ASSESSING CENTRAL INDIANA'S PREPAREDNESS FOR A MASS CASUALTY EVENT

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON EMERGENCY PREPAREDNESS, RESPONSE, AND COMMUNICATIONS

OF THE

COMMITTEE ON HOMELAND SECURITY HOUSE OF REPRESENTATIVES

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CONTENTS

ASSESSING CENTRAL INDIANA'S PREPAREDNESS FOR A MASS CASUALTY EVENT

Tuesday, August 6, 2013

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

The subcommittee met, pursuant to call, at 10:00 a.m., at Carmel City Hall, One Civic Square, Carmel, IN, Hon. Susan W. Brooks [Chairman of the subcommittee] presiding.

Present: Representative Brooks.

Also present: Senator Donnelly and Representatives Young and Walorski.

Mr. BRAINARD. I want to welcome everybody here to the City of Carmel and to City Hall. I want to thank the subcommittee for getting out of Washington. It is a good month to get out of Washington. Our humidity is a little lower here, I think. But we certainly welcome you here for today's event. I want to thank the staff that put so much time into putting this all together.

We all recognize that no one wants a tragedy, and we like to think we are immune, but we all recognize that they do occur, and they occur everywhere, and sometimes in the least expected places, and that planning and preparation are important so that we are prepared.

We are proud of our public safety departments here in Carmel. First, I think some of you know that Carmel was ranked by CNN's *Money* magazine as the No. 1 place to live in America last September, and that is due in part to the safety here in Carmel. According to the on-line magazine *Neighborhood Scout,* an organization that compiles data about neighborhoods and locations, we are the 33rd-safest city in America.

But we do recognize that no community is immune from crime or a wide-spread natural disaster. So it is important to constantly improve our ability to respond in an emergency. Our public safety officials, key directors, and school administrators recently had tabletop exercises to review emergency procedures to better respond to various scenarios. So we truly appreciate the opportunity today to learn first-hand from the witnesses gathered here, to share their knowledge of emergency preparedness.

I don't think Carmel has ever hosted a subcommittee or a committee meeting of the U.S. Congress before, and once more I would like to thank Susan Brooks and the other representatives for being here, and to have arranged it here at City Hall. We appreciate it

and I want to commend you for getting out. This is good, I think, for committees of Congress to get outside of the Beltway and be here, and so thank you and welcome.

At this time, I am pleased to turn it over to our Congresswoman, Susan Brooks.

Mrs. BROOKS. Thank you. Thank you, Mayor Brainard.

Mr. BRAINARD. If I could just ask everyone please to just make sure all phones and electronic devices are silenced, are powered off, and ask everyone to please turn the flashes off on your camera. Thank you very much.

Mrs. BROOKS. The Committee on Homeland Security, Subcommittee on Emergency Preparedness, Response, and Communications, will come to order. The subcommittee is meeting today to examine the state of emergency preparedness here in Central Indiana.

First, I want to thank everybody, including Mayor Brainard. We really appreciate the effort that your staff, led by Nancy Heck and others, had in putting this hearing together.

I would like to also thank the witnesses who are here today to testify. I would like particular thanks also to our Homeland Security staff who came out from Washington, DC to coordinate this important hearing: Natalie Nixon, Debbie Jordan, Eric Heighberger, and Moira Bergin. They came out to help work with the City of Carmel to arrange this important hearing. So I do appreciate all the effort that has been taken with respect to this hearing, including my own staff, that put a lot of time and energy into making sure that all of you were here to learn about this important topic today.

This is not a town hall meeting. This is an official Congressional hearing. So unlike a town hall meeting, we abide by certain rules of the Committee on Homeland Security and the House of Representatives. I kindly wish to remind our guests today that demonstrations from the audience, including applause and verbal outbursts, as well as any use of signs or placards—I didn't see any coming in—are a violation of the rules of the House of Representatives. It is important that we respect the decorum and rules of this committee.

Also, so that you are aware, this hearing is being webcast live on the committee's website, which is *homeland.house.gov*.

I now recognize myself for an opening statement.

As Chairwoman of the Subcommittee on Emergency Preparedness, Response, and Communications, it is a great honor to be here in Carmel City Hall to discuss Central Indiana's preparedness for a mass casualty event. As a former deputy mayor of Indianapolis and a United States Attorney for the Southern District of Indiana, I have had the privilege of working with some of the finest first responders, law enforcement, and emergency managers in the State. I also had the opportunity to travel to FEMA's training academy in Emmetsburg, Maryland long ago and received valuable training on crisis communications as well. This training further demonstrated that those involved in preparing for, responding to, and recovering from a disaster are selfless professionals.

We are fortunate to have so many dedicated individuals here in Central Indiana as we face our fair share of threats and hazards.

According to Indiana's recent Threat Hazard Identification and Risk Assessment or, known in the emergency management community as THIRA, natural disasters, industrial emergencies, and cyber attacks ranked among our highest concerns. I also received a briefing just last week from the Department of Homeland Security regarding threats posed by weapons of mass destruction and what they would look like. Chemical, biological, nuclear, and radiological attacks are still very real threats. A successful attack in the Indianapolis or Central Indiana area could severely strain our medical and hospital systems and have grave consequences for our people and our economy.

After the tragic events of September 11, 2001, the 9/11 Commission, which was co-led by former Indiana Congressman Lee Hamilton, stated that one of the main failures that led to the attack was the lack of our own imagination. Although Central Indiana may be more susceptible to events such as flooding and tornadoes, for which we have all trained and prepared, we must not let our own failure of imagination catch us flat-footed, and we must be prepared for the range of threats to which we are vulnerable.

For example, there are many unexpected incidents that can occur in any area. As we saw just recently in West, Texas, a fertilizer explosion just a few months ago, an industrial incident, whether intentional or accidental, can cause great damage, injury, and loss of life.

At this time, I would like to pay my respects to some Zionsville residents, Jeanette and Tim White, who are here with us today. Jeanette's brother, Kevin Saunders, was a first responder in West, Texas. They are Zionsville residents, and we thank you for your attendance today. We also last week entered on your behalf a letter that Mr. White prepared to the Homeland Security Committee ensuring his request to make sure that we all work together to make sure that our first responders know what they are running into and what the dangers are that they are facing. So, thank you for being here.

In addition, we know we must be ready for large events here in the State of Indiana. We host the incredible Indianapolis 500 every year. We like to host Final Fours as often as we can; and the Super Bowl, which we hosted and would love to host again. But these all present unique situations and challenges for law enforcement responders and emergency managers.

As we approach September, which is National Preparedness Month, we must ask ourselves: Are we doing everything we can to be prepared? After the Boston bombings, I asked myself once again: How would we have handled a similar attack? In Boston, we saw a coordinated response from first responders, law enforcement personnel, and medical personnel that no doubt saved many lives and mitigated damages. Are we as prepared as Boston was?

Boston's success was, in part, due to their preparations for this type of an event. They effectively used their Federal grant dollars to improve their security programs. They held training and exercises to test their plans, and they promoted the use of interoperable communications across multiple jurisdictions and sectors.

In fact, in November of last year, Boston took part in an exercise called Urban Shield. This scenario was designed to assess that re-

gion's overall response capabilities to a series of complex incidents, and the exercise tested, among other things, their coordination of public health and medical service capabilities.

Additionally, a helicopter-borne imaging unit that the Massachusetts State Police used to locate and capture Djokar Tsarnaev was purchased with State Homeland Security Grant Program funds.

Now, we have held, as well, emergency-related exercises here in Indiana many, many times. But right now, Indiana is involved in another mass training exercise. Beginning on July 21, USNORTHCOM began an exercise called Vibrant Response 13–2 at Muscatatuck Urban Training Center. This exercise simulates a nuclear detonation in an urban environment. It spans 5 weeks and includes 8,000 personnel from 22 States. Later this month, the Navy and Department of Energy will conduct an exercise focusing on the derailment of a train transporting spent nuclear fuel shipments. This exercise is designed to provide practical experience to emergency management personnel and policymakers.

Today, I want to learn what Central Indiana is doing to prepare for a mass casualty event, and I hope this causes communities all across the country to be asking the same question. I would like to hear what planning, training, and exercises are taking place. I also want to hear of any areas where we may need to improve in order to be as prepared as we can be.

Benjamin Franklin once said, "By failing to prepare, we are preparing to fail." Let's use our imaginations. In doing so, I believe we will be better prepared for both the known and the unknown.

We have two very distinguished panels of witnesses here today, and I look forward to their testimony.

I am also very pleased that my Indiana colleagues who were able to be here with us today took the time out of their incredibly busy schedules back here at home in the State of Indiana and in their own districts to be here, and so I am very honored to be having with us today the Senator from Granger, Indiana, Senator Donnelly, for any opening statement he might have.

Senator DONNELLY. Thank you, Madam Chairwoman.

I want to thank Chairwoman Brooks for organizing this field hearing and for allowing me to participate; and to Mayor Brainard, the City of Carmel, Hamilton County, and the State of Indiana for all the hard work you do every day to keep us safe.

I am pleased we have the opportunity to bring this discussion on the security of Hoosier communities from Washington, DC to Indiana. To all of our first responders who are here with us, thank you, and around the State. You put your lives on the line every single day. Your family never knows whether you are going to be coming home at night. So to all of you, thank you for your dedication.

Central Indiana has grown enormously over the last decade and is an economic hub for our State. We must be prepared with the resources and the assistance on a local, State, and Federal level to successfully respond to a mass casualty event. The timing of this hearing is excellent, as Congresswoman Brooks was saying. I was at the Urban Training Center in Muscatatuck yesterday where we observed the largest homeland security exercise conducted annually in our Nation, the Vibrant Response Northern Command exercise. We had 27 different State National Guards here in Indiana.

We had over 6,000 people working on this exercise. Muscatatuck has become, across the entire country, the central place for training for incidents here in the entire United States. We are very proud of our own National Guard and what they have done to make Muscatatuck the center of choice.

This exercise prepared the military, homeland security personnel, and first responders for responding to a nuclear attack in an urban area down at Muscatatuck yesterday. I was deeply impressed by what I saw, and I look forward to hearing your expertise today and perspective on preparing for an emergency event on a local level.

Central Indiana frequently hosts world-class sporting events, as Congresswoman Brooks was saying: The Super Bowl, our own Indy 500. We are proud to host these events, and to continue to be considered for them, we must be fully prepared to respond to a major disaster. I am especially interested in learning more about how we communicate and coordinate our actions between Federal, State, and local agencies to ensure a seamless response to affected communities.

I thank the witnesses for being here, and I especially want to thank the Chairwoman for hosting this, and to Congressman Young and Congresswoman Walorski for being here today as well. I look forward to hearing the testimony. Thank you.

Mrs. BROOKS. Thank you, Senator Donnelly.

I would now like to recognize the gentleman from Bloomington, Mr. Young, for any opening statement he might have.

Mr. YOUNG. Well, thank you so much, Madam Chairwoman, and I thank all of you for being here today, for taking time out of your busy and important days to testify, for those that are testifying, and just to be privy to the testimony that is delivered, for everyone else who is here with us today.

I want to thank the City of Carmel. As a Carmel High School graduate myself, I am a bit parochial and proud to be back here in Carmel.

Listen, the topic that we are discussing today, the preparedness of Central Indiana for a mass casualty event, is not only an essential one that we air publicly, it is one that is near and dear to my heart. Each of us is sort-of shaped by our own personal experiences, and before coming to Congress I had spent 10 years in the military. In the course of that time, I was trained in anti-terrorism and force protection. This was the pre-9/11 era, and today happens to be, dictated by our Federal Government, a period of heightened preparedness and alert as a result of circumstances and intelligence we have collected around the world. So I think this is certainly a timely hearing.

I would also say after I left the military, I spent my last day at a think tank in Washington, DC, and it happened to be 9/11, and that was a formative experience and reminded me that we as a Nation had a long way to go in terms of coordinating our efforts between agencies and with the American people themselves in order to figure out what happens during a day of mass chaos, and such days will come again as a result of either terrorist attacks or natural disasters or industrial accidents or what-have-you.

Within weeks after leaving that job, I worked for a United States Senator, Senator Lugar. I happened to be in the office during the time of the largest bioterrorism attack in American history. Remember the anthrax attacks on Senate and House office buildings and some other sites.

So all of these things have reinforced my belief that we need to continue to do everything possible to prepare for these contingencies. Now, since I have been in Congress, I represent the Ninth District, which runs from just south of Indianapolis to the Ohio River. It is also tornado country, at least it has been in recent years, and we suffered a horrible, deadly tornado that went through many of our towns. I see a lot of familiar faces in the audience, people who helped us through that tragic event and came together.

Together we learned that though much progress has been made, much remains to be made in terms of coordinating our efforts between agencies and among personnel in order to help people when they need it the most.

So my expectation, my hope today is that we can tease out exactly what is being done to prepare for the next disaster, what has been done, and how we can help at the Federal level, help enable all of you to do your jobs in a more effective way, how to educate our constituents about how to prepare for a mass casualty event and reduce the number of casualties.

With that, I will yield back to Madam Chairwoman and thank all of you again for being here today.

Mrs. BROOKS. Thank you.

At this time, the Chairwoman now recognizes the gentlewoman from Jimtown, Mrs. Walorski, for any opening statements you might make.

Mrs. WALORSKI. Thank you, Madam Chairwoman. I, too, am grateful to be here today, and I am grateful for your leadership in hosting this field hearing today.

I serve on the Armed Services Committee. I am from the Second District in Indiana, which is in the South Elkhart and Northern Indiana area. One of my extreme, I would say, passions is making sure that we keep our Nation safe. My husband and I were living in Eastern Europe during 9/11, and when we watched it on TV from thousands of miles away, it changed my perspective forever on what National security is to this country. We didn't know if we would ever see our families again, and we didn't know if we would ever get home again and what home would look like. They started the evacuation process in Europe where we were to move all Americans to a safe place.

In the Second District, we had our issues as well with Mother Nature. But I am grateful to sit here with Senator Joe Donnelly, Representative Todd Young, and under the leadership of Congresswoman Brooks so that we can figure out a way that Indiana can again lead the Nation. Our State is leading the Nation in virtually every matrix that has any kind of comparable grid in it, and this is also an area. I can tell you, to the mayor and to the resources here in Carmel, I toured some of the trucks outside before we came in here, and what a system we have, and that we have a chance to learn how to do better.

So the issue that we are learning about today is certainly Central Indiana. I can tell you as well, Grissom Air Reserve Base is doing training exercises this weekend. This is a very appropriate time to be talking about this, as Congressman Young just said, when we have 21 embassies around the world that are continuing to be closed as we lead up to September 11 again. Whether it is an attack from individuals who seek to do us harm, or living in the Midwest where we live and the dangers that we face with Mother Nature, I am here to learn, take notes, and just ask questions on how we can do things better; and to, again, I know, stand and be proud of this Hoosier State because we do all things well.

So to every first responder, I am the daughter of a city fireman, and I so much appreciate every one of you that fights the fight every day for us on the front lines. So I look forward to hearing from our panels today.

Thank you again, Madam Chairwoman, and I yield back the remainder of my time.

Mrs. BROOKS. Thank you to the gentlelady from Jimtown, Indiana.

We are pleased today to have two panels of very distinguished witnesses before us today on this important topic. I am now going to introduce the first panel, and they will then testify, and then we will switch to the second panel after they have given their opening statements and testify.

To my left, Mr. Andrew Velasquez is the administrator of the Federal Emergency Management Agency's Region V. In this role, he coordinates preparedness response, recovery, and mitigation activities for the States of Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Mr. Velasquez was appointed to this position in April 2010 after serving as director of Illinois' Emergency Management Agency. So, thank you for coming and joining us.

Next on the panel is Mr. Mark Bowen, who is the sheriff of Hamilton County, Indiana, a position to which he was elected in November 2010. Sheriff Bowen has been with the Hamilton County Sheriff's Department since 1991 and was appointed chief deputy sheriff in 2003. Prior to being elected sheriff, he served many roles in the sheriff's office, including field training officer, firearms instructor, accident reconstructionist, Special Emergency Response Team member, Tactical Tracking Team member, and Honor Guard member.

Next is Mr. Steve Orusa. Chief Orusa is the fire chief of Fishers, Indiana. Chief Orusa is a published author and a frequently invited speaker on public safety leadership and development techniques. He has provided analysis on public safety response for *USA Today, Fire Chief* magazine, *Fire Engineering* magazine, and has also appeared on BBC, MSNBC, Fox News, and CNN to provide expert analysis on disaster response.

Next to the chief is Mr. John Hill. He is the executive director of the Indiana Department of Homeland Security, a position Governor Pence appointed him to in January of this year. Mr. Hill is responsible for the State's emergency management and homeland security efforts, which include planning and assessment, preparedness and training, emergency response and recovery, fire and building safety, and field services. Prior to joining IDHS, Mr. Hill served

as the administrator of the Federal Motor Carrier Safety Administration. He also served as a member of the Indiana State Police from 1974 to 2003, providing expertise as commander of the Commercial Vehicle Enforcement Field Enforcement and Logistics Division.

Finally, I would like to have the opportunity to see if Senator Donnelly would like to introduce a witness on behalf of the Democrats.

Senator DONNELLY. Thank you very much, Madam Chairwoman.

I would like to introduce Ms. Diane Mack. Ms. Mack is the IU Director of Emergency Management and Continuity. She is responsible for ensuring that all IU campuses have viable and adequately-tested emergency response plans, and that each IU department has plans in place to ensure critical functions can be recovered quickly if they are interrupted by emergencies such as a building fire or tornado damage.

I know that is a location of great fondness to Congressman Young as well, and if you would like to say a word, go right ahead, sir.

Mr. YOUNG. Thanks for your service. Thank you for affiliating yourself with such a fine university, and just if you ever need anything, please do call. We are all here to help.

Mrs. BROOKS. Thank you.

At this time I would like to inform everybody that the witnesses all have submitted full written statements and testimony, and that will appear in the record.

I just also would like for everyone to realize that we are on a timer system, and there is a timer here up at the podium, and everyone has 5 minutes to testify. When the light turns to yellow, that means you have 1 minute remaining. When the light turns to red, that means that your 5 minutes are up.

We are going to begin now with Mr. Velasquez. Thank you, and we will now recognize you for your testimony.

STATEMENT OF ANDREW VELASQUEZ, REGIONAL ADMINISTRATOR, FEMA REGION V, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. VELASQUEZ. Good morning, Chairman Brooks, Senator Donnelly, Congresswoman Walorski, and Congressman Young. Thank you for the opportunity to appear before you to discuss what FEMA Region V is doing to support the States in our region, including the great State of Indiana, to prepare for all hazards and how those efforts could support our response to a mass casualty event.

As stated before, I am Andrew Velasquez, the Region V administrator, and in addition to serving the State of Indiana, Region V is also responsible for serving the States of Illinois, Michigan, Minnesota, Ohio, and Wisconsin, and 34 Federally-recognized Tribes. Region V enjoys a very close working relationship with each of our six States, partnering with our State directors, our homeland security advisers, as well as our adjutant generals, as we work together to enhance safety and security for our region and the residents that live within our region. I hope that you will learn from our testimony today that we have been continuing that partnership with Director Hill since his recent appointment.

FEMA operates on the principle that all disasters, regardless of scale, are inherently local. As such, county and local first responders play a vital role during the initial response to any emergency. As we all know, if a local jurisdiction or a county jurisdiction becomes overwhelmed, then the Governor can request assistance from the Federal Government through FEMA. This is the tiered response philosophy that we employ. It is how the emergency management system and process operates in this country for most incidents. If the Federal support becomes necessary, FEMA will help coordinate response activities, including leveraging support from our volunteer, faith-based, and private-sector partners.

This does not mean that the Federal Government is passive in its support to our States. We are in regular contact with our State partners so that when severe weather threatens or there are reports of any unusual activity, we can begin preparations such as prepositioning commodities, activation of response personnel, and the activation of our Regional Response Coordination Center.

With that basis, please allow me to explain the various efforts that are currently undertaken to increase preparedness throughout the region for any hazard that may present itself, including those that could result in significant levels of damage or destruction.

Our frameworks. Consistent with the principles and directives established by the National Preparedness System, FEMA is developing a series of National frameworks which describe the roles and responsibilities of all stakeholders. These frameworks include the NRF, the National Response Framework, which has been in place since 2008 and updated this year. This framework aligns roles and responsibilities across Government and the private sector in a unified approach.

The National Disaster Recovery Framework, which was recently rolled out across the country, focuses on how to restore, redevelop, and revitalize the health, social, economic, natural, and environmental fabric of the community, as well as build a more resilient Nation.

The foundation of these frameworks rests on the understanding of the potential threats and risks that affect the State. A process known as THIRA, which was recently mentioned, and risk assessments are used to determine what can happen, where it can happen, when it can happen, and how bad it could be.

With regard to funding, FEMA works to increase State and local preparedness by supporting a variety of grant programs and working to ensure that they are managed effectively. As a Nation, we have made significant investments in National preparedness capabilities throughout our various grant programs during the past decade. Through our various grant programs during the past decade, we have seen preparedness in the area of building capabilities, equipment purchases. We have also—due to certain reductions in overall preparedness grants, grantees are currently required to focus their funding on the maintenance and sustainment of current capabilities and closing gaps in core capabilities.

Given today's topic of the hearing, I would also like to note the increased emphasis on mass casualty events represented in the grant guidance for fiscal year 2013. The Homeland Security Grant Program guidance specifically prioritizes on improving immediate

emergency victim care at mass casualty events. Within this priority, there are two key objectives: Improving emergency care to victims of mass casualty events, including mass shootings; and improving community first aid training.

FEMA has provided more than $547 million to the State of Indiana through 23 different preparedness grant programs since fiscal year 2002. In 2012, the total amount of grant funding was just over $24 million. These dollars have come from a wide variety of programs to support different initiatives in the State of Indiana. They have supported building capacity and capability through the State level, through planning grants, safety of key infrastructure such as ports, chemical facilities, and transit, promoting preparedness of individuals through Citizen Corps programs, increased capability of local first responders through the fire grant, and staffing for adequate fire and emergency SAFER Grant programs.

In closing, FEMA Region V is continuously working to evolve our approach to preparing America's citizens and responding to events that threaten their lives and livelihoods, and to better fulfill FEMA's mission. To that end, we are actively working with our Government partners at the State, Tribal, and local levels, as well as our non-Governmental partners, to prepare for whatever may impact the region, and we look forward to continuing that great work.

I appreciate the opportunity to appear before you today, and I look forward to answering any questions you may have. Thank you very much.

[The prepared statement of Mr. Velasquez follows:]

PREPARED STATEMENT OF ANDREW VELASQUEZ

AUGUST 6, 2013

INTRODUCTION

Good morning Chairman Brooks, Ranking Member Payne, and Members of the subcommittee, I am Andrew Velasquez, Region V administrator for the Federal Emergency Management Agency (FEMA).

Thank you for the opportunity to appear before you to discuss what FEMA's Region V is doing to support the six States in its Region: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin, in addition to assisting 34 Tribal governments in their efforts to prepare for all hazards.

FEMA's mission is to support our citizens and first responders to ensure that as a Nation we work together to build, sustain, and improve our capability to prepare for, protect against, respond to, recover from, and mitigate all hazards. We accomplish this through grants, training, exercises, and other support, and work with our State, Tribal, territorial, and local partners to lessen the impact of future disasters through mitigation efforts.

