revised plan for the National Biosurveillance and Integration Center incorporates subject matter experts at the National laboratories, and data fusion architecture from the Department of Defense. What is it about this plan that you believe will enable the Office of Health Affairs to get past the major challenge that other agencies simply do not want to coordinate with DHS on this issue and share information?

Answer. The Office of Health Affairs (OHA) is in the process of developing an emergent strategy for the future of the National Biosurveillance Integration System (NBIS) and the center that supports it. This process has involved both the retrospective review of relevant reports from the Government Accountability Office (GAO), the National Biosurveillance Advisory Subcommittee (NBAS), the National Academy of Sciences (NAS), and others, as well as the engagement of stakeholder groups within and from outside of Government to help identify and craft a sound way forward.

Our ultimate success depends on trust. In a renewed effort to be more inclusive, we are taking steps to build upon existing relationships while forging new ones with thought leaders. Rather than a top-down approach, we are listening intently to the observations of engaged stakeholders who share the view that we all need to work together to “get this right”.

OHA believes it important and appropriate to leverage and reinforce the successful investments of others in Government as part of any system design. To that end, OHA has been exploring the incorporation of tools and expertise from a wide range of Government activities, including those at the Department of Defense (DOD) and the National laboratories. The emergent strategy will be based on feedback we have received and will incorporate elements of outside entities where that makes sense. These initiatives are aligned with and designed to complement the on-going activities of the National Security Staff (NSS) and the Office of Science and Technology Policy (OSTP) with respect to the overall state of National biosurveillance.

RISK COMMUNICATION

Question 4a. Homeland Security Presidential Directive—10 (Biodefense for the 21st Century), issued in 2004, called for the Department of Homeland Security, in coordination with other appropriate Federal departments and agencies, to develop comprehensive coordinated risk communication strategies to facilitate emergency preparedness for biological weapons attacks. This includes travel and citizen advisories, international coordination and communication, and response and recovery communications in the event of a large-scale biological attack.

Has a coordinated risk communication strategy for biological attacks been issued to date?

Question 4b. If not, when can we expect to see it?

Answer. A draft coordinated risk communication strategy for biological attacks has been developed by the DHS Office of Public Affairs. A “For Official Use Only” copy of the draft is attached to the main workflow.

EXECUTIVE ORDER ON MEDICAL COUNTERMEASURE DISTRIBUTION AFTER A BIOLOGICAL ATTACK

Question 5. Please provide the Department’s status in implementing the Presidential Order on “Establishing Federal Capability for the Timely Provision of Medical Countermeasures Following a Biological Attack.” Traditional points of dispensing (“PODs”), while a critical piece of our Nation’s medical response, may not be sufficient by themselves to meet the time-sensitive need for medical countermeasures immediately after exposure to certain biological agents.

Specifically, considering the short 48-hour window to dispense medical countermeasures after an anthrax attack, what is OHA doing to ensure DHS employees, first responders, and the general public are all protected?

Answer. DHS Office of Health Affairs has been working closely with DHS Component and Offices (Federal Emergency Management Agency (FEMA), Policy, Operations Coordination, and others), as well as with Federal interagency partners, including Health and Human Services (HHS), Department of Defense (DoD), Veterans Affairs (VA), U.S. Postal Service (USPS), and Department of Justice (DOJ) to respond to and implement all actions called for in Executive Order (EO) 13527.

Section 2 of the EO directed the establishment of a National U.S. Postal Service Medical Countermeasures (MCM) dispensing model for U.S. cities to respond to a large-scale biological attack, as well as a plan for supplementing local law enforcement personnel with local Federal law enforcement and other appropriate personnel, to escort U.S. Postal workers delivering MCM. That National Postal Model (NPM) and plan were developed and submitted to the National Security Staff (NSS) on June 30, 2010. Since the approval of the NPM by the NSS, HHS and USPS Joint Program Enterprise have continued to develop this capability by conducting pilot programs and exercises in Minneapolis/St. Paul, MN and Louisville, KY.