FEMA is committed to getting resources into the hands of State, local, Tribal, and territorial governments and their first responders, who are often best-positioned to prepare for and respond to acts of terrorism, natural disasters, and other threats. Here, in Region V, it is my job to coordinate preparedness activities among our State and Tribal partners.

FEMA operates on the principle that all disasters, regardless of scale, are inherently local. Local fire, police, and emergency management agencies will always be the first to respond and the first to begin the process of recovery. As such, local and county first responders play a vital role during the initial response to any emergency. If a local jurisdiction becomes overwhelmed, the community can request the assistance of their county, which can provide immediate assistance and if necessary request additional assistance from the State.

If the response is beyond the State's or Tribe's capability, then the Governor or Tribal official is able to request assistance from the Federal Government through FEMA to the President. This tiered response philosophy is how the emergency man-

agement system operates to support an impacted community for most incidents. If the President determines that Federal support is necessary, FEMA will help coordinate response activities, including leveraging support from its volunteer, faith-based, and private-sector partners.

This does not mean that the Federal Government is passive in its support to States and Tribes. FEMA, through its 10 regional offices and headquarters, is actively monitoring open-source media and reports from Federal partners, such as the National Weather Service and the U.S. Geological Survey. FEMA is also in regular contact with its partners so that when severe weather threatens, or there are reports of any unusual activity, the Region can begin preparations, such as the prepositioning of commodities, activation of response personnel (e.g., Incident Management Assistance Teams, collocation of FEMA staff with State Emergency Operations Centers, Urban Search and Rescue teams), and activation of the Regional Response Coordination Center (RRCC) for any potential response that may be warranted.

DOCTRINE

The emergency management field has evolved significantly since the terrorist attacks of September 11, 2001. The attacks that day exposed a reality that we must now not only consider, but also plan for. One of the outgrowths of those attacks was Homeland Security Presidential Directive 8. This Directive was updated to reflect the evolution of our understanding of these types of events and of lessons learned.

In March 2011, the President signed Presidential Policy Directive 8 (PPD–8), which focused on preparing for the threats that pose the greatest risk to the security of the Nation, including: Acts of terrorism, cyber incidents, pandemics, and catastrophic natural disasters. PPD–8 establishes, among other things:

- A National Preparedness Goal, which contains our collective focus for success and provides a basic definition of the core capabilities;
- A National Preparedness Report, which enables us to report on our progress toward building capacity;
- A series of National Planning Frameworks, which set the strategy and doctrine for building, sustaining, and delivering the core capabilities across the five mission areas—prevention, protection, mitigation, response, and recovery.

FEMA has worked with representatives from across the whole emergency management community to develop these products. PPD–8 emphasizes creating a robust capability based on cross-jurisdictional and readily-deployable State and local assets. This would mean that Federally-funded capabilities, such as equipment and teams, can be deployed across the Nation in response to a catastrophic event. Second, planning focuses on those events that severely stress the Nation's resources and lead to major impacts on our communities. This does not mean that we will abandon our planning related to reoccurring hazards and those events that are most likely to happen. However, it does mean that we need to step outside of our comfort zone and think about those threats and hazards that could overwhelm us and stress the Nation's emergency management system.

PPD–8 focuses on a shared responsibility approach to all phases of emergency management, not just response. In this approach, the whole community is engaged before, during, and after a disaster.

FRAMEWORKS

Four of the five frameworks have been published. The National Disaster Recovery Framework (NDRF) which was released in September 2011 and recently rolled out across the country, focuses on how to restore, redevelop, and revitalize the health, social, economic, natural, and environmental fabric of the community and build a more resilient Nation. The updated National Response Framework (NRF), as well as the new National Prevention and National Mitigation Frameworks, were rolled out on May 6, 2013. Each of these frameworks addresses the unique expectations and challenges for each mission area.

The NRF aligns roles and responsibilities across Government and the private sector in a unified approach in responding to any threat or hazard.

Prevention-related activities are covered in the first edition of the National Prevention Framework. This framework focuses on addressing the challenges stemming from an imminent terrorist threat.

Fostering a culture of preparedness—centered on risk and resilience to natural, technological, and human-caused events—is what the first edition of the National Mitigation Framework is all about. The document provides context for how the whole community works together and how mitigation efforts relate to all other parts of National preparedness.

The Protection Framework is under development. We are working closely with our partners in DHS and across the emergency management community to ensure that the development of the Protection Framework is closely aligned with the implementation of Presidential Policy Directive 21 and Executive Order (EO) 13636, which address infrastructure protection and cybersecurity respectively. This alignment will ensure that the efforts undertaken under PPD–21 and EO13636 will be linked to the larger protection mission space.

FUNDING

In addition to doctrinal changes, FEMA works to increase State and local preparedness by supporting a variety of grant programs and working to ensure that they are managed effectively.

These grants are grouped into three broad categories, including:

- Overarching homeland security grant programs in support of State, local, and Tribal governments;
- Targeted infrastructure protection grants which support specific critical infrastructure protection initiatives within identified jurisdictions; and
- Firefighter grants programs, which provides funding for staffing and equipment directly to fire service agencies based on a competitive process.

As a Nation, we have made significant investments in National preparedness during the past decade. Due to reductions in overall preparedness grants, grantees are currently required to focus their funding on the maintenance and sustainment of current capabilities along with closing gaps in core capabilities as identified in the THIRAs and State Preparedness Reports.

Given the topic of today's hearing, I would also like to note the increased emphasis on mass casualty events represented in the grant guidance for the Fiscal Year 2013 Homeland Security Grant Program. The guidance specifically prioritizes on improving immediate emergency victim care at mass casualty events. Within this priority there are two key objectives: Improving emergency care to victims of mass casualty events, including mass shootings; and improving community first aid training.

The DHS/FEMA Regional Catastrophic Preparedness Grant Program (RCPGP), which started in 2008, identified 10 High-Threat Urban Areas to receive funding to develop regional catastrophic incident plans. One of the 10, the Illinois-Indiana-Wisconsin Combined Statistical Area (Il-In-Wi CSA) encompasses 16 counties and the City of Chicago. Since the program began, the area has received more than $14 million. The RCPGP focuses on three primary goals: (1) Fixing shortcomings in existing plans; (2) building regional planning processes and relationships; and (3) linking operational and capabilities-based planning to resource allocation. The four primary core capability areas are Transportation/Evacuation; Mass Care and Sheltering; Public Information and Warning; and Logistics and Resource Management. With this funding, the Regional Catastrophic Planning Team, consisting of representatives from the 16 counties, has coordinated planning efforts with county and local representatives to develop and integrate the county and local emergency management plans, as well as evacuation plans for the combined statistical area. In addition, they have developed the Gear Up Get Ready campaign, which focuses on preparing citizens to become more resilient during emergencies and disasters.

FEMA has provided more than $547 million to the State of Indiana through 23 different preparedness grant programs since fiscal year 2002. In 2012, the total amount of grant funding was just over $24 million. These dollars have come from a wide variety of programs to support initiatives in the State of Indiana. They have supported building capacity at the State level through planning grants, the safety of key infrastructure sectors like ports, chemical facilities, and transit, promoted preparedness of individuals through the Citizen Corps program, and increased capacity of local first responders through the Fire Grant and Staffing for Adequate Fire & Emergency Response (SAFER) Grant programs.

We also work to increase resilience by reducing the impact of future disasters, whether they are floods, tornadoes, severe storms, or terrorist attacks. The agency's mitigation grant programs are available to State, Tribal, territorial, and local governments. These programs support cost-effective projects that will lessen the impact of future disasters by encouraging the development of local mitigation plans; acquisition and removal of flood-prone properties; and construction of storm water detention basins.

FEMA has provided Indiana approximately $46 million in mitigation funding since fiscal year 2008. This funding has improved resilience through the removal of flood-prone properties, which is a priority for the State of Indiana. When all of the existing projects are completed, nearly 950 flood-prone homes will have been permanently removed from danger and their owners compensated to move. Indiana has

also undertaken projects to promote the development and adoption of local hazard mitigation plans, public awareness campaigns, and tornado alert sirens.

As we look to further strengthen our ability to prepare for events, the President's fiscal year 2014 budget proposes to reform the grant programs and establish a National Preparedness Grant Program. Creating this program would create a robust National network of capabilities, eliminate redundancies, and make the most of our limited resources, while strengthening our ability to respond to evolving threats across America.

RISK ASSESSMENT

As a condition of grant funding, DHS/FEMA requires a Threat and Hazard Identification and Risk Assessment (THIRA) for States and Urban Area Security Initiative (UASI) cities and recommends county and municipal emergency management programs also conduct a THIRA.

The THIRA process helps communities identify capability targets and resource requirements necessary to address its anticipated and unanticipated risks.

THIRAs also help the Federal Government understand regional trends and gaps where Federal resources may be needed to support State and local governments. FEMA Region V has actively engaged its States to cooperatively undertake this assignment. Working together to identify capability requirements, FEMA is able to more quickly ensure that should Federal support be needed, it will be in the best position to deliver what States and Tribes need, when they need it.

PLANNING

Region V, in coordination with its Federal, State, and Tribal partners, collaborates on catastrophic planning initiatives for events that stretch the capabilities of local and State governments beyond their typical response efforts. For example, our planning includes projects, such as All-Hazards Response Planning, Catastrophic Earthquake Planning, and planning for an Improvised Nuclear Device. Our plans are built around both the Response Core Capabilities found in the National Preparedness Goal and on the administrator's intent to include whole community concepts in planning efforts.

One way that we are ensuring we incorporate the views of our key operational partners is through quarterly Regional Interagency Steering Committee meetings, held at our Regional offices in Chicago and around the region. These meetings give us the opportunity to discuss various emergency management planning and preparedness issues with our partners.

Having a wide variety of stakeholders involved in the development of our plans helps ensure that responders at all levels know what their respective roles are and how they interrelate, which leads to a more coordinated response.

Region V All-Hazards Plan

The notion of all-hazards planning has been a driving force in emergency management for many years. Region V developed its All-Hazards plan utilizing a combination of planning factors such as, Metropolitan Statistical Area (MSA) information, potential infrastructure vulnerabilities, State capabilities, historical disaster information, modeling, and the unique characteristics of Region V.

While Region V faces a wide range of hazards, we have identified nine National Planning Scenarios that guide our planning efforts. These include an Improvised Nuclear Device, Pandemic, Catastrophic Dam or Levee Failure, Nuclear Release, Major Winter Storm, New Madrid/Wabash Valley Seismic Zone Earthquake, Chemical/Biological Incident, Major Summer Storm and Multi-State Flooding.

Using MSA information based on demographic data pulled from the 2010 Census provides us with an immediate snapshot of potential resource needs that may arise in the event of an overwhelming disaster in any of our States. We analyze the population of an area, the number of households, the number of children, as well as percentages of households that are below the poverty line, in assisted living, have persons with disabilities or other people with access and functional needs, have transportation needs, and those with Limited English Proficiency.

Using the expertise of other Federal agencies and our own resources within DHS, we are also looking at potential infrastructure vulnerabilities that could negatively affect survivor outcomes and response capabilities. Each State also has identified critical infrastructure that they believe to be vulnerable in the event of a catastrophic incident.

As I mentioned earlier, information pulled from State Preparedness Reports and THIRAs is a critical element of our Regional All-hazards planning. This information

allows the Region to survey each State and determine potential resources the Federal Government may need to provide in the event of a catastrophic incident.

As you know, Region V, which is centered in the middle of the United States, has a number of characteristics that make our All-Hazards planning unique. We are home to 17 percent of the National population, including Chicago, the third-largest U.S. city; 10 cities within Region V are designated under the Urban Area Securities Initiative; we are a major transportation shipping point with 15 percent of all U.S. freight shipments (by weight) originating within Region V and 25 percent of all U.S. rail traffic traveling through Chicago to reach other points within the United States. In addition, Chicago is a major hub for telecommunications, natural gas, and air travel.

Region V Earthquake Plan

The FEMA Region V earthquake plan provides guidance on how the Region will coordinate and execute its responsibilities and mission to effectively respond to and provide immediate Federal resource support following a catastrophic earthquake, aftershock, or cascading impacts from such events. Region V has two notable potential earthquake threats, the Wabash Valley Seismic Zone and the New Madrid Seismic Zone. Region V States, including Indiana, have established a history of successful planning efforts in preparation for a catastrophic earthquake, particularly within the New Madrid Seismic Zone, though the lessons learned and processes used also have value for a Wabash Valley incident. The earthquake plan was developed around a 7.7 magnitude New Madrid Seismic Zone scenario, which was based on seismic modeling conducted by the Mid-American Earthquake Center.

This planning effort included workshops, exercises, and on-going planning with Federal, State, and local partners. These workshops, held in each of the potentially impacted New Madrid States between 2006 and 2010, focused on the Response Core Capabilities outlined in PPD–8, as well as on resource allocation. These workshops culminated in National-Level Exercise 2011, which focused on a catastrophic earthquake event in the zone.

Following this large-scale exercise, we are continuing to work with our partners to expand our planning efforts, focusing on logistics, operations, and planning. These workshops placed a heavy emphasis on commodities, staging, and logistical needs in disaster response. The next milestone for this plan will be a CAPSTONE exercise, driven by the Central United States Earthquake Consortium and its member States, to examine the private-sector resources in a New Madrid event.

Improvised Nuclear Device Planning

The third planning effort that has helped us tremendously to expand our preparedness for all hazards, and in particular for large-scale disasters, is our planning for an Improvised Nuclear Device (IND). Our IND planning effort focuses on identifying effective response tasks that could save and sustain lives. While such an incident would have specific impacts, the process that we used to develop the plan is one that we could use to expand our preparedness for other catastrophic events.

With this in mind, Region V is developing a contingency plan for a 10-kiloton explosion. The plan is being developed collaboratively with more than 300 partners at the Federal, State, and local levels, as well as from private-sector and voluntary agency representatives.

The resulting document is a blueprint for common understanding that outlines how partners need to respond to an event from hour 1 to hour 96.

NEW INNOVATIONS/LESSONS LEARNED

As we move forward, it is important to note that we are constantly working to improve our operations. We are learning lessons not just from past disasters, but also from disasters to which we are currently responding. We are implementing new force structures to improve the way we deliver services, new technologies to improve our situational awareness and coordination, new logistical models to improve the way we deliver commodities, and new partnerships to expand the notion of whole community in preparedness and response.

New Force Structures

To ensure that we are consistently delivering a high level of service to disaster survivors and to our State, local, and Tribal partners, while at the same time ensuring we continue to complete our non-disaster response functions, FEMA is moving toward a new force structure that maximizes our staff and capabilities. To this end, the agency recently stood up new, full-time Incident Management Assistance Teams (IMATs), and is hiring disaster response staff that can deploy for longer periods of time.

FEMA has also established members of the DHS Surge Capacity Force, made up of employees from other DHS components and Federal agencies. During Hurricane Sandy, we deployed more than 1,100 of our co-workers from the various DHS component agencies in support of the response operations. We have also adopted a new model for serving disaster survivors by standing up Disaster Survivor Assistance Teams (DSATs) to replace the former Community Relations function. These new DSATs are deploying to the field fully trained and equipped not only to share information about the help available after a disaster, but also to go into neighborhoods and register survivors, answer case-specific questions, and facilitate survivor access to our full range of post-disaster services.

Any incident that would generate mass casualties would involve the deployment of large numbers of FEMA and DHS staff. These new force structures and programs ensure a more nimble and robust response and a higher level of service to disaster survivors. Region V was the first region to utilize the DSAT model in response to severe flooding in Illinois, allowing it to be more survivor-centric by bringing services to survivors, rather than asking them to come to FEMA.

New Technologies

FEMA is implementing new technologies to improve our preparedness and response capabilities, using satellite imaging and flood modeling to improve disaster response, engaging with the public through social media, and adopting new technologies to improve interactions with our response partners.

We have adopted, and actively use WebEOC, which is an emergency management information-sharing tool that allows us to work toward a common operating picture among multiple partners in real time. FEMA recently joined States in using this technology, allowing for greater collaboration between these partners. We are also using EMNET, a satellite-based information-sharing system, to ensure productive collaboration.

Commodity Warehousing

FEMA Region V is piloting a new model for the storage and delivery of emergency supplies in the event they are needed for disaster response. We are working with regional food bank distribution centers to shave valuable time off FEMA commodity delivery. We will store FEMA commodities at no cost at six food bank centers located across Region V, in addition to utilizing commodities stored at FEMA's existing Distribution Centers that are located in coastal States. With this new initiative, an initial supply of commodities, such as water and Meals Ready to Eat (MREs), will reach disaster survivors more quickly and establish the supply chain from more remote centers.

FEMA worked with Feeding America—the Nation's leading domestic hunger-relief non-profit organization—to develop the plan. Feeding America's mission is to provide nutrition support through a Nation-wide network of member food banks and engage the country in the fight to end hunger. The Region estimates that we will be able to store 5 to 7 truck-loads at the distribution centers, which is enough to respond to a mid-size disaster. Commodities in storage include water, shelf-stable meals, and infant/toddler supplies.

As we all know, all commodities have a shelf life. In the event that the food we put in storage is not used, our plan outlines a process that would allow the food banks storing the commodities to request, through FEMA's established surplus process, donation to that food bank before they expire.

The new storage plan will deliver a number of other benefits to regional operations. For example, deliveries coming from distribution centers on the East Coast or in the South may be delayed by weather conditions or other disaster disruptions, making speedy delivery a concern. Region V will have initial supplies pre-staged locally which will increase the speed of delivery and decrease the potential for weather- or travel-related delays.

The six food banks in Region V currently under consideration for this initiative are:

- Second Harvest Heartland, St. Paul, MN;
- Greater Chicago Food Depository, Chicago, IL;
- Northern Illinois Food Bank, Geneva, IL;
- Gleaners Food Bank of Indiana, Inc., Indianapolis, IN;
- Cleveland Food Bank Inc., Cleveland, OH;
- Gleaners Community Food Bank of Southeastern Michigan, Detroit, MI.

Private-Sector Partnerships

FEMA continues to expand its outreach to and engagement with the private sector. Region V has a full-time staff member who works to conduct outreach to a wide range of non-Governmental partners, including small, medium, and large business,

as well as academia, trade associations, and other organizations. Throughout the year, FEMA's Private Sector staff works with the private sector to provide information on tools and resources to support preparedness, and integrate the private sector into the emergency management effort. FEMA's National Private Sector team is comprised of headquarters staff, 10 regional liaisons, and a disaster workforce cadre of approximately 40 reservists.

During steady-state, non-disaster operations, this FEMA office focuses its efforts on ways to engage the private sector in activities ranging from education campaigns, to opportunities for providing feedback on National policies, to participation in joint exercises.

FEMA established a special Private Sector Representative (PSR) position in 2010 to communicate, coordinate, and collaborate between public and private-sector stakeholders before, during, and after disasters. Unlike the full-time Federal positions established starting in 2008, a PSR is a member of the private sector who serves as a Special Government Employee (SGE) during their 90-day tenure with FEMA, effectively representing the entire private sector while they are a PSR.

When the NRCC is activated, these special Government employees serve as critical liaisons between FEMA and private industry by leveraging private-sector coordination and collaboration capabilities and sharing situational awareness information.

The PSR in Region V is currently filled by a representative from Walgreens. At FEMA Headquarters, representatives from eight companies, including Target, Big Lots, Brookfield Properties, Systems Planning Corporation (a small business), Verizon, Citi, Wal-Mart, and Dominion Power Company serve a similar role.

FEMA has also been instrumental in helping to establish the National Business Emergency Operation Center (NBEOC). The NBEOC is a virtual network of National corporations, Federal, State, local, Tribal, territorial governments, and trade associations that have roles in disasters. Illinois is the only State in the Region that has a dedicated Business Emergency Operation Center (BEOC). The BEOC activates whenever the State Emergency Operations Center activates and provides situational awareness to the Regional Response Coordination Center and to the Regional Private Sector Liaison.

In Indiana, we are actively engaged with the Northwest Indiana Information Sharing Workgroup. This group is comprised of the private sector, State, and local emergency managers, academia, faith-based groups, and other Federal agencies. This workgroup is part of the Homeland Security Information Network—Critical Sectors (HSIN–CS). HSIN–CS is a secure, unclassified, web-based system that serves as the primary, Nation-wide DHS information-sharing and collaboration system. Members of this group meet regularly and were active in planning for the recent NATO meetings in Chicago.

FAITH-BASED, COMMUNITY, AND VOLUNTEER PARTNERSHIPS

Ultimately, FEMA is only one part of our Nation's emergency management enterprise. This effort is a shared responsibility and our partners at all levels help communities prepare for, protect against, mitigate, respond to, and recover from all hazards.

The agency relies on our voluntary agency partners to help us support State and local governments by providing services that we may not be in the best position to provide. Our collective response is greatly enhanced by the on-going efforts of faith-based, community, and volunteer organizations. We depend on them as true partners to help on the front lines as well as behind the scenes, to receive and distribute commodities, manage and staff shelters and mass feeding facilities, provide counseling services and much more.

During my emergency management career, beginning as the executive director of Chicago's Office of Emergency Management and Communications, then as the director of the Illinois Emergency Management Agency, and now as a regional administrator for FEMA, I have been a strong supporter of working closely with faith-based and community partners, and believe that their engagement is vital to our Nation's resilience.

Whether it is through providing shelter, food, or clothing to those in need, removing debris to help communities begin the road to recovery, or helping families rebuild their homes, faith-based and community organizations have always played a vital role in meeting the needs of Americans. In an incident that generates mass casualties, the effective execution of these support functions will be essential to the region's preparedness and response.

As regional administrator, I have charged our Region V team to work collaboratively with local, State, Tribal, and National partners to support faith-based and

community leaders to determine how best to provide assistance to disaster survivors. With the support of the DHS Center for Faith-Based and Neighborhood Partnerships, we have been able to make strong progress over the past 4 years, hosting several events to strengthen those relationships. It is my belief that as we strengthen these partnerships today, we will be better-positioned to deliver essential services during our disaster response.

CLOSING

In Region V, we are continuously working to evolve our approach to preparing America's citizens to respond to the events that threaten their lives, homes, and livelihoods, and to better fulfill FEMA's mission. To that end, we are actively working with our Governmental partners at the State, Tribal, and local level, as well as with our non-Governmental partners to prepare for whatever may impact the Region and look forward to continuing that good work.

I appreciate the opportunity to appear before you today and look forward to answering any questions you may have.

Mrs. BROOKS. Thank you, Mr. Velasquez.

The Chairwoman will now recognize Sheriff Bowen.

STATEMENT OF MARK J. BOWEN, SHERIFF, HAMILTON COUNTY, INDIANA

Sheriff BOWEN. Thank you, Chairwoman Brooks. Chairwoman Brooks, Senator Donnelly, Representative Walorski, Representative Young, and Members of the subcommittee, it is truly an honor to appear before you today. My name is Mark Bowen, and I am the elected sheriff of Hamilton County, Indiana. I would like to thank you for the opportunity to appear before you today, along with my esteemed colleagues, to discuss Central Indiana's preparedness for a mass casualty event.

Mrs. BROOKS. Excuse me, Sheriff. Is your mic turned on? Thank you.

Sheriff BOWEN. While Indiana still remains a wholesome, midwestern State known primarily for its agriculture and basketball, Central Indiana has grown into a thriving metropolitan community, making a name for itself throughout standing primary, secondary, and higher-educational institutions, affordable housing, low taxes, low crime rates, and high-profile events such as the NCAA Final Four, PGA BMW Championship, Indianapolis 500-mile race and mini-marathon, the Brickyard 400, and the 2012 NFL Super Bowl.

As Indiana continues to grow, develop, and to host National events, it is more important than ever that we focus on our preparedness plans to protect Hoosiers and those who visit our fine State.

As we have seen through incidents across the country, from Columbine to 9/11, to Hurricane Katrina, to Sandy Hook, and to the Boston Marathon bombings, Americans are vulnerable, and Hoosiers are no exception, as evidenced by the Indiana State Fair stage collapse, the Henryville tornado, and the Richmond Hills gas explosion. It is not a question of if a mass casualty event will occur in Indiana but when will it happen, how will it happen, to what magnitude it will happen, and will we be prepared for it when it does happen?

Indiana has come a long way in the past 10 years when it comes to preparing for mass casualty events. The events of 9/11 and other large-scale disasters have forced public safety to look at large-scale disasters not only from a local perspective but from a regional per-

spective as well. Indianapolis, Indiana and the surrounding region has been part of the Urban Area Security Initiative for the past 8 years. As a UASI region, we have worked diligently to meet the guidelines set out in Presidential Policy Directive 8. State and local officials in the Indianapolis urban area have been working in conjunction with the Indiana Department of Homeland Security to ensure that threat and hazard identification and risk assessments are being done and updated annually.

Hazard mitigation plans are being implemented, core capabilities are being identified, assets are being secured, memorandums of understanding are being executed, and training is being conducted. Unfortunately, we cannot do all this work and then put it on a shelf until an event happens. We must be ever-vigilant, constantly updating our risks, evaluating our plans, updating our training, and maintaining our resources and equipment. Complacency can easily become our Achilles heel.

This is where we need your help, the help of our local emergency management agencies, and the help of the Department of Homeland Security. Risk assessment, threat assessment, planning, training, resource allocation, communications and interoperability are just a few of the critical components necessary to our success in mitigating hazards and restoring order. While local first responders are the primary resources inserted into a mass casualty event, these resources are quickly overwhelmed and must rely on mutual aid from other jurisdictions, including State and Federal agencies.

Through the cooperation of IDHS, Central Indiana has become a well-structured and well-organized UASI region and, by its virtue, become more stable and better prepared to deal with major events, including mass casualties. The State Fair, Henryville, and Richmond Hills are prime examples of success stories due in large part to the planning, training, organization, and teamwork that has been developed through the efforts of homeland security. It is critical that these agencies continue to function at a high level, especially in times of peace and serenity, in order to ensure that our local jurisdictions are up-to-date on their training, that they are conducting their threat assessments, updating their policies and procedures, maintaining their equipment, and following training in ensuring best practices, fostering and building relationships, establishing funding sources and conducting training so that we do not become complacent and be caught off-guard when the event does happen.

I want to thank you all for taking the time to meet with us here today and for your interest in Indiana's preparedness for mass casualties and for all that you do to keep the homeland safe and secure. Thank you.

[The prepared statement of Sheriff Bowen follows:]

PREPARED STATEMENT OF MARK J. BOWEN

AUGUST 6, 2013

Chairwoman Brooks, Ranking Member Payne, Senator Donnelly, Representatives Walorski and Young, and Members of the subcommittee, it is truly an honor to appear before you today. My name is Mark Bowen and I am the elected sheriff of Hamilton County, Indiana. I would like to thank you for the opportunity to appear before you today along with my esteemed colleagues to discuss central Indiana's preparedness for a mass casualty event.

While Indiana still remains a wholesome mid-western State known primarily for its agriculture and basketball, central Indiana has grown into a thriving metropolitan community making a name for itself through outstanding primary, secondary, and higher educational institutions, affordable housing, low taxes, low crime rates and high-profile events such as the NCAA Final Four, PGA BMW Championship, Indianapolis 500-mile race and Mini Marathon, Brickyard 400, and the 2012 NFL Superbowl.

As Indiana continues to grow, develop, and to host National events, it is more important than ever that we focus on our preparedness plans to protect Hoosiers and those who visit our fine State. As we have seen through incidents across the country from Columbine to 9/11 to Hurricane Katrina to Sandy Hook to the Boston Marathon bombings, Americans are vulnerable and Hoosiers are no exception as evidenced by the Indiana State Fair stage collapse, the Henryville tornado, and the Richmond Hills gas explosion.

It is not a question of if a mass casualty event will occur in Indiana but when it will happen, how it will happen, to what magnitude it will happen, and will we be prepared for it when it does happen?

Indiana has come a long way in the past 10 years when it comes to preparing for mass casualty events. The events of 9/11 and other large-scale disasters have forced public safety to look at large-scale disasters not only from a local perspective but from a regional perspective as well.

Indianapolis, Indiana and the surrounding region has been part of an Urban Area Security Initiative (UASI) for the past 8 years. As a UASI region, we have worked diligently to meet the guidelines set out in Presidential Policy Directive 8. State and local officials in the Indianapolis Urban Area have been working in conjunction with the Indiana Department of Homeland Security to ensure that Threat and Hazard Identification and Risk Assessments (THIRA) are being done and updated annually, Hazard Mitigation Plans are being implemented, Core Capabilities are being identified, assets are being secured, memorandums of understanding are being executed, and training is being conducted.

Unfortunately, we cannot do all this work and then put it on a shelf until an event happens. We must be ever-vigilant, constantly updating our risks, evaluating our plans, updating our training and maintaining our resources and equipment. Complacency can easily become our Achilles heel. This is where we need your help, the help of our local emergency management agencies (EMA) and the help of the Department of Homeland Security (DHS).

Risk assessment, threat assessment, planning, training, resource allocation, communication, and interoperability are just a few of the critical components necessary for our success in mitigating hazards and restoring order. While local first responders are the primary resources inserted into a mass casualty event, these resources are quickly overwhelmed and must rely on mutual aid from other jurisdictions including State and Federal Agencies.

Through the cooperation of IDHS, central Indiana has become a well-structured and well-organized UASI region and by its virtue become much more stable and better prepared to deal with major events including mass casualties. The State Fair, Henryville, and Richmond hills are prime examples of success stories due in large part to the planning, training, organization, and teamwork that has been developed through the efforts of homeland security.

It is critical that these agencies continue to function at a high level especially in times of peace and serenity in order to ensure that our local jurisdictions are up-to-date on their training; that they are conducting their threat assessments; updating their policies and procedures; maintaining their equipment; following trends and ensuring best practices; fostering and building relationships;, establishing funding sources and conducting training so that we do not become complacent and be caught off guard when the event does happen!

Thank you all for taking the time to meet with us here today, for your interest in Indiana's preparedness for mass casualty and for all you do to keep the Homeland safe and secure.

APPENDIX

Question 1. What are the main threats facing Indiana?

Answer. Indiana like any other State across our great Nation is vulnerable to a multitude of threats both natural and man-made. In 2012 a Threat and Hazard Identification and Risk Assessment (THIRA) was conducted by the Indianapolis Urban Area in accordance with Presidential Policy Directive 8. The following Threats and Hazards were identified.

Natural

Acts of Nature

- Flood
- High Wind
- Snow
- Tornado
- Hail
- Ice
- Heat Emergencies
- Disease Outbreak
- Drought
- Epidemic

Technological

Accidents or Failures of Systems

- HAZMAT
- Accidental Explosion
- Dam/Levee Failure
- Power Failure
- Airplane Crash
- Radiological Release
- Train Derailment

Human—caused

Intentional Acts

- IED/VBIED
- Arson/Incendiary Attack
- Cyber Attack
- Chemical Agent
- Conventional Attack
- Hostage Taking
- Biological Attack (contagious)
- Biological (non-contagious)
- Aircraft as a Weapon
- RDD
- Food and Water Attack
- Nuclear Attack
- Agro-Terrorism
- Civil Disturbance
- Cyber Incidents
- Sabotage
- School Violence
- Terrorist Acts
- Active Shooter

One of the primary natural threats/hazards facing Indiana is a tornado. Indiana is prone to tornados and has experienced many significant events in its history. The most recent event, an EF 4 tornado that touched down in Henryville, Indiana in March 2012, is a prime example of the profound impact that a significant storm can have on a densely-populated community during peak hours.

One of the primary technological threats/hazards facing Indiana is that of a hazardous materials explosion which could involve mass casualties, mass evacuation, and profound public health concerns.

One of the primary human-caused threats/hazards would be an act of terrorism committed at a large-scale public event such as the Indy 500, the Brickyard 400, a Colts game, or any number of other large-scale publicly-attended venues.

Question 2. What are we doing to prepare for these events?

Answer. Indiana has come a long way in the past 10 years when it comes to preparing for mass casualty events. The events of 9/11 and other large-scale disasters have forced public safety to look at large-scale disasters not only from a local perspective but from a regional perspective as well.

Indianapolis, Indiana and the surrounding region has been part of an Urban Area Security Initiative (UASI) for the past 8 years. As a UASI region, we have worked diligently to meet the guidelines set out in Presidential Policy Directive 8. State and local officials in the Indianapolis Urban Area have been working in conjunction with the Indiana Department of Homeland Security to ensure that Threat and Hazard Identification and Risk Assessments are being done and updated annually, Hazard

Mitigation Plans are being implemented, Core Capabilities are being identified, assets are being secured, memorandums of understanding are being executed and training is being conducted.

Question 3. How well are we prepared for the range of threats facing our State?

Answer. Overall, Indiana is positioned very well to deal with the range of threats facing our State. While we cannot possibly train for every possible scenario that may play out, we can and have identified what we believe to be the most likely threats and hazards facing our community. Public Safety Agencies and personnel have been briefed on these potential hazards and are enhancing their policies and procedures and their training as well. As a result of lessons learned from incidents that have taken place across the country, situational awareness has been elevated not only in the public safety arena but also in the private sector and by the general public. More attention has been given to pre-planning of events and to incident action plans. The National Incident Management System (NIMS) has become standard operating procedure and critical delays in responding to incidents, establishing command, assessing needs, and executing operating procedures has been greatly reduced.

In 2012, central Indiana was tested on a number of occasions. One primary example would be the EF 4 tornado that hit Henryville, Indiana, in March. The tornado swept through a densely-populated community in the middle of the day causing catastrophic damage, killing several people, and injuring numerous others.

Another noteworthy event was the Richmond Hill subdivision explosion in November 2012 which was determined to be a man-made event that resulted in the death of two people and the catastrophic damage to a 3-block radius in a residential community.

These events were mitigated successfully using an all hazards approach and the NIMS model.

Question 4. How does IDHS work with FEMA to plan for the various threats facing Indiana?

Answer. This question is not applicable and left for IDHS response.

Question 5. What assistance does the State receive from FEMA and the Federal Government?

Answer. This question is not applicable and is left to IDHS.

Question 6. What training do our first responders receive?

Answer. Law enforcement first responders receive training in threat identification and assessment, first aid, hazardous materials identification and assessment, National Incident Management Systems (NIMS) procedures, perimeter security and containment, evidence preservation and collection, active-shooter training, and personal protective equipment (PPE) training.

The training has not only been conducted within individual departments but in conjunction with other agencies across the region. Partnerships have been developed with schools, businesses, and crime watch organizations to include them in active-shooter and other scenario-based training.

Question 7. What plans are in place at the various levels of government for the threats?

Answer. Many areas of local government have taken a proactive approach to the threats and are assessing their policies and procedures, identifying critical infrastructure needs, establishing Continuity of Operation Plans and Continuity of Government (COOP & COG) plans, implementing training and executing memorandums of understanding with one another, and constantly updating these plans.

Question 8. What exercises have been held in the past year?

Answer. In the past year, table-top exercises have been conducted on scenarios that involved a mass casualty event at the Indy 500, an active-shooter/terrorist situation at the Fort Benjamin Harrison Finance Center, an airport mass casualty, a fair train mass casualty, and an active-shooter public/private partnership scenario with Rolls Royce.

Hamilton County is currently working on a weather-related all-hazards live training drill involving police, fire, and EMS that is scheduled to take place in October.

Question 9. How have different jurisdictions worked together to plan for such events?

Answer. Discussions and training have taken place through organizations such as the International Association of Chiefs of Police (IACP) and the Indiana Sheriff's Association (ISA). Through the Commission on Accreditation for Law Enforcement Agencies (CALEA), accredited agencies are required to implement and update all-hazard and unusual occurrence policies. Table-top exercises have taken place and full-scale exercises have taken place and/or are being discussed. Dialogue has increased throughout the region, assets and resources have been identified, memoran-

dums of understanding have been executed, data sharing and interoperable communications have been discussed.

Question 10. Are intra-state agreements in place to facilitate cooperation between jurisdictions?

Answer. Many local jurisdictions have been in discussions with their neighbors to facilitate cooperation and many have executed inter-local agreements to provide support in cases of emergency.

Thankfully, the Mid-west mentality and desire to work together to get the job done remains strong!

Question 11. Are the communications systems of the first responders able to talk to each other before, during, and after an incident?

Answer. Central Indiana first responders work off of a number of different communications systems. Not all are interoperable before an incident takes place. In most cases, local jurisdictions are able to communicate with one another but when first responders have to travel outside of their primary areas of responsibility, communications can become an issue.

Patches can be established through most systems or radios can be switched to the State Mutual Aid frequencies but this takes time and often results in poor connectivity.

The State is working on enhancing the State-wide radio network and bridging the gap by bringing the system up to P–25 standards. Hamilton County has also implemented plans to enhance their radio infrastructure and bring it up to P–25 standards.

Unfortunately, the burden is on local units of government to build and maintain these complicated systems and many simply can't afford it.

Mrs. BROOKS. Thank you, Sheriff Bowen.

The Chairwoman now recognizes Chief Orusa to testify.

STATEMENT OF STEVEN ORUSA, FIRE CHIEF, FISHERS, INDIANA

Chief ORUSA. Chairwoman Brooks, Senator Donnelly, Representatives Walorski and Young, good morning. On behalf of the town of Fishers town council president John Weingardt and town manager Scott Faultless, thank you for the opportunity to discuss Central Indiana's preparedness for a mass casualty event.

From the 2011 State Fair collapse to the 2012 Richmond Hills explosion to the Colonial Hills Baptist Church bus crash just last month, our firefighters, paramedics, and EMTs are at the tip of the spear during these tragic events, but they weren't the only first responders. Bystanders, neighbors, and people given the chance to go about their business decided to stay and help our personnel serve professionally and heroically. Mass casualty events are an amazing example of humanity, service, and teamwork.

Both the work leading up to these events as well as quick action following the events highlight the significant progress that we as a region have made over the past years responding to mass casualty incidents. But there is still more work to do, and we are continuing to learn from these events to strengthen our preparedness and training and exercise programs as they relate to mass casualty and hostile situations.

Marion and Hamilton counties have worked with FEMA to assess gaps and prioritize grants and investments. In 2012, we completed a Threat and Hazard Identification and Risk Assessment, the THIRA, a process for assessing regional capability gaps required by each State and urban area designed to prioritize investments and key deployable capabilities. Many of the capabilities demonstrated in the aforementioned events and aftermath were built or enhanced and have been sustained through the preparedness suite of homeland security grant programs, including UASI

Urban Area Security Initiative Grant Program, and the State Homeland Security Program.

As a former paramedic, UASI task force member and chief, I can attest to the importance of preparing our public safety men and women for whatever may come. Grant funds provided commodities and training that were essential in response incidents. In part because of the investment made in the system, and in no small part because of the outstanding work of our first responders, patients were triaged, treated, and transported in an orderly manner to the appropriate hospitals based on their needs.

Mass casualty incidents are high-risk, low-frequency events. This means we cannot rely on our call volume alone to be safe and effective. In order to assess capabilities, identify gaps, and create improvement plans, we must conduct tabletop, functional, and full-scale exercises to improve and sustain our capacity and safely and effectively rise to the occasion of a mass casualty incident.

Individual agencies can practice blocking and tackling, but until we scrimmage together and rehearse under game-like conditions, we cannot identify and analyze the gaps critical to improve capability. These operational readiness exercises provide us an environment where mistakes can be made and lessons learned when they are affordable, in a controlled training environment. The alternative is too costly.

Quite simply, our preparedness system works like it should, but we need your help. The challenge is providing the backfill and overtime required to engage our people in realistic, high-quality, scenario-based exercises and at the same time keep our communities protected. Historically, we have depended on UASI funding and State Homeland Security Program funding. Central Indiana did not qualify for UASI funding in 2013, and it is unknown for 2014. As a consequence, State Homeland Security funding may be reduced.

In closing, our public safety men and women pride themselves on doing whatever it takes, no matter what the conditions, to serve those in need, but I believe we owe them more than that. We owe them a system which plans, organizes, exercises, and evaluates the capabilities. We owe them a system that prepares them to be successful. Our covenant with them is to do everything in our power to keep them safe and effective. When we commit them to harm's way, we commit their families to harm's way. We have no greater responsibility. We need your help to support UASI funding in Central Indiana.

On behalf of the first responders we all serve, it is an honor and a privilege to be here today. Thank you for this opportunity, and I look forward to answering your questions.

[The prepared statement of Chief Orusa follows:]

PREPARED STATEMENT OF STEVEN ORUSA

AUGUST 6, 2013

Chairman Brooks, Ranking Member Payne, Senator Donnelly, Representatives Walorski and Young, and Members of the subcommittee: Good morning, I am Steven Orusa, fire chief for the Town of Fishers Department of Fire and Emergency Services. On behalf of town council president John Weingardt and town manager Scott Fadness, thank you for the opportunity to discuss central Indiana's preparedness for a mass casualty event.

From the 2011 State Fair Stage Collapse to the 2012 Richmond Hills Explosion to the Colonial Hills Baptist Church bus crash last month, our firefighters, paramedics, and EMTs are the tip of the spear during these tragic events, but they weren't the only first responders. Bystanders, neighbors, and people given the chance to go about their business decided to stay and help our personnel serve professionally and heroically. Mass casualty events are an amazing example of humanity, service, and teamwork.

Both the work leading up to these events, as well as quick action following the events, highlight the significant progress that we, as a region, have made over the past years responding to Mass Casualty Incidents. But there is still more work to do, and we are continuing to learn from these events and others to strengthen our preparedness and training and exercise programs as they relate to mass casualty and hostile situations.

Marion and Hamilton Counties have worked with FEMA to assess gaps and prioritize grant investments. In 2012, we completed a Threat and Hazard Identification and Risk Assessment (THIRA), a process for assessing regional capability gaps required by each State and urban area designed to prioritize investments in key deployable capabilities.

Many of the capabilities demonstrated in the aforementioned events and aftermath were built or enhanced and have been sustained through the preparedness suite of Homeland Security Grant Programs (HSGP), including the Urban Area Security Initiative (UASI) Grant Program and the State Homeland Security Program (SHSP).

As a former paramedic, US&R Task Force member, and chief, I can attest to the importance of preparing our public safety men and women for whatever may come. Grant funds provided commodities and training that were essential in response to incidents. In part, because of the investment made in the system, and in no small part of the outstanding work of our first responders, patients were triaged, treated, and transported in an orderly manner to the appropriate hospitals based on needs.

Mass casualty incidents are high-risk/low-frequency events. This means we cannot rely on our call volume alone to be safe and effective. In order to assess capabilities, identify gaps, and create improvement plans, we must use table-top, functional, and full-scale exercises to improve and sustain our capacity to safely and effectively rise to the occasion of a mass casualty incident.

Individual agencies can practice "blocking and tackling," but until we scrimmage together and rehearse under "game-like" conditions we cannot identify and analyze the gaps critical to improve capability. These operational readiness exercises provide an environment where mistakes can be made and lessons learned when they are affordable: In a controlled training environment. The alternative is too costly.

Quite simply, our preparedness system works like it should, but we need your help. The challenge is providing the backfill and overtime required to engage our people in realistic, high-quality, scenario-based exercises and at the same time keep our communities protected. Historically we have depended on UASI funding and SHSP funding. Central Indiana did not qualify for UASI funding in 2013 and it is unknown for 2014. As a consequence SHSP funding may be reduced.

In closing, our public safety men and women pride themselves on doing whatever it takes, no matter what the conditions, to serve those in need, but I believe we owe them more than that. We owe them a system which plans, organizes, exercises, and evaluates their capabilities; we owe them a system that prepares them to be successful. Our covenant with them is to do everything in our power to keep them safe and effective. When we commit them to harm's way we commit their families to harm's way. We have no greater responsibility. We need your support to return UASI funding to central Indiana.

Mrs. BROOKS. Thank you, Chief Orusa.

I now recognize Mr. Hill to testify.

STATEMENT OF JOHN H. HILL, EXECUTIVE DIRECTOR, INDIANA DEPARTMENT OF HOMELAND SECURITY

Mr. HILL. Good morning, Madam Chairwoman, Senator Donnelly, and Representatives Walorski and Young. Thank you for having us here today. I really represent the whole Department of Homeland Security, but also thousands of first responders, as Chief Orusa just indicated. So I certainly don't stand here 6 months into the job with all the rewards and success that we have had so far.

I would also like to thank the panel members. It is a pleasure to work with them and to experience first-hand meetings with them and to do planning and work together.

The Department of Homeland Security is committed to providing State-wide leadership, responsiveness to our public safety professionals, and subject-matter expertise to continually develop the State's public safety capabilities while working for the well-being of our citizens, property, and communities.

Indiana Governor Michael Pence is committed to a coordinated public safety system in Indiana. To better provide for the needs of the States, it is essential for us to constantly evaluate our plans, preparedness, processes, and procedures. Therefore, Governor Pence, on his first day in office, invited me and his whole public safety team to his office to really address the need for public safety and preparedness in our State. One of the things that he directed me to do was to have an objective external view of our agency and conduct an assessment of the Department of Homeland Security to allow it to improve and take it really from good to great.

One of the things that we have done is we have engaged a firm known by many people in the private-sector world of emergency preparedness and crisis communication, James Lee Witt and O'Brien, Witt O'Brien Associates. They are doing an assessment of our agency, and the report has just been delivered to me, and we will be engaging in some updates of that in the next 6 months.

The assessment included experts from not only public safety, but they talked to people all throughout the State, and I look forward to working with our first responders to improve our response in the next few months.

I have submitted a very lengthy report to the panel, and I am going to defer further discussions so we can get into questions, and I look forward to taking your questions later.

[The prepared statement of Mr. Hill follows:]

PREPARED STATEMENT OF JOHN H. HILL

AUGUST 6, 2013

Chairman Brooks, Ranking Member Payne, Senator Donnelly, Representatives Walorski and Young, and Members of the subcommittee, it is an honor to appear before you today. My name is John Hill, and I am the executive director of the Indiana Department of Homeland Security (IDHS). Thank you for inviting me to testify on Central Indiana's preparedness for a mass casualty event, and for your interest in this critically important issue. I would also like to thank Federal Emergency Management Agency (FEMA) Region V administrator, Mr. Velasquez, Sheriff Bowen, Chief Orusa, Mr. Chad Priest, and other panel members for their on-going partnership with IDHS' preparedness and response activities. The Indiana Department of Homeland Security is committed to providing State-wide leadership, responsiveness to our public safety professionals, and subject-matter expertise to continually develop the State's public safety capabilities while working for the well-being of our citizens, property, and economy. The agency was founded in April 2005, with the merger of the State Emergency Management Agency, State Fire Marshal's Office, Office of the State Building Commissioner, Public Safety Training Institute, and the Counter Terrorism and Security Council.