Section 3 of the EO directed the establishment of a rapid Federal response capability to augment an affected community’s resources to dispense medical countermeasures following a biological attack. On March 30, 2010, the Secretary of Health and Human Services (HHS) and the Secretary of Homeland Security (DHS) submitted a concept document (*Operational Concepts and Requirements for a Federal Medical Countermeasures Rapid Response*) to the NSS for review. This resulted in the development of a comprehensive operational plan integrating Federal Government activities, the *Federal Interagency Operational Plan—Rapid Medical Countermeasure Dispensing (FIOP-MCM)*. The FIOP-MCM was submitted to the NSS on September 30, 2010.

The FIOP-MCM documents a concept of operation to provide rapid Federal, interagency support for medical countermeasure distribution operations within affected communities. This is accomplished through a variety of point of dispensing (POD) strategies that utilize mostly local Federal employees including the Department of Defense and National Guard. The FIOP provides a Federal plan that enhances re-

sponse efforts and can be easily and effectively integrated into State and local planning.

USNORTHCOM presented a Commander's Estimate of DoD capabilities to the NSS on June 13, 2011. These capabilities are currently being integrated into the existing FIOP-MCM along with updated information from our interagency partners to include the Department of Veteran Affairs (VA). Validation of this integrated Federal capability to support community dispensing operations will culminate in a tabletop exercise for Senior Officials that will take place before Sept. 9, 2011. Subsequently, the updated version of the FIOP-MCM will be submitted to the NSS before September 11, 2011.

Section 4 of the EO addresses the need to ensure that Executive branch mission essential functions can continue following a large-scale biological attack. A plan was developed and submitted to the NSS on June 30, 2010. An implementation plan and considerations for a concept of operations were submitted to the NSS on September 30, 2010. In follow-up to feedback received from the NSS in January 2011, DHS and HHS have co-chaired a Federal interagency working group to develop Department and agency plans that meet the specific intent of the EO. Seven pilot agencies, as chosen by the NSS, have agreed upon four tenets that will serve as the minimal level of engagement across the interagency. Planning will initially focus on pilot participants including HHS, DHS, Department of Justice (DOJ), USPS, Environmental Protection Agency (EPA), VA, and DoD.

DHS Workforce Health Efforts

OHA has developed a DHS Medical Countermeasures (MCM) Program at the direction of Secretary Napolitano to provide emergency antibiotics to all DHS employees in the event of a biological attack. Currently, OHA has purchased and stockpiled over 6 million tablets of antibiotics for DHS employees and individuals in the custody or care of DHS and has identified 2 dozen medical storage locations for local MCM stockpiles, or "caches." OHA has pre-positioned MCM in these medical storage caches around the Nation and is currently exploring options for expanding pre-positioned stockpiles to additional storage locations throughout the country that will, when achieved, significantly increase the efficiencies of MCM distribution to DHS employees.

PERSONNEL BUDGET

Question 6. Your fiscal year 2012 budget requests \$1.5 million for DHSTogether, described as an initiative to ensure that Department employees have the tools and resources they need to manage the stress inherent to their occupations. Can you please explain what this is, and what this money will achieve?

Answer. DHS' ability to protect the Nation depends upon a healthy and operationally ready workforce who must work effectively under stressful and demanding conditions. In October 2009, the Office of Health Affairs (OHA) was tasked to create a cross-cutting Department of Homeland Security (DHS) employee and organizational resilience and wellness program. OHA proceeded with a unified "One DHS" approach to improve consistency and standardization of employee and organizational support across the Department through creation of the DHSTogether program. In 2010, DHSTogether launched the first-ever DHS-wide employee resilience training to be completed by the DHS workforce. Since the beginning, this program has proven to be very well received and has achieved success across its offerings of trainings, symposia, and studies. Moving forward, OHA will utilize an overarching resilience framework that will unify existing activities, provide a platform for leadership, and build a culture of support. The program will have a direct impact on the resiliency and wellness of the DHS workforce and provide the resources and information necessary to effectively manage the stress associated with protecting the Nation. The annual planning, production, and distribution of resilience training and information on a Department-wide scale will maximize participation and increase the program's ability to effectively improve the resilience of the workforce.