Indiana's Governor, Michael R. Pence, is committed to a coordinated public safety system in Indiana. The goal of this system is to exhibit the maximum efficiency of primary public safety agencies in the State, while removing unnecessary redundancies where they exist and employing Federal, State, and local resources in a harmonized fashion.

To better provide for the needs of the State, it is essential for us to constantly evaluate our plans, preparedness, processes, and procedures. Governor Pence on his

first day in office directed me to undertake a thorough review of Indiana's emergency preparedness and response capabilities and report the findings to him. Realizing that an objective and external observation and assessment of IDHS would provide important feedback, the agency engaged Witt O'Brien to identify weaknesses and opportunities for improvement. Witt O'Brien is an internationally recognized authority in crisis and disaster management. The assessment included review by public safety experts to evaluate IDHS and other State and local organizations, which served as the basis for findings and recommendations to improve Indiana's readiness. Witt O'Brien recently submitted a draft of its report concerning the Indiana Department of Homeland Security. The report is being reviewed. Implementation will commence in the next month to improve Indiana's emergency management practices.

FEDERAL, STATE, LOCAL PARTNERSHIP

The State of Indiana has spent considerable time, effort, and resources in preparing for, responding to, and recovering from emergency situations. Our State is organized into ten distinct districts, each a partner of the other nine, and all uniquely prepared for emergencies. Each county has its own emergency management agency or emergency manager, with significant training, preparedness, and mitigation opportunities for emergencies and disasters. Routinely, counties join together to train for and respond to emergencies in their respective district. This multi-layered approach—Federal, State, district, county, and city—creates multiple levels of partnership and preparedness.

We have excellent coordination with our State and local partners—organizations like the Indiana State Department of Health, Indiana National Guard, Indiana State Police, and county emergency management agencies, local police and fire departments, among others. In conjunction with Federal partners, such as the Federal Emergency Management Agency (FEMA), U.S. Department of Homeland Security (DHS), Federal Bureau of Investigation (FBI), Nuclear Regulatory Commission (NRC), Department of Energy (DOE), and Department of Defense (DOD), we work to create a safer, better-prepared State for Hoosiers.

EMERGENCY RESPONSE

Just as public safety requires the coordination of many multi-faceted and fluid elements to be successful, there are several functional aspects to the diverse IDHS organization. One high-profile area, especially during times of emergency or disaster, is led by the emergency response and recovery division, which monitors situations around the State and provides coordination of Indiana's considerable resources to assist whenever and wherever needed.

To coordinate Indiana's significant resources, we have a State Emergency Operations Center (EOC) that is staffed 24 hours a day each day of the year. The EOC serves not only as a communications hub for on-going public safety coordination throughout the State, but also as a command-and-control center during large-scale disasters where all necessary parties are represented with their respective emergency support function (ESF) linkage. ESF functions include both Governmental and private representatives.

The EOC facility has been recently toured by responders from other States and countries, including representatives from the Australian Consulate in Chicago, and public safety professionals from Great Britain, Israel, and South Korea.

DISASTER RECOVERY

Long after the immediate response by emergency workers, the work of recovery for a community can be daunting. Homes and businesses may be affected; and, completing damage assessments is an incredibly important process. Once again, this necessitates careful coordination among Federal, State, and local authorities. These assessments are crucial to determining eligibility for individual and public assistance from FEMA.

We have learned that local emergency managers need assistance from the State to properly understand and administer the assessment for damaged property. Chairman Brooks, you saw, first-hand as you toured flood-ravaged areas in April of this year, how many of your constituents suffered property loss, both individually and as part of their community infrastructure. As devastating as it was, the millions of dollars of loss did not qualify for Federal assistance. In recent years, the threshold to qualify for Federal disaster aid has steadily increased. Indiana must increasingly shoulder more of the financial burden for our residents. Fortunately, the Indiana General Assembly anticipated this and established a State Disaster Relief Fund (SDRF) which provides for limited financial assistance to individuals and commu-

nities under certain conditions. As a result of the April 2013 flooding, Governor Pence declared an emergency for affected counties and the residents and communities were eligible to apply for SDRF compensation. Disbursements for the 2013 central Indiana flooding will be the largest ever awarded for disaster relief using the SDRF.

An integral aspect of response and recovery is mitigation, which seeks to reduce or eliminate threats and risks of known hazards. Recovery and mitigation efforts go hand-in-hand with one another. Recovery operations evaluate damage that resulted from a disaster, and determine next steps to assist individuals. From that and other assessments, our mitigation efforts are born. By understanding the potential damage in a given disaster, we can better prepare for them and work to find ways to reduce or even eliminate risks associated with them. The Indiana Standard Hazard Mitigation Plan and Hazard Mitigation Grant Program provide a base and framework for mitigation efforts.

TRAINING AND EXERCISE

Training and participation in simulated exercises is another key component to the IDHS' ability to coordinate the State's disaster preparedness. Exercises can range from seminars and drills, to full-scale exercises involving hundreds of individuals from many areas of the State. In fact, IDHS has organized exercises that have included multiple States, and even observers from foreign countries. In the last 3 years, IDHS has organized the training of more than 37,000 responders in classes that have connections to mass casualty, weapons of mass destruction, and CBRNE (chemical, biological, radiological, nuclear, explosive).

The Muscatatuck Urban Training Center is a highly-regarded training complex that provides unique learning situations, and is in our own backyard. Having the ability to configure buildings or collapsed structures into real-life scenarios with role players not only improves the training environment, but also provides emergency responders with vital experience that exceeds a traditional classroom training environment.

During one recent full-scale exercise, we had an international visitor in emergency management indicate he had never seen a facility like Muscatatuck in his considerable experience. The facility is used by emergency responders from around the world and includes military and civilian role players. Indiana is remarkably poised to not only better equip our responders but to also encourage regional and National training activities that are essential when faced with large-scale disasters such as an earthquake or WMD event. Even as we are now having this hearing, nearly 7,000 members of the U.S. military from NORTHCOM are engaged with local responders at the Muscatatuck venue in an exercise called Vibrant Response. Next week, Ohio authorities will deploy 150 responders and officials to coordinate a simulated WMD attack. Members of IDHS will be observing the exercise to learn how to adapt and apply our plans to different emergencies that may arise, and to better coordinate regional response that would be required should central Indiana experience a mass casualty event. I have directed our staff to fully participate in the Vibrant Response exercise in 2014 and 2015.

During my experience in working on Hurricane Katrina relief in 2005 and coordinating numerous activities with the U.S. military active duty, reserve, and National Guard forces, I saw how critical it is to understand not only the resources and capability that active-duty forces bring to large-scale disasters, but also how coordination must be carefully integrated with civilian authorities for maximum effectiveness.

A variety of training sessions are used to supplement exercises. These sessions can range from search-and-rescue and emergency medical services training, to hazardous materials (HAZMAT), radiological emergency, and terrorism and weapons of mass destruction (WMD) training. Our first responders have a wide array of learning tools available. Regular interaction and coordination within the public safety community, along with extensive training utilizing the National Incident Management System (NIMS), contributes to our State's response to emergency situations. For example, just in the past month, I authorized more than a dozen of our local responders to travel to wild fires in Alaska and California to better provide them with training to understand their importance in coordinating disaster response and organizing resources for appropriate deployment, all the while working within the NIMS framework. It is worthwhile to reiterate that the availability of Federal training grant dollars, State coordination, and local participation makes such shadowing/learning opportunities possible. Indiana is committed to an integrated approach in support to our local community emergency managers and responders.

STRATEGIES AND TACTICAL PLANS

Planning is another important aspect to IDHS. The planning division is charged with establishing the strategies and tactical plans used throughout the State for emergency management, but it also includes multiple disciplines, including the State-level agencies of the Indiana State Department of Health, Indiana State Police, Indiana National Guard, Indiana Department of Transportation, Indiana Department of Correction, and Indiana Department of Environmental Management; local agencies including fire, law enforcement, emergency management, emergency medical service, and more; and Federal agencies, such as U.S. Department of Homeland Security, Federal Emergency Management Agency, U.S. Department of Energy, and the Federal Bureau of Investigation.

IDHS has actively participated in the preparation, review, and publication of more than 50 plans or annexes to prepare for a variety of emergencies. Such plans require regular updates and validation. Our planning division is required to not only develop comprehensive emergency plans but must engage in the training and exercise of plans to ensure what is intended is being achieved.

GRANTS SUPPORT LOCAL AND STATE AGENCIES

Another important function within the IDHS Planning Division is grant management. Grant management works to effectively administer funding to local communities as provided either from the State or the Federal Government. These funds provided to IDHS are distributed throughout the State for training, exercise, equipment, and personnel. In 2012, more than $11 million in grant funding was awarded. More than $7.3 million of that total, or about 64.3%, went to locals, which includes support to county emergency management agencies, by paying half of the cost of directors and, in the counties where there are additional staff, 50% of the cost of assistant directors and support staff is reimbursed. More than $4 million, 35.7%, went elsewhere in the State. Even money that goes to the State is used to benefit and provide for locals. Currently 43 IDHS employees are grant-funded, for a total of more than $2.7 million annually. The majority of these positions directly support training, exercise, planning, and emergency response and recovery. Their work is ultimately for the benefit of local emergency response efforts.

IDHS receives funding from four main Federal grants: The Homeland Security Grant Program (broken into the State Homeland Security Program and the Urban Areas Security Initiative), Emergency Management Performance Grant, Nonprofit Security Grant Program, and Hazardous Materials Emergency Preparedness Grant Program.

The Homeland Security Grant Program (HSGP) plays an important role in the implementation of the National Preparedness System (NPS) by supporting the building, sustainment, and delivery of core capabilities essential to achieving the National Preparedness Goal (NPG) of a secure and resilient Nation. Delivering core capabilities requires the combined effort of the whole community, rather than the exclusive effort of any single organization or level of Government. This grant provides planning, equipment, training, exercise, and management and administrative funding to emergency prevention and preparedness to the State of Indiana. This funding has been used to support our district task forces. We are in the process of evaluating the 2014 HSGP grant funding proposals and will align any approved requests with the agency strategic plan and Governor Pence's Roadmap for Indiana.

The purpose of the Emergency Management Performance Grant (EMPG) Program is to assist State, local, territorial, and Tribal governments in preparing for all hazards. Title VI of the Stafford Act authorizes FEMA to make grants for the purpose of providing a system of emergency preparedness for the protection of life and property in the United States from hazards and to vest responsibility for emergency preparedness jointly in the Federal Government, States, and their political subdivisions. The Federal Government, through the EMPG Program, provides necessary direction, coordination, and guidance, and provides necessary assistance, as authorized in this title, so that a comprehensive emergency preparedness system exists at all levels for all hazards. We use the EMPG primarily to support county emergency managers.

The Nonprofit Security Grant Program (NSGP) provides funding support for target-hardening activities to nonprofit organizations that are at high risk of a terrorist attack and are located within one of the specific UASI (Urban Areas Security Initiative)-eligible urban areas.

The Hazardous Materials Emergency Preparedness (HMEP) grant program is intended to provide financial and technical assistance as well as direction and guidance to enhance State and local hazardous materials emergency planning and training. The HMEP Grant Program distributes fees collected from shippers and carriers

of hazardous materials to emergency responders for HAZMAT training and to Local Emergency Planning Committees (LEPCs) for HAZMAT planning. IDHS uses this grant to advance our CBRNE training and risk prevention efforts.

A breakdown of these grants since 2010 is as follows.

	2010	2011	2012	2013
HSGP—SHSP	$11,326,441	$5,663,221	$2,801,316	$3,459,364
HSGP—UASI	7,104,700	0	1,250,000	0
EMPG	6,562,747	6,529,870	6,749,053	6,592,684
NSGP	0	0	28,161	0
HMEP	512,532	512,532	537,270	536,745
TOTAL	25,506,420	12,705,623	11,365,800	10,588,793
$ CHANGE (prev. year)	.....	−12,800,797	−1,339,823	−777,077
% CHANGE (prev. year)	.....	−50.18%	−10.54%	−6.83%

FIRE AND BUILDING SAFETY

Also under IDHS's organizational umbrella is the State Fire Marshal, who leads IDHS's fire and building safety. This includes commercial building construction plan review, general building inspection, and specific responsibility for the compliance of elevators and boiler and pressure vessels. Inspections also occur for annual festivals, fairs, and other entertainment venues, including amusement rides. Arson investigators are also placed throughout the State to assist with local fire investigations when help is requested.

IDHS' certification branch administers the licenses for firefighters, emergency medical services personnel, and conducts ambulance inspections.

MASS CASUALTY RESPONSE

The agency provides assistance with State-wide HAZMAT and CBRNE response and expertise. Many local communities have highly-qualified HAZMAT responders and central Indiana is fortunate to have considerable expertise when needed. Having capabilities such as CBRNE will be crucial during a mass casualty incident as a result of either an accident or terrorist attack.

With volunteers from a variety of groups in the medical, mental health, and funeral director communities, the Indiana Disaster Portable Mortuary Unit (DPMU) is maintained by IDHS and is designed to relieve overwhelmed morgues where a disaster has occurred. It has all of the necessary tools which are required during such a mass casualty.

Another organization crucial to the State's planning and response is the Office of Faith-Based and Community Initiatives (OFBCI). OFBCI works to link organizations to those in need by using grants and services. It advocates for volunteerism, including faith-based initiatives which make a difference in the community both before and after a crisis has endangered a community. The OFBCI offers support for Emergency Support Function 14, Long-Term Community Recovery. It also works with the Indiana Voluntary Organizations Active in Disaster (VOAD) team to provide support and relief in the aftermath of disaster situations. The combination of these two organizations assisted in harnessing the power of volunteers just last year when devastating tornadoes ripped numerous Indiana communities. Their efforts resulted in substantially lower costs, saving millions of dollars for those affected by the Southern Indiana tornado event recovery in 2012. Debris removal was an excellent example with not only volunteers, but strategic use of other State resources.

Several of these aspects come into play when working to increase our preparedness for a mass casualty incident. Over the past 5 years, nearly $1.2 million in grant funding has been allocated toward preparedness, specifically for CBRNE or WMD events. From that, more than $850,000 has assisted central Indiana. This support provides equipment to our first responders, vehicles to aid in response and recovery, and training classes and conferences for added education.

Chairman Brooks has properly identified the importance of focusing also on events that could result from terrorist activity or a consequence of man-made events. The recent tragic bombing during the Boston Marathon illustrates the need for integration and coordination among intelligence gatherers, fusion center analysts, law enforcement agencies, and local responders. Following the Boston bombing, Indiana adapted planning efforts for the events in central Indiana such as the

Indianapolis 500 Festival Parade and 500 Mile Race. Traffic was diverted from critical infrastructure, screening techniques were employed that clearly elevated detection protocols and heightened intelligence activities all combined to improve threat identification and risk management at one of the country's largest sporting events.

Our on-going preparedness is on three levels: Federal, State, and local. At the Federal level, we work with military and non-military entities to enhance safety efforts, train, exercise, and plan.

Groups like FEMA and the FBI offer resources to aid in our preparation. FEMA Region V has been responsive to the needs of the State, especially during times of emergency. The FBI is a teammate of ours in CBRNE response and radiation training. The FBI also holds an annual conference on WMDs, which IDHS promotes and attends. IDHS recently held a comprehensive planning exercise involving policy leaders from IDHS, ISDH, Indiana Board of Animal Health, Indiana Department of Transportation, Indiana State Police, Indiana State Department of Agriculture, State Chemist, Department of Natural Resources, Utility Regulatory Commission and Indiana National Guard's 53rd Civil Support Team to simulate an ingestion pathway from nuclear reactor radiation release and how it could affect Indiana residents and businesses. We also have established close relationships with the Nuclear Regulatory Commission and the Department of Energy to better prepare for and understand these lead Federal agencies' role in a nuclear disaster.

State partners, including the Indiana State Department of Health, Indiana Department of Transportation, and Indiana National Guard regularly complement and enhance IDHS' work. We not only prepare for events in the future, but also strive to secure the everyday safety of our citizens.

LOCAL AGENCIES: KEY TO INDIANA'S EFFORTS

Local partners are really the backbone of Indiana's efforts. When an emergency or disaster occurs, local agencies and responders are the first to experience the event and they are best equipped and trained to handle the situation. Just over a week ago, Indianapolis witnessed a horrific mass casualty event with an overturned bus returning from a week of church camp. Tragically, four individuals lost their lives but a rapid and professional response by numerous fire and emergency medical personnel treated or transported over 30 injured passengers, several hospital staffs coordinated the treatment of the injured and law enforcement continues to conduct an in-depth analysis of the crash's cause. The response by professional local responders was an example of how well they have prepared for tragedy when our communities are affected.

The Indiana State Department of Health (ISDH) and Red Cross also perform active roles in aiding our initiatives and furthering the overall emergency preparedness of our State. The IDHS and ISDH began the development of the Indiana Disaster Medical System, intended to provide a structure and protocols for the State to support local mass casualty response. In support of the Indiana Disaster Medical System, the ISDH is in the process of procuring a 50-bed mobile hospital to provide a medical facility for communities suffering from disasters and an operating location for medical and non-medical volunteers. The ISDH has also developed the Advance Medical Supply Unit, which contains the most common types of supplies that medical personnel on the ground may need during mass casualty response. The ISDH has also nearly completed development of the new volunteer management system, SERV–IN, which will be utilized to better manage both medical and non-medical volunteers.

The Red Cross has several internal training courses for their volunteers, which closely reflect the training provided by IDHS. These courses provide information on the effects of weapons of mass destruction and terrorism, CBRNE events, and mental health considerations during a WMD or terrorist event. This training makes Red Cross an important partner during times of emergency. Volunteers are necessary in a variety of roles during mass casualties and perhaps even more importantly, in providing long-term care and support for those visibly injured and others who are mentally traumatized.

IDHS, along with its partner organizations, casts a wide net over the State of Indiana. By coordinating activities and initiatives with Federal, State, and local partners, IDHS is working diligently every day for Indiana.

CONCLUSION

In closing, I would like to thank Chairman Brooks, Ranking Member Payne, Members of the Indiana Congressional delegation in attendance, and the Members of the subcommittee for calling this hearing today. The issues discussed here are vital to the lives not just of Hoosiers, but to all Americans. I am proud to work every

day to provide for the needs of the State, and the safety of our citizens. I am committed to working with the committee and our public safety partners to promote a safer, more secure State for all.

Mrs. BROOKS. Thank you, Mr. Hill.

The Chairwoman now recognizes Ms. Mack to testify.

STATEMENT OF DIANE MACK, UNIVERSITY DIRECTOR, EMERGENCY MANAGEMENT AND CONTINUITY, INDIANA UNIVERSITY

Ms. MACK. Good morning, Chairwoman Brooks. I appreciate this opportunity to work with you again. Senator, Congressman, and Congresswoman, thank you also for the opportunity to share with you a university perspective.

I represent the Office of Emergency Management and Continuity with Indiana University. IU has eight campuses within Indiana across a distance of 300 miles and with approximately 150,000 students, faculty, and staff. We also have centers in Wisconsin, Montana, and Kenya, and 6,000 world-wide travelers each year. We abide by National voluntary emergency management standards and comply with Federal regulations, most notably the Higher Education Opportunity Act and the Clery Act.

The Clery Act, while noble in its intent, is focused on after-the-fact data accounting. While IU abides by such regulations, our priority is on prevention, mitigation, and preparedness to reduce the need for response and recovery.

In my office, the emergency management directors have somewhat different roles than local emergency managers. We are not just coordinators but rather we are expected to be in command of our largest incidents. We expand our own knowledge base through integration with other teams such as the FEMA Search and Rescue Indiana Task Force 1 and the State Incident Management Assistance Team.

We have responded in command and general staff positions to the Henryville, Indiana EF–4 tornado, which covered 71 square miles, and to Hurricane Sandy on Long Beach Island, New York. We brought those lessons learned back to IU and applied them.

The university environment offers unique challenges in addition to the age-old question of how to get teenagers to pay attention to anything. We conduct camps for access and functional needs children and support camps for children of all ages during the summers. We face increasing active-shooter threats, have thousands of laboratories, including 900 in Indianapolis alone, have experienced devastation due to flooding, and most campuses of all universities in Indiana host major events.

For IU, in addition to our 60,000-person football venue, we host international swimming, diving, and track events, concerts, the Nation's largest half-marathon at IUPY in Indianapolis, and the Little 500 at IU in Bloomington. This year, the Komen Race for the Cure and Little 500 happened on the same day, and both occurred less than a week after the Boston Marathon bombings.

With so many events of significant size, preparations for mass fatality and mass casualty incidents is forefront. Two weeks ago I presented on mass fatality and mass casualty incidents at the National Sports Safety and Security Conference. My focus in these ef-

forts is to expand the traditional mindset of game-day operations and to the "what-if" scenarios. We need to instill a sense of advanced planning and complete synchronization of public safety and event management in advance of a major incident. We need to have a standardized common operating picture for all responders and events management and ensure adequate plans, training, and exercises in advance. We have integrated this approach into IU football and are expanding to other events and campuses as well.

In early June of this year, IU provided the Incident Management Team and served in unified command with the Bloomington Fire Department for a three-site search and rescue exercise that was spearheaded by the Indiana National Guard and Israeli Defense Forces. The lessons learned from this exercise cannot be replicated in a classroom or with any amount of equipment.

For prevention of a mass casualty incident, equipment becomes key. But for the response to a mass casualty incident, the true ability to manage the situation lies not with the equipment but with the ability of the responders to mentally grasp the situation, adapt and be flexible, and work within a larger organizational structure than most have ever faced. The incident management perspective of command of the whole incident, which consists primarily of coordination of all resources and the setting of joint priorities rather than maintaining control of individual department resources, is paramount. These organizational and individual capabilities are honed through rigorous training and exercises that build on all-hazards plans.

In advance of disasters, IU coordinates extensively with local, State, and National organizations. IU has excellent cooperation with law enforcement for active-shooter exercises, and we depend on local fire departments for day-to-day responses. We continue to work with these departments surrounding all IU campuses on the integration with IU's team, response teams, and command capabilities. IU has built incident management teams on each campus and a system-wide IM team. As a wholly-encompassed institution rather than individually-managed departments, IU has uniquely sustainable team capabilities, and we focus existing knowledge areas into incident command system roles. For example, purchasing becomes logistics. All faculty, staff, and students have a role in a disaster.

In terms of funding for preparedness, IU is confronted with the funding quandary that exists for homeland security grants. IU is a quasi-State entity, which means that we are eligible for the State portion of homeland security funding. However, very little State funding is available, and local funding is not available directly for universities.

We have been fortunate in our achievement of two emergency management for higher education grants over 5 years, but that funding stream is no longer available. Such funding, with refocused guidelines, would be helpful for universities, especially in regard to preparedness for other major incidents.

In summary, universities are progressing in their planning for mass casualty and mass fatality incidents, and increased local coordination of Federal funding would assist progress. The incident command system works well for all jurisdictions—Federal, State,

local, Tribal, and universities—not just for incidents but also for major events; and all-hazards advance planning, including the "what-if" visionary components, will increase the efficiency and effectiveness of any response.

I appreciate the opportunity to present this testimony and will answer any questions at the appropriate time. Thank you.

[The prepared statement of Ms. Mack follows:]

PREPARED STATEMENT OF DIANE MACK

AUGUST 6, 2013

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In summary, universities are progressing in their planning for mass casualty/mass fatality incidents, and increased local coordination and Federal funding would assist progress. The Incident Command System works well for all jurisdictions—Federal, State, local, Tribal, AND universities—not just for incidents but also for major events, and all-hazards advance planning—including the "what-if", visionary components—will increase the efficiency and effectiveness of any response.

I appreciate the opportunity to present this testimony, and will answer any questions at the appropriate time. Thank you.

Mrs. BROOKS. Thank you, Ms. Mack.

While typically the Chairwoman would recognize themselves for 5 minutes of questioning, it has come to my attention that Congressman Young, which is not uncommon in Congressional hearings as well, has to be other places. So I will defer my questioning to Congressman Young from Indiana.

Mr. YOUNG. Thank you so much, Madam Chairwoman. I really appreciate it. Sorry I can't be with everyone longer today.

I want to start with a question. Try to limit your response to 1 minute each. Just very quickly, Chief Orusa, Sheriff Bowen, and Director Mack, you each indicated the importance of being properly resourced to fulfill your training mission and for other purposes, to make sure you are fully prepared for a mass casualty event.

I want to know how do you measure the effectiveness of dollars spent? Of course, one metric might be the number of hours trained. Another might be conceivably the skill sets of individuals within your purview. Each of you take a turn at this so that we can assess as policymakers whether or not these monies are being spent and how they need to be spent.

Sheriff BOWEN. Well, obviously, that is a difficult question to answer and one that we hope we never have to answer. Certainly, it is important that we have the resources in play and that we have the training and those components in play to be able to deal with a hazard. But until we are actually tested, as Chief Orusa stated, we can block and tackle all day long, but until we are truly tested in an event, we really don't know what our true capabilities will be and whether our infrastructure will match up to what the needs of that specific event are.

So while I would like to say that we have tested that equipment and that training in a real-life scenario, I am proud to say that we have not had to do that and hopefully will not have to.

Mr. YOUNG. Right.

Chief ORUSA. The Homeland Security Exercise and Evaluation Program is an excellent program, and it focuses on gap analysis, core capabilities, and improvement plans. So that tactical task-level section is addressed.

Also, our training budgets through the State Homeland Security Program have very rigid budget requirements that we have to submit. So not only is there oversight financially, there is oversight from a core capability and improvement standpoint.

Mr. YOUNG. Thank you.

Ms. Mack.

Ms. MACK. I would also agree with the Homeland Security Exercise Evaluation Program. Coming up with objective criteria for measurement of such things is going to be very difficult. But we did demonstrate at this past year if the State had not provided the funding, if the homeland security funding had not come through and been applied to the Muscatatuck exercises, which allowed us to expand our capabilities and be able to manage that in an exercise environment, we would have had a much more difficult time for the Henryville tornado and also in Long Beach, New York. It was very clear that the people who worked at those exercises, those large State-level and National-level exercises, were much more prepared.

Mr. YOUNG. It can be very difficult. I know it is an imprecise science, trying to measure a low-risk, high-impact sort of event, and that is what we are dealing with here. It is hard to assess probabilities. But nonetheless, we do have the gap analysis, and an independent study has been commissioned, Director Hill, you indicated, to assess emergency preparedness and assess overall capabilities of our entire State operation. You indicate you are still reviewing that report, but within the next month or so we can expect to see implementation of some of the findings.

Could you share with us some of the initial gaps identified within that report, sir?

Mr. HILL. Sure.

Mr. YOUNG. Thank you.

Mr. HILL. I appreciate the question, and I can understand that there is a lot of sensitivity to this because it is not intended really to replace what we have been doing. There has been a lot of tremendous work done in the last few years regarding the State of Indiana.

I would say to you that one of the biggest gaps is making sure that we have integrated at the local level planning capability, not just at the State level. By that I mean do people at the Emergency Management Agency level in each county have resources that help them do planning, based upon what Chief Orusa said, in terms of threats, hazards, identification, risk analysis, the THIRA.

One of our goals this year is to really get out into those local communities as a part of that and identify those risks at the local level, not just what Indianapolis thinks but what do the local com-

munities identify as their risk? That is going to be critically important in doing that.

In regard to the cost savings, Representative Young, I would just say to you that one of the things that we do to measure cost-effectiveness, in the Henryville tornadoes, FEMA actually assessed the damage, and they estimated debris removal at $40 million. Due to the resources, the tremendous work that was done with local agencies, Department of Corrections, not-for-profit groups, we actually ended up with a bill of about $11 million. So that is one big cost analysis that we were able to do on the mitigation side after preparedness.

Mr. YOUNG. Thank you for your encouraging responses, and I yield back.

Mrs. BROOKS. I thank you, the gentleman from Bloomington. I really appreciate your participation in this panel today. I welcome you back to your hometown of Carmel and just really appreciate the interest that you have shown in ensuring that our first responders and our medical professionals have the resources that they need, and I just want to thank you for being here today.

At this time, I would ask the gentleman from Granger, Indiana for any questions he might have.

Senator DONNELLY. Thank you, Madam Chairwoman. To all of you, thank you for your service, and to all the first responders.

Sheriff Bowen, you had mentioned that Central Indiana first responders work off of different communications systems, and I was wondering if there is any effort now to try and be on the same system, and what issues this causes when an event occurs?

Sheriff BOWEN. Well, there are issues when an event occurs. Obviously, being on different communications systems causes breakdowns. Hamilton County is looking at moving forward with their communications technology to a P–25 platform, which is the state-of-the-art National recommended communications network. So we are moving in that direction. That will allow interoperability with the City of Indianapolis and other regions.

So it is critical that communications are functioning at a high level. Any time that you are involved in a mass casualty incident, bringing folks together from other regions that have different types of communications systems, it is challenging. So there are things that can be done to network those systems together, but obviously it takes time and expertise.

Senator DONNELLY. Right. Are there any efforts or discussions going on to get everybody together as they go forward with communications purchases, for instance, with other sheriffs' offices or other counties or other cities, to see if we can all get on the same platform?

Sheriff BOWEN. There is certainly a move towards that. The State is working towards the P–25 system. Obviously, funding is a critical component to any communications network. It is very technical and very expensive, and the funding component is really the roadblock as we move forward.

Senator DONNELLY. Okay.

Chief Orusa, thank you for your service. You come from a very fast-growing place. All you have to do is drive in in the morning to find that out.

[Laughter.]

Senator DONNELLY. As you look at the challenges you have, how do you keep up with the businesses coming in, knowing what is in place in those businesses, in the subdivisions that are going in, in the various plants that are in Fishers? How do you make sure that you know what is going on there, and what requirements you have, and how do you cope with the growth that you are dealing with?

Chief ORUSA. Any challenges for us—and growth is well-stated as one of them—the foundation of the organization and the operational philosophy and leadership philosophy is really that any challenge, whether it is growth, whether it is disaster, whether it is laying off fire fighters, whether it is no pay raises, has to do with our values and our mission. Through collaboration with all the people in our organization, we did a values audit and we re-wrote our values and our mission statement, and we adopted a certain leadership philosophy which means there is no more leadership out of self-promotion, pride, or self-protection, fear. It is service-driven, out of a dedication to a cause or relationship.

So it starts with that, and then the next step is putting the best and brightest in our organization together to collaborate, to have a vision that anticipates the growth and identifies and defines what the challenges are, and then getting support from our policymakers financially to try to get ahead of that growth.

Senator DONNELLY. How do you get word, for instance, if a company is coming in to handle these particular chemicals or these particular things? How do you find that out?

Chief ORUSA. We have a fire prevention bureau, and we have an EMA director that works closely with our department head in economic development and business development. So right away, we are in the decision-making process. When that happens, we can identify that as a target hazard before it is built, identify and define any risks, and then try to prevent and mitigate those risks before they become——

Senator DONNELLY. Okay.

Mr. Hill, we are a proud agricultural State that does an extraordinary job, and obviously a lot of fertilizer and related products are handled in our State as well. I was just wondering what the procedures are for those facilities that store fertilizer, that make fertilizer, what inspections are planned and what rules you have regarding that.

Mr. HILL. Well, Senator, there is something called the Community Right to Know, and basically what it amounts to is any facility that has those kind of chemicals are required to report those various storage capacity and quantities on-hand to the State Department of Environmental Management.

Senator DONNELLY. Do you have an inspection plan that you work together with these locations to make sure—or, in effect, I think it is helpful to them to know, hey, here is how we would like you to handle these products?

Mr. HILL. Yes. We are required to go out and inspect those sites, and just this year after the West, Texas event, I was very concerned about it and asked the fire marshal to come in and have a discussion with me, and we used a GIS application to identify any facility that stored fertilizers within 500 meters of any school, hos-

pital, community gathering-place, and then we went out and personally inspected those facilities immediately to make sure we knew what was in the building, to confirm what they had reported was accurate; and then second, to make sure that they were, in fact, following fire building code safety.

So those kind of processes are in place. There are a lot of facilities. We have an annual inspection where we go around and inspect them. We work with the State chemist, who is based out of Purdue University, and we also work with him very closely.

Senator DONNELLY. Very good. Thank you.

I think I am out of time.

Mrs. BROOKS. Thank you.

I must say, I attended the hearing on West, Texas and saw the diagram of that fertilizer plant explosion, and it was in very close proximity to a school and an apartment complex, and so there was incredible damage.

At this time, I would ask the gentlelady from Jimtown for any questions she might have.

Mrs. WALORSKI. Thank you, Madam Chairwoman.

I think I have to address my remarks to Mr. Velasquez since we are talking also about Northern Indiana, and to Mr. Hill. Again, thanks for all of you being here.

But I want to go back to the question that Senator Donnelly asked because I think it is applicable, especially in places like Northern Indiana, where it is a very diverse area where we have significant athletic—the University of Notre Dame—activity just about every weekend in the fall, but also surrounded by rural areas. In many cases, there are fire territories and fire districts.

I am just wondering, I guess, Mr. Velasquez, from the position of our proximity even to Chicago, closer to Chicago than we are to Indianapolis, does that present a different set of circumstances? If so, how is the communication handled between local, State, and Federal in the event of, say, an attack on Chicago? When the communication systems go down, what do you do in rural areas?

Mr. VELASQUEZ. That is a great question. I appreciate that. I will say that, obviously, as Director Hill mentioned, what is critically important as it relates to planning for whatever hazards may befall us is that integrated approach to emergency planning. That is one of the things that we have taken on at FEMA Region V as a priority, making sure that as we plan for whatever events may affect us, whether they are natural or whether they are on the terrorism side, to ensure that everyone is coming to the table from an integrated perspective to plan for those events. That is the only way that you can better understand capabilities and what people can bring to the table.

I will mention one of the areas that we focused our attention on in the region and really embraced planning for is improvised nuclear devices and an improvised nuclear device detonation in a large metropolitan area. We have basically spearheaded one of the most comprehensive planning initiatives to confront this type of threat, and I can tell you that Indiana has been at the table with us with regard to that planning effort.

We have partnered with the counties, the northern counties. In Indiana, folks have attended a number of our meetings to discuss

the impacts of an event of this magnitude, the primary, secondary, tertiary effects of this type of an event, what evacuation would look like, what are those types of needs, what are the capabilities, how we can provide funding support through FEMA's public assistance program in terms of how we would provide funding for host States in an evacuation-type of a circumstance, how we would communicate, what would that mean, the wind speed, direction, plume, time, shielding. All of those factors play a role in our decision-making process, how we would communicate that.

So I can assure you that we have taken on, as Director Hill has mentioned, a very integrated approach to planning, making sure that as we plan for whatever events may befall us, we are bringing everybody to the table to ensure that we have an effective and a coordinated response to an event.

Mrs. WALORSKI. I appreciate it.

Mr. Hill, what do we do in rural areas with volunteer fire departments in districts and territories?

Mr. HILL. Volunteer fire departments are very important, as you know. Seventy percent geographically of our State is served by volunteer fire departments. One of the things that Governor Pence has asked me to do through our staff is to look at the feasibility of a State-wide Fire Academy. So he has dedicated funding in his budget. As you know, this was a pretty tight year. So we are going to be looking at, how do we improve fire service in the rural areas?

I have been in contact with members of Noble County just recently and I learned that they have plenty of equipment, but they are having trouble staffing some of that equipment during the daytime because people are working. That is a very real issue that we have to address.

To answer your question, we work regularly with them through our Fire Marshal's Office, but I also want you to know that I went around and visited every one of the 10 districts after assuming office, and I will be going around to those 10 districts again after we get done with this assessment, talking through this.

But there is tremendous capacity that has been built up both equipment-wise and organizationally in our 10 homeland security districts that make local response viable, as opposed to somebody coming in from Indianapolis and helping them.

Mrs. WALORSKI. I appreciate it.

Mr. Velasquez, just one quick question. So are we victims in Region V? Has sequestration taken resources that we need in Region V?

Mr. VELASQUEZ. We have done a good job of leveraging our resources, our capabilities. We have taken a very regional approach to leveraging resources. So I think we are doing a pretty decent job and making sure that we are leveraging all of those capabilities that exist in the region, and that regional approach is critical.

Mrs. WALORSKI. I appreciate it.

Madam Chairwoman, I yield back the remainder of my time.

Mrs. BROOKS. Thank you. I believe I mentioned in my statement the last week before heading back to Indiana I had an in-depth discussion with Doctor Tara O'Toole, who is the Under Secretary for the Department of Homeland Security's Science and Technology Directorate, because I wanted to ask her, because I didn't have a lot

of knowledge about the consequences and threats in a mass casualty attack when a biological weapon or a nuclear weapon might be used. One of the issues we discussed was whether or not to evacuate an area when you don't have this kind of advanced warning, as Mr. Velasquez just talked about, of what is called an IND, or an improvised nuclear device detonation.

What I am curious about, we have obviously, throughout the country and in Indiana as well, issues involving flooding or maybe have issues involving hurricanes on the East Coast. I am curious what kind of training and what kind of discussions take place in communities and in our communities here with respect to whether or not evacuation is necessary, and I think I will start with you, Mr. Hill.

Mr. HILL. Well, it is a very probing—it is a very insightful question, but I will say a couple of things.

Mrs. BROOKS. Well, and if I could, because what Mr. Velasquez reminded us, and if you think about a nuclear device, you have to think about issues or an attack involving wind speed and the plume and the direction and all those things, and these are things that we don't think about very often here in Indiana. So, I am sorry.

Mr. HILL. That is all right. Just last month, the policy team at State of Indiana met to deal with this issue of a nuclear mishap or intentional act, and we spent 5 hours in the policy room talking through scenarios. FEMA was there. They were doing an evaluation of us. This wasn't just something to make us feel good. We were being evaluated on our effectiveness in being able to do that.

I can tell you that the key thing in this kind of decision is having the right people in the room that have expertise. For example, you mentioned in Northern Indiana the farms. You have to have people in the room who understand agriculture, who understand how this radiation can be transported, how it can move through food. I don't have that knowledge. We have to bring in the proper people to make those decisions.

Second, I would say to you one of the things that amazed me at the Boston bombing was the way, when they asked for the people to stay in their homes, the way they did it. That is incredible for the City of Boston.

So I think what we have to realize is that communication of expectations is going to be very important, through the media, social media, all kinds of venues, that we clearly communicate, after policy decisions are made, what we expect the public to do for their safety. It is going to be hard to keep people indoors when they want to get home to their families and so forth, but I think sometimes sheltering in place, from what I have been reading and studying, is a very key element in this decision making.

Mrs. BROOKS. Thank you so much.

Sheriff Bowen, anything you would like to comment on with respect to evacuations?

Sheriff BOWEN. Well, obviously, this is critically dependent upon the size and scope of the incident and the accuracy of the intelligence, and the time frame for conducting an evacuation. It is important that we do get it right because we could run into the "boy who cried wolf" mentality if we continue to ask people to do things

and it becomes unnecessary. Then we are going to lose the faith of the community. As Mr. Hill stated, in the Boston situation, it worked, and it worked very well. But we run the risk of crying wolf oftentimes, as we had seen in Hurricane Katrina when people were asked to leave. People had been through those types of incidents before and didn't respect the request to evacuate and chose to ride the storm out.

Obviously, we are dealing with a much more catastrophic event than ever seen or ever prepared for, and that only leads to the situation for the mass incident and what we have to do in preparation and cleaning up afterwards and helping those folks.

So if warnings are not heeded within the critical time frame, all we can do is shelter in place and hope for the best. It is very much a case-by-case situation, and as Director Hill said, we must rely on the experts in the field, the weather forecasters, the health experts, and those that are in the know to help make the best decision possible.

Mrs. BROOKS. Thank you. Thanks.

Ms. Mack, I can't even imagine, having been in higher education at Ivy Tech as General Counsel. We didn't have residents, though, at Ivy Tech, and all of those students that you are responsible for. What kind of discussions do you have at IU?

Ms. MACK. We are having those very similar evacuation versus shelter-in-place discussions. With our increasing population of international students, evacuation is incredibly difficult for them. So we have to take that into consideration as well. This is why we stress the all-hazards planning. In having those tools in your toolbox, depending on the scenario, depending on the situation on the ground, you can pick which tools you need for the appropriate situation and apply it.

Mrs. BROOKS. Thank you very much. My time is up.

We are now going to start a second round of questioning, and I will yield to the gentleman from Granger.

Senator DONNELLY. I think this is the lightning round.

[Laughter.]

Senator DONNELLY. Sheriff, at the end of the day when you sit there in your office and you think about the things that you are challenged with and you look at the scenarios that are possible, what is the one thing you say, look, this is the area we really need to get better at?

Sheriff BOWEN. Well, I would say that with regard to the challenges that we face, it is in making sure that we are training, preparing, identifying threats and hazards, working as a community to help protect our citizens not only from public safety but from the private sector as well. It is a group effort. It is an organized effort on all of our parts to help keep our communities safe.

Senator DONNELLY. Okay. Mr. Hill, this year at the Indy 500, it was shortly after Boston, and one of the challenges we faced—and I know they were working very hard. But one of the challenges we faced was all the coolers coming in and all the traditions that we have had at the 500. How do you keep our traditions in place while at the same time keeping people safe and making sure that they can enjoy the race in safety? Are you working directly with the folks at the Indy 500 at the present time?

Mr. HILL. Senator, following the Boston event, I attended the planning session for the Indianapolis 500, and we are integrally involved in the planning process leading up to that. One of the things that had to be discussed was the reality of what they just saw in Boston and how pervasive it was in terms of the public's endangerment. So we made a decision, not me personally but the Public Safety Committee, the chief of the Speedway Police and so forth. They made an intentional effort to bring up this cooler issue, and it wasn't very pleasant at the time but most people understood why it was important, that we protect our people coming to that event.

There was also another key part of that planning process that was adjusted that they hadn't done previously. They blocked off Georgetown Road, which then protected the whole backside of the infrastructure from having any kind of opportunity for an IED or any kind of mass explosion there. So there were some very specific things that were integrated into this year's planning process as a result of that Boston process. In fact, I attended a de-brief from the Fusion Center in Boston with the FBI, and we talked about that. As a result of that, we led to some of these discussions.

Senator DONNELLY. Is that a process that for next year you have already begun working together with the 500 folks?

Mr. HILL. Well, the people meet monthly leading up to that, so they are already meeting for next year's event. So this is an ongoing process. It began really before last year, but it is something that is institutionalized, and it is a very effective tool in working through planning for these major events.

Senator DONNELLY. Thank you.

Ms. Mack, when you take a look at the challenges you face, do you have a list of scenarios you go through on a constant basis, or develop additional ones as you go through? How does that take place, that you look and go here are the 10 biggest challenges we face, here are the newest challenges we face? How does that process work?

Ms. MACK. We do have, in addition to our all-hazards plan, a comprehensive emergency management plan, and we have hazard-specific annexes. Inasmuch as we try to avoid management by shiny object, we do realize that we need to capitalize on certain situations. As much as that is not a situation we ever want to be in, we do need to make sure that we are harnessing the energy, as it were, for example, with Boston. It was a tragic situation, but we did need to make changes for that. As Mr. Hill was saying with the 500, the public will understand your changes when you implement changes after a big situation.

Senator DONNELLY. I found they are always willing to step up and do whatever is necessary. I am just wondering, do you have somebody who is like the designated person who brings up the difficult scenarios and the difficult problems that may arise in events when you get together?

Ms. MACK. Absolutely. When we do our planning, I have three certified emergency managers certified by different sources who work with us and who are very good at poking holes in our plans and making sure that they are the best that they can be.

Senator DONNELLY. Thank you.

Thank you, Madam Chairwoman.

Mrs. BROOKS. Thank you.

I now turn to the gentlelady from Jimtown.

Mrs. WALORSKI. Thank you, Madam Chairwoman.

My question is, you know, I am proud to be a Hoosier, and I think we do all things well. So my question is: When it comes to best practices and kind-of back to what Congressman Young was asking prior on best usage of dollars spent, how it is measured? You all have been involved in training. Sheriff, I know you have, and the fire fighters have as well. Then I guess, Mr. Hill, you are new to the game. But as you look across the country and you go to all of these different exercises and you have colleagues around the country, my question is: What best practices have you been able to pick up and implement in the State of Indiana so that you can really say, you know what, I saw that, I learned it, and it is something we should do here? What would that be for all of you? What do we do well?

Mr. Bowen.

Sheriff BOWEN. Well, I think as Hoosiers, we are all willing to step up and do, as Senator Donnelly said, what is necessary to make sure that we are protecting our community. I think through social media and other avenues, the communication between the folks in our communities has grown. The gathering of intelligence and the sharing of that information in an effort to make our area much safer has increased.

So I think we need to continue to expand upon that again. It is not just public safety. It is not just police and fire and homeland security here to protect the citizens in our communities. It is our communities as a whole. I think that, as you say, Hoosiers are willing to step up and do their part to make sure that we are keeping our area safe.

Mrs. WALORSKI. Mr. Orusa.

Chief ORUSA. Well, I agree with Sheriff Bowen. It is about the people that participate in the interoperability and the relationships that you build ahead of a disaster. But most notably, the lessons learned were in the Super Bowl last February, where we created the use of a playbook. An incident action plan is a management tool. But the planning section chief, I believe he is in the room, Tom Seevack, created a playbook, and it had supplemental information such as responder life safety information, weather, contingency plans, key personal contact information mapping, and now that has been recognized as a best practice and it is being used at other venues that hold the Super Bowl.

So we are grateful for that. It is about the people, and we have really talented people in Indiana.

Mrs. WALORSKI. Great. Thanks.

Mr. Hill.