The budget for fiscal year 2012 requests \$1.5 million to continue DHSTogether initiatives through the following:

DHS Resilience and Wellness Study

\$500,000

DHSTogether will fund a contractor-managed evaluation of current programs within the Department and across the Federal Government to identify best practices, determine gaps, and identify resources. The study will focus on the development of a One-DHS approach to creating resilience that takes into account the diversity of DHS and its distinct missions and operations. The outcome of this study

will be a thorough long-term strategic plan aiming to ensure success as well as a significant and meaningful increase in employee resilience, wellness, and operational readiness.

DHSTogether Communications Plan

\$200,000

Funding for this initiative will support development of a strategic communications plan to inform DHS leadership and employees on resilience issues and initiatives, including interactive education and training materials. Initial communications messages will focus on the resources and tools available to assist employees in handling the stresses and other challenges that come with protecting the Nation.

DHS-Wide Resilience and Wellness Training

\$250,000

Funding for this initiative will support training, which will include the development, production, and delivery of employee and supervisor training topics to support DHS readiness and employee resiliency, including suicide prevention and risk reduction, resilient leadership, and decision-making under stress. Training will incorporate resilience and suicide prevention concepts into existing mandatory supervisor and Leadership Training Curricula, and will address critical incident stress management (CISM) needs throughout the Department.

DHS-Wide Tool for Individual Health Risk Factor Assessment

\$400,000

DHSTogether will fund a contractor-managed individual health risk assessment and management tool for DHS employees to individually determine the impacts of their lifestyle on their personal health and well-being. This health risk factor assessment will allow DHS to better understand the education, support, and training needs of our workforce, and how to target needs to the appropriate subgroups. By identifying the individual health risks of DHS employees, the Department aims to make recommendations to improve the health of its workforce, which also ensures that our operational readiness will be at the highest capacity possible. This initiative also incorporates a uniform data collection policy for tracking and measuring resiliency data.

Consistency of DHS Programs and Policies

\$150,000

DHSTogether will fund a comprehensive study to identify and measure the impact of existing Departmental policies, procedures, and programs that support employee and organizational resilience. The study will catalogue best practices and baseline capabilities through leadership interviews and a well-being index, and recommend actions to improve overall employee resiliency.

INTEGRATED CONSORTIUM OF LABORATORY NETWORKS (ICLN)

Question 7. When does OHA anticipate taking over management of the ICLN from the S&T Directorate?

Answer. Per the Technology Transition Agreement (TTA) between the Science and Technology Directorate (S&T) and OHA, transition of the ICLN to OHA is conditional upon: (1) OHA obtaining funds to support ICLN operations; (2) OHA designating Federal staff to assume full-time duties of the ICLN Network Coordinating Group (NCG) chairmanship and management of the program; and (3) S&T completing functionality of the ICLN Integrated Response Architecture (IRA). OHA has identified the funds and Federal billet to support transition of the ICLN in fiscal year 2012, and S&T is continuing efforts to promote confidence in lab networks' analytical capabilities to support other networks in surge roles. S&T is practicing the IRA and developing a more facile data exchange capability across the Networks, to assure IRA functionality prior to transition. Formal transition is currently scheduled for the third quarter of fiscal year 2012.

FIRST RESPONDER GUIDANCE

Question 8. In 2009, DHS published draft guidance for protecting emergency responders before and after an anthrax attack. What is the status for issuance of the final guidance document?

Answer. OMB and NSS staff has been working with DHS/OHA to ensure the document is responsive to the concerns raised by Federal departments and agencies that will be our partners in implementing this guidance. OHA is now finalizing the

guidance for approval and publication. Upon approval, the guidance will be posted by DHS on the responder community of interest website. Finally, OHA will inform all first responder stakeholders that the guidance has been issued. It is important to note that in the interim, the draft guidance that was initially published for public comment in 2009 should guide first responders; no major changes to that guidance are being contemplated.