Mr. HILL. Just briefly, I would say two things. First of all, there has been referenced on the panel about Muscatatuck Urban Training Center. I think we can't overstate that enough, how important that is for our people to have real-life experiences. So I would just mention that.

But second, I think Indiana has done a very good job, again credit to my predecessors, in integrating the National Incident Manage-

ment System, NIMS, and incident command structures that allows us to have a common architecture for communication, not necessarily the technology but the manner in which we communicate with one another. We are all talking from the same script. I think the formation of these teams throughout the State that allow us to communicate and respond locally to emergencies, I know that my work in the State police 30 years ago, there just was not the local capacity to respond to some of these major emergencies that we have today. Frequently, I am hearing about emergencies that are being handled totally by the local people without any involvement from outside sources. I think that is a tribute and a testimony to some of the progress that has been made.

Mrs. WALORSKI. I appreciate it.

Ms. Mack, any comments on the university level?

Ms. MACK. I would agree with what all the panelists have said, and it has allowed us, based on the teams that have been built up largely with this funding and the integration of the incident command system, we have been able to move beyond that and integrate other facets of disaster response such as volunteers and donations management, those kinds of things which are really advanced emergency management.

From a college perspective, we know that if anything happens on any of our campuses, we are going to have thousands of people, right then and there, who are ready to respond, and we need to have our process and procedures and structures in place to be able to handle that and have them help us with the response, instead of being part of another thing we need to take care of.

Mrs. WALORSKI. I appreciate it. Thank you.

I yield back my time. Thanks.

Mrs. BROOKS. Thank you. I appreciate all the testimony that everyone has given today, and you each brought a very unique perspective to this topic, and you have given us a lot to think about.

But in a bit of a lightning round as well, as you suggested, you have an opportunity which is a little bit unusual to have Members of both chambers, the House of Representatives and the United States Senate, here. Coming here, we want to hear from you what is it Congress could be doing or should be doing to help you in your efforts, to help you.

I think I will just start with you, Ms. Mack, and work backwards, this way on the panel. What can you state briefly? What can Congress be doing to assist you to make sure that you all are sleeping even better at night?

Ms. MACK. Well, I would request a couple of things. First of all, a funding line for universities I believe needs to be reinstated Nation-wide. There were limited numbers of emergency management for higher education grants that were distributed. There were only two rounds of grants, and that has disappeared. So I would request that.

I would also request the continuation and even expansion of preparedness training and exercise funding for that. That is what will move us forward in the development of our skill sets and our ability to respond from all levels of government, including the university.

I would also ask you to look at the Clery Act and potentially even refocus it. Instead of it being an accounting of the crimes that have occurred, look forward, look forward to the prevention and mitigation part of it, really gear it towards what is this doing to really achieve the objective of it. The intent is to reduce crime, especially on university campuses, and then also compare the campus crime rates, which it really focuses on, to the surrounding areas. I think you will find that universities have a much lower crime rate even than the surrounding areas, but that is not factored into the equation.

So those are the things that I would request from a university perspective.

Mrs. BROOKS. Thank you.

Mr. Hill.

Mr. HILL. I would just say a couple of things. First of all, the UASI Urban Area Security Initiative funding is really a critical component. I think the way in which that is done is a little bit uncertain to us out here in the real world. We got a document, and I understand there is a document, but there is a lot that goes into evaluating those security areas, and this last appropriations cycle I think they limited it to 25, and Indiana did not factor in.

One of the things that concerns me is that Indianapolis has done big events for so long that we are sometimes viewed as being acceptable in that area and not as big a risk, and I don't think the State should be penalized because they have done a good job in the past. There is still a lot of backfill, a lot of work that needs to be done to bring off these events. So that is one of the things.

Then second, I think continued oversight at the Federal level for FEMA is important. The THIRA process to me is critical, but we need guidance, and we need it out sooner. This is certainly not any discredit to my colleague on the panel today because I know that he doesn't have anything to do with this, but at the headquarters level we need to have that guidance out. It is very important.

Mrs. BROOKS. Thank you very much.

Chief Orusa.

Chief ORUSA. Operational readiness exercises are key to keep our people safe and effective in harm's way. We can write all the policies and procedures, we can have all the tabletop exercises, but until we have scenario-based training, which is funded through UASI, and training and exercise grants, we can't have crisis rehearsal and stress inoculation so they can function in that gray environment during a disaster, where they are forced to problem-solve and decision-make in a combat environment. It is very, very expensive to do that training, and we depend on the Federal Government to provide us the funding to do so, and it is critical that we give our people those skill sets.

Mrs. BROOKS. Thank you, Chief.

Sheriff Bowen.

Sheriff BOWEN. I would concur with Mr. Hill and Mr. Orusa. I haven't seen the benefits of being in a UASI region. It is important that we continue to fund those programs. EMA, IDHS, Homeland Security as a whole has been an integral part in making sure that Indiana has come together regionally, not just locally but regionally to prepare, to train, and plan for unknown hazards and all haz-

ards, and it is important that we continue to provide that training and that regional approach to the training.

As local agencies, we can train on our own. But as we all know, our resources will be immediately overwhelmed in a critical incident, and it is going to require those efforts from those other agencies and that cooperation to manage a mass incident.

So we would ask your assistance in considering to fund those projects and to help us as we move forward.

Mrs. BROOKS. Thank you.

Mr. Velasquez.

Mr. VELASQUEZ. Thank you, Chairman Brooks. We appreciate certainly the offer, and we also appreciate the committee's support of our department and our programs. In addition to supporting the President's budgetary requests and other programmatic requests, I think Members of Congress can certainly help us in the area of encouraging individual preparedness.

You mentioned September as National Preparedness Month, and individuals play a crucial role in helping to prepare this Nation for crisis. If we can get more and more individuals prepared to develop a preparedness mindset in this country, we would be in a better place and reduce the amount of casualties that we have in this country as a result of disasters and other crisis situations. So, thank you.

Mrs. BROOKS. Thank you.

I would like to thank the witnesses for their valuable testimony. This panel is going to be dismissed.

I do want to allow the members of this panel to realize that Members of the subcommittee may be submitting questions to you in writing, and the hearing record will be open for 10 days for you to respond in writing if you should receive any further questions.

So at this time, the clerk will prepare the witness table for the second panel.

Again, I thank you all so very much for your testimony today.

We will be having those on the second panel please proceed to the witness table. Thank you.

Our first witness is Mr. Chad Priest, the chief executive officer with the MESH Coalition, Inc. Prior to joining MESH, Mr. Priest was an attorney at the law firm of Baker and Daniels, practicing public health and health care law in Indianapolis, and in the Washington, DC offices. He served on active duty in the United States Air Force as a family practice primary care optimization nurse, and while in the military he specialized in emergency preparedness-related issues.

Next on our panel is Dr. Virginia Caine. She is the director of the Marion County Public Health Department. Dr. Caine is a past president for the American Public Health Association, the Nation's oldest and largest public health organization, and was the recipient of the National Medical Association's 2010 Practitioner of the Year Award. Throughout her career, Dr. Caine has worked to promote and advance public health locally, Nationally, and internationally through innovative programs and unprecedented collaborations.

Next on the panel is Dr. Louis Profeta. He is the medical director of disaster preparedness at St. Vincent Hospital. Dr. Profeta served as the clinical instructor of emergency medicine at Indiana Univer-

sity and is the founder of Emergency Room Advice Safety and Education. Dr. Profeta also authored the popular book, "The Patient in Room 9 Says He's God." Sounds like an interesting read.

Next on our panel is Dr. Cliff Knight. He is the chief medical officer of the Community Health Network, a position he has held since October 2009. Dr. Knight had previously served as vice president of medical affairs for Community Hospital North and Community Hospital East. Before assuming that role in 2007, he was director of Community Family Medicine's residency program, and his peers honored him as the Family Medicine Teacher of the Year.

Next on the panel is Dr. R. Lawrence Reed. He is the director of trauma services at Indiana University Health Medical Hospital. Dr. Reed's past professional responsibilities have included associate chief of the Trauma Service and Surgical Intensive Care Unit at Herman Hospital in Houston, Texas; and director of the Surgical Intensive Care Unit and director of the Trauma Center at the Duke University Medical Center, just to name a few. Dr. Reed has authored more than 60 periodical articles and 27 book chapters, most on the topic of critical care.

At this time, I would now like to turn to Senator Donnelly for any introductions he might have.

Senator DONNELLY. Madam Chairwoman, I want to thank the witnesses for being with us, for sharing their views on this extraordinarily important topic. With that, I would be happy to turn it over to you.

Mrs. BROOKS. Okay.

Senator DONNELLY. Oh, and I would like to introduce also Dr. Obeime. Dr. Obeime has worked for the Sisters of St. Francis since July 1996. She helped start and served as medical director of the St. Francis Neighborhood Health Center from 1998 to 2010, when she became the director of Community and Global Health at Franciscan St. Francis Health. I want to mention that the Sisters of St. Francis provide medical care across our State, do an extraordinary job from Lake Michigan to the Ohio River, and please let the Sisters know we are in their debt for all of their hard work.

Dr. Obeime graduated from the University of Benin in Nigeria in 1998 and completed a clinical genetics fellowship in Family Medicine residency at IU in 1996. Dr. Obeime is board-certified in family medicine, bariatric medicine, and hospice and palliative medicine.

Thank you so much for being here with us today.

Mrs. BROOKS. I would just now like to thank all of the witnesses who have also submitted full written statements, and those will appear in the record.

At this time, the Chairwoman will now recognize Mr. Priest to testify for 5 minutes.

STATEMENT OF CHAD S. PRIEST, CHIEF EXECUTIVE OFFICER, MESH COALITION, INC.

Mr. PRIEST. Good morning, Chairwoman Brooks, Senator Donnelly, Congresswoman Walorski, and the staff of the subcommittee. On behalf of the MESH Coalition, we appreciate the opportunity to be before you today, and we applaud your commitment and dedication to the important issues that we have been discussing.

I would like to share three points with the committee today. First, I want to briefly describe what the MESH Coalition is and how through our coalition partners, many of whom are seated here today, we are building resilience in the health care community and Central Indiana.

Second, I would like to discuss that our public-private coalition model that we have developed here we believe is one of the most sophisticated and progressive models in the United States. We believe it is replicable throughout the United States, and we think that is an imperative to promote health care resilience.

Finally, I would like to discuss how we might partner to build sustainable and resilient funding for health care emergency management that isn't solely reliant on grants but that takes health care entities in their usual financial reimbursement models and considers those so that we can be assured of continued funding for this important work.

At the outset, I am pleased to report that through the work of the partners here next to me and coalition partners all over Central Indiana, we believe we are uniquely well-prepared to respond to events here in Central Indiana. While it would be hubris to guarantee a successful response to any incident, especially those that would overwhelm any region's ability to respond, such as a widespread biological attack or a nuclear attack, we believe that the systems and processes that we have built here are some of the most robust and sophisticated in the Nation.

The MESH Coalition is a Nationally-recognized nonprofit, public-private partnership that enables health care providers to respond effectively to emergency events and remain viable through recovery. Our programs increase capacity in health care providers to respond to these events such as mass casualties. It protects our critical health care safety net and promotes integration and coordination between the Government and the private sector.

Our subscribing partners include the Marion County Public Health Department, the Richard Roudebush VA Medical Center, Community Hospitals of Indiana, Franciscan St. Francis Health, Wishard Health Services, Indiana University Health, St. Vincent Hospital, the Indiana University School of Medicine, and the Indiana University School of Nursing. We routinely work with a wide array of partners, including our State partners like the State Department of Health and the Department of Homeland Security.

All of these partners recognize an essential truth, and that is that we are, in fact, better together. None of our health care facilities and organizations can go it alone in a crisis, and even in a competitive health care environment, what you see here today is a recognition that we all must come together when the going gets tough.

MESH does a few core things. We provide health care intelligence services to the health care community to allow them to prepare and respond to events. We utilize social media not only to push information out but to monitor and predict and analyze threats. We issue a daily intelligence brief to health care providers across the city. We conduct community-based planning which brings people together from disparate professions and backgrounds. An example would be the building of the Super Care Clinic at the

Super Bowl, a primary care model that actually helped manage surge throughout the event.

We conduct sophisticated legal, regulatory, and financial policy analysis, recognizing that the delivery of health care is essentially a complex business enterprise, as well as a clinical one. Health care viability depends in large measure on sustaining revenue cycles to continue operations, and we pay very close attention to that.

Finally, we recognize that effective response, the difference that makes a difference between hospitals that do well in crisis and those that don't, are good clinicians that can make good decisions under tough conditions. To that end, we provide advanced clinical training to technicians, doctors, and nurses to make them better prepared to respond when the going gets tough.

We had a unique funding approach at MESH that pairs traditional emergency management funding with private support. Our hospitals have not just made a brief or casual commitment to emergency management; they have made that commitment with their dollars, and that has built the MESH Coalition. It is a model that is unique. We are extremely proud of the vision that these health care leaders have had in building our coalition, and we are also helping to promote this through partners such as the Northwest Healthcare Response Network in Seattle, and the Northern Virginia Hospital Alliance, which operates in the National capital region, leveraging our communities.

We know that grant funding in and of itself is not a sustainable model for health care emergency management. As stewards of public resources, we have to find creative ways to incentivize health care response. However, there is, in fact, a Federal role here, and as you all know, that Federal role is most helpful when it is sustainable and it continues on. Hospitals do deserve a predictable way to manage emergency issues.

I want to thank you for your leadership in this area. Thank you for including us on this distinguished panel. We are pleased to be here. I look forward to discussing this with you further.

[The prepared statement of Mr. Priest follows:]

PREPARED STATEMENT OF CHAD S. PRIEST

AUGUST 6, 2013

Good morning Chairman Brooks, Senator Donnelly, Congresswoman Walorski, Congressman Young, and staff of the subcommittee. On behalf of the MESH Coalition, we appreciate the opportunity to discuss health care emergency management in Central Indiana with you today and applaud your commitment and dedication to this important issue.

I am pleased to report at the outset of my testimony that as a result of the cooperative efforts of Central Indiana health care, public health, emergency management, and public safety partners through the MESH Coalition, the health care infrastructure in Central Indiana is well-positioned to respond and recover from a wide range of crises and emergencies. While it would be hubris to guarantee a successful response to any incident, especially those that would almost certainly overwhelm any region's ability to respond, such as a direct nuclear or widespread biological attack, Central Indiana is a National leader in health care infrastructure resilience and we believe our systems and processes are some of the most robust and sophisticated in the Nation.

I would like to address how we have developed this resilience, in part, through closely-coordinated cooperation among the public and private sectors through the MESH Coalition. The MESH Coalition is a Nationally-recognized, nonprofit, public-private partnership that enables health care providers and organizations to respond

effectively to emergency events and remain viable through recovery. We provide health care intelligence, community-based planning, policy analysis, and clinical training to our health care, public safety, public health, and emergency management colleagues. Our programs increase capacity in health care providers to respond to emergency events, including mass casualties, protect our critical health care safety net, and promote integration and coordination between the Government and private sector.

Today, I would like to share three points with the committee:

1. The public-private partnership coalition model that our partners have developed here in Central Indiana is one of the most progressive and sophisticated models of health care emergency management in the United States, and we believe that this model can, and should, be replicated throughout the United States.
2. Through a comprehensive portfolio of programs, the MESH Coalition is continuously improving Central Indiana's ability to mitigate, prepare, respond, and recover from both small and large-scale emergency events.
3. We believe that in order to promote the spread and adoption of health care coalitions, we must work together to find creative and cost-effective means of providing sustainable, on-going support to these efforts, while maintaining appropriate stewardship of public resources.

THE MESH COALITION MODEL

The MESH Coalition enables health care providers to respond effectively to emergency events and remain viable through recovery. Through the MESH Coalition, health care providers, public health practitioners, emergency medical service providers, emergency managers, law enforcement agencies, fire departments, and private businesses are working together to plan, train, share information, and shape policies that protect the health care system and facilitate an effective emergency response. Our public-private partnerships increase capacity in the health care system to respond to emergency events, protect our critical health care safety net, and promote integration and coordination between the Government and private sectors.

This unique partnership was founded as a grant project of the Indiana University School of Medicine and Wishard Health Services with a $5 million award from the United States Department of Health and Human Services Emergency Care Partnership Grant Program. MESH was one of five organizations funded through this Program to develop innovative models for health care emergency management, and was the only non-profit successfully formed because of the award.

Our Board of Directors is comprised of hospital chief executives and clinical leadership, as well as community partners. These entities include: The Indiana University Schools of Medicine and Nursing, The Marion County Public Health Department, Richard Roudebush Veterans Affairs Medical Center, Community Hospitals of Indiana, Inc., Franciscan St. Francis Health, Wishard Health Services, Indiana University Health, and St. Vincent Hospital & Health Care Center, Inc.

One of the unique aspects of MESH that helps us be successful is our funding model, which pairs public grant funding with private fee-for-service and subscription funds—meaning that our coalition partners have all put "skin in the game," creating powerful incentives for executive and system engagement in critical emergency management activities. While historically we have received Federal grant funding from the Emergency Care Partnership Program, the Urban Areas Security Initiative (UASI) program, and the Metropolitan Medical Response System (MMRS), subscription fees from partnering health care organizations are nearly 45% of our total revenues. In addition, our fee-for-service programs continue to minimize the gap between private and public funding streams. This is of particular importance given that there have been significant reductions in Federal grant programs, and we anticipate further cuts in the future.

CENTRAL INDIANA PREPAREDNESS

Central Indiana communities are as prepared as any other across the country to respond to an emergency event. However, we believe that an effective response is a necessary, but not sufficient, condition to safeguard the health care infrastructure during crisis events. It is critical that we improve the overall resilience of our health care system to respond to a range of threats, then quickly return to baseline operations in order to provide effective care to our community. The MESH Coalition helps build resilience through four core services: (1) Health care intelligence services; (2) community-based planning; (3) policy analysis; and (4) clinical education and training. I would like to take a moment to describe how each of these services better prepares Central Indiana to respond to a mass casualty event.

Health Care Intelligence Services

In order for health care providers to effectively manage significant increases in patient volume during major mass casualty incidents, they must operate from a Common Operating Picture. To build this Common Operating Picture every day, the MESH Coalition conducts real-time monitoring of disparate data streams for potential threats to the health care sector. These data streams include open-source sites such as news media and weather, restricted sources such as homeland security and other access-controlled portals, and radio communication sites such as those streaming aircraft and public safety radio traffic. In addition, we monitor and utilize social media platforms such as Twitter and Facebook, an area in which you, Chairman Brooks, have been an extraordinary proponent.

The threats we detect are distributed to our partners via email, social and news media, public safety information channels, and the MESH Daily Situational Awareness Brief. The *Brief* is an email we send daily to health care providers, emergency managers, and public health professionals throughout Central Indiana, and it provides specific, actionable information on threats to the health care sector, from severe storms to emerging infectious diseases and everything in between. What makes the *Brief* unique is the inclusion of specific action steps that allow recipients to immediately improve their preparedness for potential emergency events. The *Brief* is frequently used in hospital team meetings and bed huddles as an intelligence source and discussion initiator.

At the direction of the Marion County Public Health Director, and in cooperation with the Indianapolis Division of Homeland Security, we also serve as the Marion County Medical Multi-Agency Coordination Center (MedMACC). The MedMACC is staffed and operational 24 hours a day, 7 days a week, 365 days a year to provide a critical link between Marion County health care facilities, the Marion County Public Health Department, the City of Indianapolis, and the Indianapolis Division of Homeland Security. The MedMACC is activated to support everything from mass casualty incidents like the recent bus accident on the northeast side of Indianapolis, to supporting emergency responders during large-scale events like the Indianapolis 500, to coordinating health care response during disasters like the stage rigging collapse at the Indiana State Fair in August 2011. In 2012 alone, the MedMACC was activated 17 times.

During an activation, the MedMACC manages hospital surge by assisting with the distribution of patients during mass casualty incidents. For example, during a mass casualty incident, the MedMACC is dispatched and completes just-in-time hospital emergency department polling. We relay this information to field command units via public safety radio systems to facilitate better patient transport decision-making and avoid overwhelming any one facility. During large-scale emergency events, the MedMACC provides direction through an executive-level Policy Group consisting of individuals from various health care entities throughout Marion County, many of whom serve on our Board of Directors. The MedMACC also has the capability to identify and secure resources for health care providers and organizations during emergency events, to assist public health authorities in providing care to vulnerable populations during crisis events, and to provide just-in-time subject matter expertise on Chemical, Biological, Radiological, Nuclear, and high-yield Explosives (CBRNE) threats, as well as emergency medical, legal, and policy issues. In the event of an area-wide or regional mass casualty incident, we can also deploy critical resources such as core medical supplies, and up to four Multi-Agency Support Tactical Facilities, which are equipped to function as emergency mobile field hospitals. An example of one of these facilities is deployed outside today in coordination with the Hamilton County Emergency Management Agency.

Community-Based Planning

Health care in Central Indiana is, to say the least, a highly-competitive enterprise. In many communities, intense health care competition has made it challenging—or impossible—to bring providers together to prepare for disaster and crisis events. We are fortunate in Central Indiana, as our health care organizations fully understand that coming together to plan for emergency events saves lives and is in the best interest of everyone. In fact, our health care partners have made a commitment to not compete on safety or emergency management issues and the MESH Coalition is the result of that commitment.

Traditionally, health care emergency planning has focused on preparing hospitals to be "floating islands" capable of withstanding emergency events and remaining open to provide patient care. This approach has resulted in redundant spending on equipment and supplies in hospitals across the country. Working in silos is not an effective approach to emergency preparedness. Through MESH, Central Indiana hospitals team up to share resources and engage in joint emergency planning. Each

month, Hospital Preparedness Officers throughout Indianapolis work together in MESH working groups to collaborate on policy, training, and exercises. Using this community-based approach, we include stakeholders such as hospitals, first responders, and other local officials to coordinate and prepare for potential threats, as well as large-scale anticipated events such as the Indy 500 and the NCAA Final Four. This enables staff to develop effective plans and programs while generating new knowledge about health care emergency management.

One example of this innovative approach to health care emergency planning is highlighted by our community's preparation for Super Bowl XLVI, where we created the Super Care Clinic®. As part of the Super Bowl Village, and in partnership with the Super Bowl Host Committee, the Super Care Clinic® represents an innovation in how volunteers and attendees are treated at large-scale events. Located inside Indianapolis' Union Station, this fan-facing forward medical station served as a clinic for fans, but was intentionally designed as a surge management strategy in the event of a mass casualty incident. In an extraordinary gesture, caregivers from Community Health Network, Franciscan Alliance, Indiana University Medical Group, St. Vincent Medical Group, Wishard Health Services, and Indiana University Health volunteered their time to work at the clinic during the entire week of Super Bowl activities. This was the first clinic of its kind to be created in the United States and serves as a model for providing health care services during other mass gathering events.

MESH has also established a host of professional working groups to address emergency preparedness issues for vulnerable populations. The Sexual Assault and Domestic Violence Working Group, for example, works to ensure that health care organizations are able to detect and respond to domestic violence during emergency events, and that residential and non-residential Sexual Assault and Domestic Violence providers are able to continue perform essential functions during an emergency event. Similarly, the Maternal/Child Health Working Group works to ensure the needs of new and expectant mothers and their children are considered in the disaster planning process. This group, in coordination with providers at Riley Hospital for Children at Indiana University Health and Peyton Manning Children's hospital at St. Vincent, is currently developing a registry of Central Indiana home ventilator-dependent children, with the ultimate goal being to provide early warning during emergency events. This registry is the first of its kind in Indiana and is designed to engage patients and families in strategies that increase community resiliency by protecting access to electricity during natural weather events. Weather-related power outages are common in Indiana and loss of electricity can be catastrophic to these patients and their families.

Beyond facilitating regular working groups, we also recognize that the health care response in Central Indiana is critical to both Regional and State-wide response. By working together with the Marion County Public Health Department and the Indiana State Department of Health to plan for seasonal flu outbreaks and emerging threats such as the Middle East Respiratory Syndrome Coronavirus (MERS CoV) and the Avian Influenza A virus, we have helped the Central Indiana health care community maintain necessary readiness to respond to all types of biological hazards, whether they are naturally occurring or an act of terrorism.

We have also taken a leadership role in wider community-planning efforts. For example, in 2011 we designed, coordinated, and executed the first full-scale exercise between the City of Indianapolis and the Central Indiana health care community, which focused on testing portions of the downtown Indianapolis Evacuation Plan, and have also worked with local, State, and Federal partners to plan for terrorist incidents by participating in the Joint Counterterrorism Awareness Workshop Series.

Policy Analysis

Health care systems are in the business of taking care of patients and saving lives, not necessarily responding to disasters. Moreover, they generally do not have the resources to address the policy, legal, and regulatory issues associated with emergency events. The MESH Coalition is a resource for our partners because we can provide objective analyses of the most pressing disaster-related policy issues facing Coalition partners. This analytical work supports our mission to enable health care providers to respond effectively to emergency events and, importantly, remain viable through recovery. In other words, we help our coalition partners to think not only about responding to disasters, but also to plan for long-term sustainability following an emergency event.

Revenue cycle protection is a considerable factor in ensuring the availability of health care during and after an emergency event. In a large-scale emergency, care may be administered at Alternate Care Sites—substitute locations that serve to ex-

pand the capacity of a hospital or community to accommodate or care for patients. Given the limited scope of FEMA public assistance grants, reimbursement through Federal Health Care Programs such as Medicare and Medicaid is critical to a hospital's financial viability when care is provided in an alternate location. However, depending on State licensure rules, these Alternate Care Sites may operate outside of the scope of the hospital's existing license, creating compliance issues, which may jeopardize reimbursement.

Several States have developed solutions that allow hospitals to establish an Alternate Care Site without jeopardizing reimbursement. For example, the Arizona Department of Health Services permits hospitals to provide off-site services without a separate license during a public health emergency declared by the Governor. In North Carolina, at the request of the State Emergency Management Agency the Division of Health Service Regulation can waive rules for hospitals providing temporary services during a declared emergency. In Texas, the law exempts temporary emergency clinics in disaster areas from licensure requirements.

In addition to these statutory solutions, many State departments of health are granted broad waiver authority during emergencies. For example, the New Jersey Department of Health has the authority to waive hospital-licensing rules upon determining that compliance would create a hardship for the hospital and that the exception would not adversely affect patients. We in Indiana, on the other hand, have no mechanism for waiving hospital licensure requirements. As such, MESH is actively working with the Indiana State Department of Health to ensure that safe and effective health care can be provided in an Alternate Care Site, while at the same time enabling hospitals to receive reimbursement for their services and thereby protecting the long-term viability of our health care infrastructure following a large-scale emergency event.

It is also important that clinicians and policymakers understand the nuances of what the Institute of Medicine has come to refer to as "crisis standards of care," or the optimal level of care that can be delivered during a disaster. Clearly, this complex issue has far-reaching implications in terms of one's ethical responsibility and legal liability. Even during an emergency event, victims are entitled to expect reasonable care under the circumstances. The ISDH has taken a leadership role on this issue by providing guidance for providers on how to develop consistent procedures for allocation of scarce resources in the event of an officially-declared public health emergency, in addition to recommending an ethical framework and clinical algorithms. MESH Coalition staff have also sought to protect individuals' rights to reasonable care, and support effective health care response, by effectively explaining this issue to health care providers both locally and Nationally.

Clinical Education and Training

Locally, one of MESH's most important contributions to Central Indiana is the clinical education and training we provide to a wide array of stakeholders. While traditional health care emergency management education and training programs have focused on emergency management core-knowledge such as the Incident Command System (ICS), evidence from mass casualty and disaster events demonstrates that effective health care response requires—first and foremost—well-trained clinical providers who are able to make good decisions under tough conditions. As a result, we have developed and implemented courses in emergency response and clinical decision making that are hands-on, practical, and utilize high-fidelity simulation to prepare providers to respond to all-hazards scenarios. To date we have trained thousands of responders, including physicians, nurses, EMTs, Paramedics, police officers, firemen, and members of the public.

The benefit of courses being developed and conducted by the MESH Coalition is that we are capable of reaching a wider range of participants than any single organization, and we are able to provide centralized resources, thereby lowering per-unit costs. Group offerings such as Simple Triage and Rapid Treatment (START) training, mass casualty exercises, limited-resource emergency care courses, and operational hazardous materials training also give participants from different health care organizations the experience of learning together. This method creates consistency between and among providers, which in turn leads to a uniformity of response during an emergency event. In addition, we offer regular Continuity of Operations planning workshops, Emergency Operations Planning workshops, and crisis communications workshops to partner organizations in order to further build our community's response capacity.

To facilitate learning opportunities from around the world, we also coordinate an annual Grand Rounds series that brings National and international experts in health care emergency response to Indianapolis to present cutting-edge ideas and programs. These events are free, open to the public and, through our partners at

the Indiana University School of Medicine, eligible for Continuing Medical Education and Continuing Education Units at no cost to attendees. The 2012–2013 Grand Rounds series included presentations on Continuity of Operations Planning by Dr. Paul Kim, M.D., who is the director of incident management integration for the National security staff in the White House, and on Denver's mass casualty emergency response to the Aurora Colorado theater shootings by Christopher Colwell, M.D., who is the chief of emergency medicine at Denver Health.

In addition to our group trainings and Grand Rounds, we have a strong commitment to clinical education, as evidenced by our multi-disciplinary internships and fellowships. Each year we provide opportunities for physicians, nursing students, public health graduate students, law students, and librarians to learn from a team of dedicated professionals and gain valuable experience in health care emergency management. In 2012, MESH collaborated with the Indiana University School of Medicine to create a Disaster Medicine Fellowship. The fellowship just welcomed its first fellow, who will spend time this year travelling with our executive staff to Monrovia, Liberia, where they will help that community's largest hospital redesign its emergency department and help build the hospital's emergency management plan. Concurrently, we will have an opportunity to learn from hospital and community leaders about how they have maintained health care resilience through significant social crises. This experience will no doubt provide valuable strategies that can be implemented in our own community and further enable us to better respond in situations where resources are limited.

THE PATH FORWARD

As previously noted, we are extremely proud of the vision our Central Indiana partners have had in the development the MESH Coalition. We are also convinced that the future of health care emergency preparedness is directly tied to the development of public-private health care coalitions such as ours. The U.S. Department of Health and Human Services has also acknowledged this future by requiring Hospital Preparedness Program and Public Health Emergency Preparedness grant program grantees to form strong and resilient coalitions.

We are helping to promote "coalition building" through our partnership with the Northwest Healthcare Response Network in Seattle and the Northern Virginia Hospital Alliance in the Capital Region and Virginia. This partnership, the National Healthcare Coalition Resource Center (NHCRC), is sponsoring an annual National Healthcare Coalition Preparedness Conference, and is available to provide technical assistance and training opportunities to assist communities in meeting their grant deliverables to develop functional health care coalitions.

However, there are challenges associated with the current funding mechanism and, as stewards of public resources, we must be creative about incentivizing the development of health care coalitions, funded in part by the private health care sector. This does not mean, however, that there is no role for Federal support. While grant funding is not, in and of itself, a sustainable solution to protecting and preserving public health and safety, private-sector health care should not be solely responsible for preparing and responding to issues of National significance. For example, in preparing to respond to CBRNE mass-casualty events, many of which would constitute acts of war against the United States, the Federal Government must remain a strong funding partner. Hospitals cannot, and should not, be expected to shoulder this burden alone. Hospitals deserve a predictable way to manage the expense of providing care during an emergency event. Indeed, the coalition model must continue to be a strong public-private partnership, and not become a private-private partnership.

Chairman Brooks, Senator Donnelly, Congresswoman Walorski, Congressman Young, and staff of the subcommittee, on behalf of the MESH Coalition, I thank you for the opportunity to provide testimony on our efforts to prepare Central Indiana to respond to a mass casualty event. We are thrilled to be included today, and hope that you will continue to advocate for proven, cost-effective best practices in health care emergency response. We also hope that our experiences will provide insight for coalitions across the country. Finally, we look forward to working with you to creatively incentivize private-sector participation in health care preparedness.

Thank you again for your leadership on this important topic; I am happy to respond to any questions my might have.

Mrs. BROOKS. Thank you, Mr. Priest.

The Chairwoman now recognizes Dr. Caine to testify for 5 minutes.

STATEMENT OF VIRGINIA A. CAINE, DIRECTOR, PUBLIC HEALTH ADMINISTRATION, MARION COUNTY PUBLIC HEALTH DEPARTMENT

Dr. CAINE. Thank you. Good morning, Chairman Brooks, Senator Donnelly, and Congresswoman Walorski; and our hosts, Mayor Brainard and County Commissioner Christine Altman. I would like to thank you for the opportunity to come here today to discuss our efforts to prepare for a mass casualty event in Marion County. I hope this is the first of many opportunities to work with the subcommittee.

The Marion County Public Health Department is responsible for the Emergency Support Function 8, which functions in a National response framework, which means that the health department is not only responsible for the public health but the medical care needs of the entire population of Marion County during an emergency event. This can include anything from medical treatment to providing clean drinking water and sanitation. In addition, the health department is also responsible for coordinating Emergency Support Function 11 activities, which identifies food, water, our ice needs, and temporary shelters for animals in the aftermath of an emergency.

One of our most important responsibilities, though, is protection against chemical, biological, nuclear, radiological, and high-yield explosive threats. To monitor and respond to these threats, the health department operates an environmental emergency response team which collaborates with our local and State partners, which includes the Indianapolis Fire Department, the Hazardous Materials Team, the Indiana Department of Homeland Security, and the Indiana State Department of Health. Because of this team, Central Indiana maintains an excellent state of readiness.

We are also responsible for coordinating the U.S. Department of Homeland Security's Bio-Watch Program. In partnership with the Indiana Departments of Environmental Management and Health, the Indianapolis Metropolitan Police Department, the Indiana Department of Homeland Security, Hamilton County Health Department, the U.S. Army Civil Support Team, and the FBI, we do daily monitoring for the potential of airborne bioterrorism threats which occur.

So, one of the things that we responded to was a suspicious powder, including a recent incident at Riley Children's Hospital at Indiana University Health. We are the only health department's environmental emergency response team, the only team in Indiana, that keeps a ready supply of appropriate test kits to detect ricin, as well as anthrax, botulism toxin, and poxvirus. While these kits are very costly to maintain, we have made our capabilities a priority, and we believe that the financial investments are necessary to be able to respond to any events that occur.

This proved to be a valuable investment because last year, when letters containing ricin were being mailed across the country, we were the only public health department in the State of Indiana with the ability to test for ricin.

Another important function for Marion County is that during a biological threat event, we run the point-of-dispensing system. We are responsible for delivering critical medications and vaccinations

from either the strategic National stockpile or the State strategic stockpile to the citizens of Marion County.

We routinely work with our collaborating counties that are part of the District V hospital and public health department's programs collaboratively, doing training exercises, and our best demonstration was the Super Bowl, where we worked with the FBI, the Environmental Protection Agency, and other Federal agencies in supporting this event.

We maintain a volunteer medical reserve corps.

Last, I just want to say that Marion County has a population of nearly 1 million people, approximately one-sixth the State of Indiana. One of our essential stints is our public-private partnership with our health care providers. And not only the hospitals; we work with community health centers, urgent care facilities, dialysis centers, social workers, psychologists, to build up a great health care sector in Central Indiana.

One of our key partners is Wishard Health Services. It is a safety-net hospital in Central Indiana. It is one of only two Level I trauma centers in the city and routinely provides support to mass casualty events. They have a special obligation to vulnerable populations during and following disaster mass casualty events, and they take that responsibility seriously.

Shortly, they are going to move to a new facility, and they are going to have the opportunity to test its ability to evacuate an entire hospital and relocate patients, and they are going to do it by the incident command system.

So we are looking forward to it, and I want to thank the staff for giving us an opportunity to testify on our efforts to prepare Central Indiana for a mass casualty events. Thank you for your leadership and your emphasis on this important area of emergency preparedness. Thank you.

[The prepared statement of Dr. Caine follows:]

PREPARED STATEMENT OF VIRGINIA A. CAINE

Good morning Chairwoman Brooks, Senator Donnelly, Congressman Young, Congresswoman Walorski, and staff of the subcommittee. On behalf of the Marion County Public Health Department, I would like to thank you for the opportunity to come here today to discuss our efforts to prepare to respond to a mass casualty event in Marion County. I hope this is the first of many opportunities to work with this subcommittee.

Today I would like to share some of our response capabilities here in Marion County and emphasize the importance of building partnerships between the public and private sectors. Here in Central Indiana, we have built a truly unique health care coalition that allows the Health Department, Emergency Medical Services, and other public agencies to effectively collaborate and to work together with our private sector health care partners. We are prepared to respond to all hazards, whether natural disasters, disease outbreaks, terrorist threats, or weapons of mass destruction, because we have built a coalition that enables all partners to work together to respond.

THE HEALTH DEPARTMENT'S ROLE

The Marion County Public Health Department is responsible for Emergency Support Function (ESF) 8 functions under the National Response Framework, which means the health department is responsible for the public health and medical care needs of the entire population in Marion County during an emergency event. This can include everything from medical treatment to providing clean drinking water and sanitation. In addition, the health department is responsible for coordinating Emergency Support Function (ESF) 11 activities which entails identifying food,

water, and ice needs and temporary shelter for animals in the aftermath of an emergency.

One of the most important responsibilities of the Health Department is protection against chemical, biological, radiological, nuclear, and high-yield Explosive (CBRNE) threats. To monitor and respond to these threats, the Health Department operates an Environmental Emergency Response team that collaborates with local and State partners including the Indianapolis Fire Department Hazardous Materials (HazMat) team, the Indiana Department of Homeland Security, and the Indiana State Department of Health. This team plays a very important role, especially concerning our response to chemical and biological threats. Because of this team, Central Indiana maintains an excellent state of preparedness for chemical and biological threats.

Marion County Public Health Department is also responsible for the coordinating activities under the U.S. Department of Homeland Security's BioWatch program. In partnership with Indiana Departments of Environmental Management and Health, Indianapolis Metropolitan Police Department, Hamilton County Health Department, the U.S. Army Civil Support team and the FBI, daily monitoring for the potential of airborne bioterrorism threats occurs.

Our Environmental Emergency Response team responds in conjunction with the Indianapolis Fire Department HazMat team to secure, sample, and process hazardous or suspicious materials, especially when biological hazards are suspected. They respond to all incidents involving suspicious powders, including a recent incident at Riley Children's Hospital at Indiana University Health. Marion County Public Health Department's Environmental Emergency Response Team is the only team in Indiana that keeps a ready supply of appropriate test kits to detect ricin, as well as Anthrax, Botulinum toxin, and poxvirus. While these kits are very costly to maintain, we have made our CBRNE capabilities a priority and have made the financial investments necessary to be able to respond when these events occur. This proved to be a very valuable investment last year when letters containing ricin were being mailed around the country and we were the only Public Health Department in Indiana with the ability to test for ricin.

Another important function that the Marion County Public Health Department performs to protect our community during a biological threat event is to run the Point of Distribution (POD) system that would be responsible for delivering critical medications or vaccinations from either the strategic National stockpile or the State strategic stockpile to the citizens of Marion County. In addition to running these points of distribution, we would also maintain communications with the public to keep them informed of the biological threat and the best practices they can take to respond to that threat. We continuously plan and regularly conduct trainings and drills to ensure that we could effectively distribute vaccines and medication to protect the population of Central Indiana in the event of either a natural or a terrorist biological threat.

Because we have invested in a great team, which allows us to maintain a high level of preparation to respond to environmental emergencies, we are also called on to lend assistance and to be a resource beyond the borders of Marion County. We routinely work with the surrounding counties to provide mutual aid support, engage in collaborative planning, and participate in mutual training exercises with local, State, and Federal agencies so that we can be prepared across the entire Central Indiana Region. One of the best demonstrations of this collaborative spirit was evidenced in during the Super Bowl last year, where we maintained a 24-hour support team that worked with the FBI, the EPA, and other Federal agencies involved in supporting the event.

Marion County also collaborates to ensure that we have a resilient community by maintaining a volunteer Medical Reserve Corps. We keep an on-going registry of licensed medical providers who have the ability to serve in the event of a disaster or attack by a weapon of mass destruction, and we call upon these volunteer providers for assistance during emergency events. These providers include physicians and nurses to provide immediate medical attention, but we also go beyond the immediate medical needs to maintain a registry of volunteers who can treat the deeper health needs of the community, including social workers and psychologists. We recently had an opportunity to deploy some of these volunteers to assist the Central Indiana community when we responded to the home explosion in Richmond Hills. Our social workers and community psychologist partners worked together with us to help that community heal after dozens of people were evacuated from their homes in response to the explosion.

THE IMPORTANCE OF PUBLIC-PRIVATE PARTNERSHIPS

Marion County has a population of nearly 1 million people, or approximately one-sixth of the population of the entire State of Indiana. When you include the population of the surrounding counties of Central Indiana whose residents are not technically a part of our service area, but who frequently utilize hospitals and other care providers within Marion County, health care facilities in Marion County could be asked to service the medical needs of up to 1.7 million people. The majority of all health care emergency response needs would have to be met by private-sector providers. One of the things we realized early on was the critical importance of working together with the private sector to plan for major disasters or weapons of mass destruction.

In order for the Health Department to effectively perform its ESF–8 functions, we also determined that it was essential to form strong partnerships between and amongst the private hospitals, as well as with local public safety partners who would be able to facilitate appropriate responses to emergency events. In order to bring about this capability, we collaborated to form a non-profit health care coalition, the MESH Coalition. MESH is an organization that helps health care providers, who are competitors in regular business, work together with the Health Department, public safety agencies, and other private-sector organizations to prepare and respond to treats in Central Indiana. No other city has the kind of partnership between public agencies and the private health care sector that we have formed here in Marion County.

Our spirit of partnership with private-sector health care providers is not limited to hospitals, but also extends to the other health care facilities within the county. We partner with dozens of other provider organizations, including community health centers, urgent care facilities, dialysis centers, social workers, and psychologists to built preparation throughout the health care sector in Central Indiana. One of our key partners is Wishard Health Services. It is the safety net hospital in Central Indiana. Wishard is one of only two Level 1 Trauma Centers in the city, and routinely provides support to mass casualty events. They have a dedicated vice president-level executive who is responsible for emergency management issues. Wishard has a special obligation to vulnerable populations during and following disaster/mass-casualty events and takes that responsibility seriously—leading to innovation in outreach and disaster management for these patients. They will shortly be moving to a new facility, in which it will have the opportunity to test its ability to evacuate an entire hospital and relocate patients. Wishard will use emergency management principles, including the Incident Command System (ICS) to organize the move. Wishard houses/hosts MESH, and was an early founding member of the coalition. Our philosophy is that to develop a prepared community, a community which can be resilient in responding to and recovering from a public health crisis, you must first build a healthy community. A healthy community foundation is required in order to respond to a natural disaster or terrorist situation, which means that people in that community must have access good quality health care, a strong social support fabric, and the public resources they need to address a crisis situation.

Chairwoman Brooks, Senator Donnelly, Congressman Young, Congresswoman Walorski, and staff of the subcommittee, I would like to thank you for the opportunity to testify today on our efforts to prepare Central Indiana for a mass casualty event. I would also hope that our the accomplishments we have made in building a public-private health care coalition are something that other cities can benefit from to improve their health care systems' ability to respond emergencies.

Again, thank you for your leadership and your emphasis on the importance of emergency preparedness.

Mrs. BROOKS. Thank you so much, Dr. Caine.

I now call on Dr. Profeta to testify for 5 minutes.

STATEMENT OF LOUIS M. PROFETA, M.D., F.A.C.E.P., MEDICAL DIRECTOR OF DISASTER PREPAREDNESS, ST. VINCENT HOSPITAL, INDIANAPOLIS, INDIANA

Dr. PROFETA. Chairwoman Brooks, Senator Donnelly, Representative Walorski, thank you for allowing me the opportunity to come speak here and for taking an interest in this very important topic.

The development of pre-hospital and emergency management of victims of mass casualty disasters arose in the mid-19th Century in the United States to address the needs of wounded soldiers in

battle. This concept continued to grow with the birth of municipal and hospital-based ambulance services, followed by the development of emergency medicine services in the mid-1950s.

In the infancy of development of EMS and emergency medicine and emergency systems, Indianapolis experienced one of the worst disasters in the 20th Century. On October 31, 1963, at the Indiana State Fairgrounds Coliseum during the opening night of the Holiday On Ice show, a gas leak explosion under the grandstands killed 74 people and resulted in 400 casualties. Fifty-four people were dead at the scene, 20 died in subsequent days, 165 people were admitted, and 209 were treated and discharged home.

Many sustained injuries as bad as, if not worse than, those that we saw in the Boston Marathon explosion because many of these people were killed in crush injuries and a subsequent fire that erupted within the Coliseum.

In 1963, there was no social media. There was no comprehensive mass casualty plan, no 24-hour news, no sophisticated trauma centers. Indianapolis EMS had just started to use two-way radio communication to coordinate ambulance dispatch, but there was no practical means to triage and distribute mass casualty patients throughout the city.

In this case, in this instance, the dying were evacuated from the burning Coliseum. They were pulled into a nearby cattle barn, and a major attempt was made to transport and triage this huge number of casualties. St. Vincent's Hospital alone saw well over 100 patients from this disaster, with more than 50 needing to be admitted, and most requiring surgical intervention. Nearly all of the 400 casualties arrived at local emergency departments in less than 2 hours, and most within 30 minutes. In fact, the first patient showed up at St. Vincent's Hospital, and that is how St. Vincent's found out about the explosion, because he showed up with bad injuries and said, hey, the Coliseum just exploded.

What is remarkable is that the injury patterns that we saw in the Coliseum explosion were very similar to those that we would expect in a suicide bomb attack in Israel, and also what we saw in Boston. St. Vincent's Hospital's prevailing disaster plan was developed from our knowledge and our reflection on these past tragedies. At St. Vincent's Hospital, we have modeled our mass casualty strategy, including emergency department mobilization staging, on the tactics and the procedures followed by several Israeli hospitals and military. Israeli expertise is considered second-to-none in organizing hospitals' methods of response to a mass casualty incident.

Specifically, we studied the strategies utilized by the Western Galilee Hospital in Northern Israel, as well as Magen David Adom, which is the Israeli version of the American Red Cross, to respond to acts of terror. Their emergency processes are predicated on speed, simplicity, reproducibility, and security.

At St. Vincent's Hospital, in the event of a multi-casualty incident, we begin by evacuating our entire emergency department and mobilizing all of our patient cots to the turnaround entrance to the emergency department to facilitate and allow easy off-loading of EMS patients.

Next, a seasoned emergency physician triages curbside so that we can send those valuable ambulances and paramedics back out

onto the street with little to no delay. In fact, we can do this within 2 to 3 minutes, have those people back out on the streets and taking care of more casualty victims. We believe our system would function very well in a Boston-type event, but we also believe it would operate expertly in a Coliseum-magnitude explosion.

Certainly, the disaster response in the Boston Marathon was well-organized, it was well-coordinated, it was well-planned, but it occurred in the middle of a situation where you were near seven of the finest medical centers in the world and where you already had 200 EMS providers, medical tents, and support personnel staged at the location near or around the event.

Some years ago, following September 11, St. Vincent's Hospital reviewed the injury pattern data from prior Israeli suicide studies and structured our emergency department's disaster response based on those studies. For example, if there are 100 victims in a suicide bombing, we can expect that 18 to 20 percent are going to die at the scene, 6 percent are going to need emergency intubation in our department, 5 percent are going to need chest tubes, 12 to 18 percent will require immediate surgery, and 8 percent are going to require laparotomies. In addition, 35 to 40 percent of those patients are going to require admission to the hospital, and the rest will be considered walking wounded.

Therefore, in the face of a large casualty, St. Vincent's emergency department can be confident in saying we can take 100 patients because we already know what we are getting. There is no need for an extensive, multilayered, mobile command center running interference. In fact, Boston was lucky when compared to other suicide bombing instances such as the Park Hotel bombing in 2002 in Israel. They actually had less fatalities and less serious injuries than what we really should have expected in an event like that.

On a yearly or biannual basis, St. Vincent's experiences events that cause patient surgeons in our emergency department. They largely go unnoticed because they don't involve a bomb and they don't involve a novel organism. Certainly, there have been significant pan-flu epidemics with H1N1 at a time when these have overwhelmed our emergency department in terms of volume but not in terms of acuity. In other words, we have a lot of patients, but they are really not that sick.

Because of the lack of high acuity in surgeries such as these, the ED can easily accommodate these extra patients without a huge strain on the system. However, the last couple of years we have seen weather events, ice storms in particular, that have resulted in surges where the average patient volumes in some of our emergency departments were 100 patients greater than what we might typically see in a 24-hour period of time, and most of those people came within a 12-hour window. Many of them had serious fractures, head injuries. Some of those people even died, especially our elderly who were on concomitant blood thinners.

Statistics actually show that in a city the size of Indianapolis, we are going to see 1,000 injuries that require emergency department visits on every single day of significant ice accumulation, and we handle those completely fine, all the hospitals do, without a whole lot of attention from the media.

In closing, as a community and as a State, we have certainly come a long way in regards to preparedness since the 1963 Coliseum events, and an increase in terrorist-type attacks have drawn disaster preparedness into the spotlight. New organizational structures such as the Indiana Emergency Management Agency Field Services Division, MESH, have sprung up to help coordinate when disasters strike. The reality, however, is that we have made very little improvement to disaster coordination and communication when these events actually occur, and we have made very little advancement in communication and coordination since 1963.

This can be illustrated in the recent bus mass casualty event that occurred on July 27. The first responder efforts were amazing. The EMS efforts were amazing. But there certainly was a breakdown in communication, both externally and internally, that led to an emergency department only 4 miles away from this mass casualty event completely mobilized, completely evacuated, only to get two patients from this event. So certainly those are issues that we need to address, again both internally and externally.

We have to place a greater emphasis and expect more Federal support for advanced communications in time of disaster. As hospital systems, we have to adopt the attitude that united we stand and divided we fall. I want to thank you for the opportunity to speak here today.

[The prepared statement of Dr. Profeta follows:]

PREPARED STATEMENT OF LOUIS M. PROFETA

AUG. 6, 2013

The development of pre-hospital and emergency management of victims of mass casualty disasters arose in the mid-19th Century in the United States to address the needs of wounded soldiers in battle.[1] This concept continued to grow with the birth of municipal and hospital-based ambulance services, followed by the development of emergency medical services in the mid-1950s.[1]

In the infancy of the development of EMS and emergency medicine, Indianapolis experienced one of its worst disasters in the 20th Century. On October 31 in 1963 at the Indiana State Fairgrounds Coliseum during the opening night of the Holiday on Ice show, a gas leak explosion under the grand stands killed 74 people and resulted in nearly 400 casualties.[2 3] Fifty-four people were dead at the scene and 20 died in subsequent days; 165 people were admitted and 209 were treated and discharged home.[2 3] Many sustained injuries as bad if not worse than those in the recent Boston Marathon bombing because the explosion was also accompanied by fire. Most of the victims who died immediately were either crushed or severely burned.[3]

In 1963 there was no social media, no comprehensive mass casualty plan, no 24-hour news, no sophisticated trauma centers. Indianapolis EMS had just begun to use two-way radio communication to coordinate ambulance dispatch, but there was no practical means to distribute and triage mass casualty patients throughout the city.[4] In this case, the dying were evacuated from the burning Coliseum, pulled into a nearby cattle barn and an attempt was made to prioritize for transport to local hospitals.[2 5] The vast majority of victims self-transported.[5]

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[1] Blackwell, Tom, MD, FACEP. "Prehospital Care of the Adult Trauma Patient." *Up to Date.* Up to Date, 29 May 2013. Web. 31 July 2013.

[2] "RetroIndy: The 1963 Coliseum Explosion." *Indianapolis Star.* N.p., 17 Apr. 2013. Web. 31 July 2013.

[3] "Coliseum Explosion." Coliseum Explosion. *Indianapolis Star,* 10 July 2001. Web. 31 July 2013.

[4] "Indianapolis EMS to Mark 125 Years of Service Indianapolis EMS." *Indianapolis EMS to Mark 125 Years of Service Indianapolis EMS.* Indianapolis Department of Public Safety, 17 May 2013. Web. 31 July 2013.

[5] Drabek, Thomas. "DISASTER IN AISLE 13 REVISITED." *DISASTER IN AISLE 13 REVISITED.* N.p., 18 May 1995. Web. 31 July 2013.

St. Vincent Hospital alone saw well over 100 patients from this disaster, with more than 50 needing admission and most requiring surgical intervention. Nearly all of the 400 casualties arrived at local emergency departments in less than 2 hours and most within 30 minutes.[5] Surprisingly, the injury patterns, morbidity, and mortality of the casualties sustained that day are remarkably similar to those sustained by both suicide bombing victims in the Middle East, as well those injured in the Boston Marathon bombing. St. Vincent Hospital's prevailing disaster plan has developed from our knowledge of and reflection on these past tragedies.

At St. Vincent Hospital, we have modeled our mass casualty strategies, including emergency department (ED) mobilization and staging, on the tactics and procedures followed by several Israeli hospitals and military. Israeli expertise is considered second-to-none in organizing hospitals' methods of response to a multiple casualty incident (MCI).[6] Specifically, we have studied strategies utilized by the Western Galilee Hospital in Northern Israel, as well as the Magen David Adom (the Israeli version of the Red Cross), to respond to acts of terror. Their emergency processes are predicated on speed, simplicity, reproducibility, and security.[7]

At St. Vincent Hospital, in the event of a multi-casualty incident, we begin by evacuating our entire emergency department (ED) and mobilizing all of our patient cots to the driveway at the entrance to the ED to allow easy offload of EMS patients. Next, a seasoned emergency physician triages curbside, so that we can send ambulances back out with little to no delay in the transfer of other injured. This procedure allows EMS vehicles and personnel to be back out on the streets and in service within 2–3 minutes of arrival to the ED.

We believe our system would function very well in a Boston-type event, but we also believe it would operate expertly in a Coliseum-type explosion as well. Certainly, the disaster response to the Boston Marathon bombing was well-organized, well-coordinated, and well-planned.[8] Fortuitously, this multi-casualty incident occurred in a location near seven of the finest hospitals and medical centers in the world. In addition there were already more than 200 EMS providers on-scene with medical tents and equipment on-hand.[8]

Some years following the September 11 attacks, St. Vincent Hospital reviewed the injury pattern data from prior Israeli suicide bombing studies and structured our emergency department's disaster response based on those studies. For example, if there are 100 victims in a suicide bombing, we can expect 18–20% to die at the scene, 6% to need emergency intubation in the ED, 5% to need chest tubes, 12–18% to require immediate surgery, and an additional 8% to require laparotomies. In addition, 35–40% of the victims will need to be admitted; the remainder of the patients will be walking wounded.

Therefore, in the face of a large casualty incident, St. Vincent ED can be confident in saying, "we can take 100 patients" because we already know what we are getting. There is no need for an extensive, multi-layered mobile command center running interference. In fact, Boston was lucky when compared to similar events such as the Park Hotel bombing in 2002 in Netanya, Israel; statistics show that many more people could have been killed at the scene in Boston.[9]

On a yearly or biennial basis, St. Vincent experiences events that cause patient surge issues in our ED. These events may largely go unnoticed because they do not involve an explosion or a novel organism. Certainly there have been significant panflu epidemics with H1N1 and these at times have overwhelmed the ED in terms of volume but not in acuity. In other words, the ED may see a lot of patients who are not really that sick. Because of the lack of high acuity in surges such as these, the ED accommodates the extra patients without a huge strain on the system.

However in the last couple years, a few weather events (ice storms) have resulted in surges where average patient volumes in some of our EDs were 100 patients more than average over a 24-hour period with most of that surge showing up in a 12-hour window. In addition, in one of those events, a large percentage of patients had serious fractures and head trauma, which required significant resources and often admission. In fact, statistics show you can expect 1,000 emergency injury vis-

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[6] Leichman, Abigail Klein. "The Israeli Sharing His Mass Casualty Expertise in Boston." *ISRAEL21c.* N.p., 24 Apr. 2013. Web. 31 July 2013.

[7] "Preparing for Emergencies: A SPECIAL MEETING OF THE RED CROSS WITH MDA ISRAEL." *MDA ISRAEL.* N.p., 25 July 2013. Web. 31 July 2013.

[8] Krisberg, Kim. "Preparedness Paid Off in Boston Marathon Bombing Response." *JEMS.com.* Journal of Emergency Medical Services, 1 July 2013. Web. 31 July 2013.

[9] "Passover Suicide Bombing at Park Hotel in Netanya-27-Mar-2002." *GxMSDev.* Israeli Ministry of Foreign Affairs, 27 Mar. 2002. Web. 31 July 2013.

its per day in a city the size of Indianapolis for each and every day of significant ice accumulation.[10]

In closing, as a community and as a State, we have certainly come a long way in regards to preparedness since the 1963 Coliseum explosion. An increase in terrorist-type attacks has drawn disaster preparedness into the spotlight. New organizational structure such as the Indiana Emergency Management Agency and Field Services Divisions along with new organizations such as MESH have sprung-up to help coordinate events when disasters strike. The reality however, is that we have made very little improvements to disaster coordination and communication when these events actually occur and have made very little advancement in communication and coordination since 1963. This was perfectly illustrated in the recent bus crash mass casualty event that occurred on Saturday, July 27. St. Vincent Hospital and Trauma Center, the second-busiest trauma center in the State of Indiana only received two patients from a mass casualty event not more than 4 miles away. We were not only the closest hospital, we were the closest trauma center, and more than likely mobilized had the most organized disaster plan in the city, yet only received two patients from this tragedy. We must place a greater emphasis and expect more Federal support to advance communications in the time of a disaster. There is no place for territorial imperatives and imperialistic attitudes from individual hospitals and EMS agencies during a disaster response. As hospital systems, we must adopt the attitude that united we stand and divided we fail.

Mrs. BROOKS. Thank you, Dr. Profeta.

The Chairwoman now recognizes Dr. Knight for 5 minutes. Thank you.

STATEMENT OF H. CLIFTON KNIGHT, CHIEF MEDICAL OFFICER, COMMUNITY HEALTH NETWORK

Dr. KNIGHT. Good morning, Chairwoman Brooks, Senator Donnelly, Representative Walorski, and the staff of the subcommittee. On behalf of Community Health Network, we sincerely appreciate this opportunity to discuss Indiana's preparedness for a mass casualty event with you today. Your commitment and dedication to this important issue shows a proactive interest that we do sincerely appreciate.

My name is Cliff Knight. I am a family physician, and I am the chief medical and chief academic officer for Community Health Network. Today I want to provide you with some basic background information about our organization, our engagement with emergency preparedness efforts, and our concerns regarding being optimally prepared for the potential of catastrophic events in Central Indiana.

We are based in Indianapolis, and Community Health Network is a private, not-for-profit system consisting of six general acute hospitals, a cardiovascular-focused acute care hospital, a freestanding rehabilitation hospital, as well as hundreds of ambulatory sites of care, encompassing a full spectrum of both primary care services and subspecialty services. In addition, we provide extensive homecare-based services. We have approximately 13,000 employees and host 2 million patient encounters each year across all of our facilities.

Each of our acute care hospitals provides emergency services. Internally, we provide extensive educational programming for in-the-field emergency medical providers, and we meet or exceed all the standards of the Joint Commission related to emergency preparedness. To accomplish this, we train staff, we track supplies, and reg-

[10] "Work-Related Injuries Associated with Falls During Ice Storms." *Centers for Disease Control and Prevention.* Centers for Disease Control and Prevention, 15 Dec. 1995. Web. 31 July 2013.

ularly communicate with our teams regarding issues and trends of importance.

Throughout our facilities, we also perform drills using a variety of scenarios multiple times per year. Community has an emergency operations plan, as well as a surge plan. Utilizing resources throughout our district support structure, we are able to help support patient influx as necessary. As a district, we drill for severe patient influx on an annual basis at least.

In Indiana, we believe our greatest and most likely risks are related to natural disasters such as tornadoes and earthquakes. However, we take very seriously the plausibility of a terrorist-initiated disaster resulting in a surge in acute care needs. We aim to be prepared in ways that accommodate the needs that would arise from a variety of causes.

Community Health Network actively participates in activities with the MESH Coalition, as well as the Indianapolis Coalition for Patient Safety. We found that both organizations uniquely are suited to support our efforts to coordinate and standardize approaches to issues common to all the hospitals in Indianapolis.

For example, our involvement in the Indianapolis Coalition for Patient Safety has resulted in our participation in city-wide efforts to standardize approaches to addressing influenza outbreaks, both H1N1 and seasonal, and the resulting surges in patient care.

Though we are confident in our preparedness for adequately responding to mass casualty situations, we strongly believe that there is more that can and should be done to optimally prepare. Our greatest fears are around our ability to quickly mobilize enough health care providers and staff in response to an emergent need. We, of course, have designated on-call personnel, but would need to mobilize additional resources quickly. We believe this can be accomplished through communication avenues utilizing standard methodologies—cell phones, text messages, social media, and public communications—but this is a theoretical given that communications may be interrupted in a large-scale event with widespread damage.

To address this, we urge continued focus on supporting redundancies and refinements in public communication infrastructure as a safeguard.

Another area of concern is related to the reality of funding for training and education of our personnel. As economic forces require us to function more efficiently, it becomes problematic to regularly remove providers and staff from their primary functions in order to free them up to focus on training and education.

In addition, our observation is that we need to be more fully involving hospitals and EMS providers in training and education. There seems to be a lack of funding to support this involvement for private hospitals and private EMS services.

In order to accomplish broader coordination and improved participation in preparation, Federal funding to support these efforts would be helpful.

Thank you all for this opportunity to provide a status report regarding our emergency preparedness in Central Indiana and for your commitment to improving our capabilities, and I look forward

to providing any other additional information for clarification or questions you may have.

[The prepared statement of Dr. Knight follows:]

PREPARED STATEMENT OF H. CLIFTON KNIGHT

AUGUST 6, 2013

Good morning Chairman Brooks, Senator Donnelly, Congresswoman Walorski, Congressman Young, and staff of the subcommittee. On behalf of Community Health Network, we appreciate this opportunity to discuss Central Indiana's preparedness for a mass casualty event with you today. Your commitment and dedication to this important issue shows proactive interest that we sincerely appreciate.

Today, I plan to provide you with some basic background information about our organization, our engagement in emergency preparedness efforts, and our concerns regarding being optimally prepared for the potential of catastrophic events in Central Indiana.

COMMUNITY HEALTH NETWORK

Based in Indianapolis, Community Health Network is a private, not-for-profit system consisting of 6 general acute care hospitals, a cardiovascular-focused acute care hospital, and a free-standing rehabilitation hospital as well as hundreds of ambulatory sites of care encompassing a full spectrum of primary care and sub-specialty services. In addition, we provide extensive home-based services. We have 13,000 employees and experience 2,000,000 patient encounters each year.

EMERGENCY PREPAREDNESS ENGAGEMENT

Each of our acute care hospitals provides emergency services. Internally, we provide extensive educational programming for in-the-field emergency medical providers. We meet or exceed all standards of The Joint Commission related to emergency preparedness. To accomplish this, we train staff, track supplies, and regularly communicate with our teams regarding issues and trends of importance. Throughout our facilities, we also perform drills using a variety of scenarios multiple times per year. Community has an Emergency Operations Plan as well as a surge plan. Utilizing resources through our district support structure, we are able to help support patient influx as necessary. As a district, we drill for severe patient influx at least annually.

In Indiana, we believe our greatest and most likely risks are related to natural disasters such as tornadoes and earthquakes. However, we take very seriously the plausibility of a terrorist-initiated disaster resulting in a surge in acute care needs. We aim to be prepared in ways that accommodate the needs that would arise from a variety of causes.

Community Health Network actively participates in activities with the Managed Emergency Surge in Healthcare (MESH) Coalition as well as the Indianapolis Coalition for Patient Safety (ICPS). We have found both organizations uniquely suited to support our efforts to coordinate and standardize approaches to issues common to all hospitals in Indianapolis. For example, our involvement in the ICPS has resulted in our participation in city-wide efforts to standardize approaches to addressing influenza outbreaks (both H1N1 and seasonal) and the resulting patient surges.

NEEDS ASSESSMENT

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functions in order to focus on training and education. In addition, our observation is that we need to more fully involve all hospitals and EMS providers in training and education. There seems to be a lack of funding to support this involvement for private hospitals and private EMS services. In order to accomplish broader coordination and improved preparation, Federal funding to support these efforts would be helpful.

Thank you all for this opportunity to provide a status report regarding emergency preparedness in Central Indiana and for your commitment to improving our capabilities. I look forward to providing any additional information or clarifications that may be helpful.

Mrs. BROOKS. Thank you, Dr. Knight.

The Chairwoman now recognizes Dr. Reed to testify.

STATEMENT OF R. LAWRENCE REED, II, M.D., F.A.C.S., F.C.C., DIRECTOR OF TRAUMA SERVICES, INDIANA UNIVERSITY HEALTH METHODIST HOSPITAL

Dr. REED. Thank you, Chairwoman Brooks, Senator Donnelly, and Congresswoman Walorski. Thank you for the opportunity to discuss this very critical task. Put very simply, preparedness saves lives. IU Health has a proven history in treating the unexpected, the complex, and the unique, and does so with the highest standard of patient quality care and outcomes.

Our work is, by its very nature, frenetic, yet requires precision. No two cases are the same. Yet, we remain fully prepared and ready for events that no one wants to acknowledge could happen, let alone see. It is like having an army primed and ready for a battle you hope you will never have to fight.

IU Health is home to two of only three Level I trauma centers in Indiana. IU Health Methodist is a verified Level I trauma facility. Wishard-Eskenazi is the other Level I trauma facility in Indiana, and Riley Hospital for Children at IU Health is the State's only pediatric Level I trauma center. This verification comes with immense responsibility and unparalleled dedication. We strive continually to refine, hone, and improve our efforts. Being a Level I trauma center means we have highly-skilled medical talent immediately available on-site 24/7, two trauma surgeons in-house, around the clock, a full emergency medical team, including emergency physicians and nurses, neurosurgeons, orthopedic surgeons, anesthesiologists, critical care specialists and hospitals, all on-site, day or night, ready to provide immediate specialized care before patients—tens, hundreds, or thousands—even hit our doors.

We have the resources at Methodist. We have 35 operating rooms, a fully-stocked blood bank and critical supplies. The IU Health system includes our lifeline fleet of critical care transport comprised of six helicopters and five bases throughout Indiana. Senior administrators throughout the State are on call 24/7 with the infrastructure and ability to immediately call in or send out support to and from sister facilities.

In the more than 100 years of Methodist history, we have never gone on diversion for trauma or emergency service, which is unusual for a private hospital.

Although surge management starts at the scene of an accident, we have elaborate plans in place at the hospital and emergency department should patients show up at our doors unannounced. A 24/7 on-duty team is constantly assessing patient flow and care, and by virtue of being a large hospital with coverage by multiple

specialties and resources that many hospitals don't have, we have experience with the cases that others can't treat.

Indianapolis is home to major activities, teams, and events, and IU Health plays a major role in supporting most of these. IU Health is the exclusive provider to the Indianapolis Motor Speedway and Lucas Oil Stadium, among others, where we care for thousands of fans each season. Indianapolis hosts sizable events, including the State Fair, the Super Bowl, the NCAA Final Four basketball tournaments, big-name concerts, and numerous conventions. Emergency preparedness is integral to the planning and success of them all. We have a seat at the table in the advanced planning for these major public events and embrace our leadership responsibilities.

But, IU Health cannot do this alone. We are proud to be part of a larger community with established emergency preparedness systems and dedication to the charge. This is where you see the community at its best, as public and private-sector resources unite to address and plan emergency preparedness. Planning and innovation has come more to the forefront for the city and State, as well as local agencies, to work with them, hospitals, and Government to prepare for the event of a mass casualty, be it a natural disaster, weapons of mass destruction, or other. We share a goal and collaborate rather than compete.

MESH has been a valuable partner in leading preparedness efforts and sharing intelligence and extending their expertise, and we are fortunate to have a National leader and partner based here in Central Indiana. IU Health is fully committed to supporting the private-sector requirements of this partnership in hopes that the funding needed for the public effort remains in place. IU Health regularly hosts hazard vulnerability assessments, preparedness drills, and shares best practices with others in the community.

After any major U.S. incident, local or National, we are privy to an after-action report and gap analysis which we can use to further refine our plans. IU Health is in constant communication with MESH, other hospitals, and partners in immediate District V and throughout the State, all with the united goal of being prepared to offer the best unexpected medical care to patients.

Just last week, or actually 2 weeks ago, we treated an influx of patients we received from an overturned bus accident that involved three fatalities. We reattached a severed hand, which can be the difference between a fairly normal life and one of inconvenience and extreme handicap.

Following the 2011 State Fair stage collapse, before we could even call in additional resources to prepare for the arrival of many injured patients simultaneously, our staff members were already reporting for new and unexpected work on a Saturday night without even being called. We did not have to activate our disaster plan. Our team knew they would be needed and responded immediately. It was an impressive showing of dedication and commitment and of typical Hoosier values as we handled a serious community emergency seamlessly. Other hospitals in Indianapolis—Wishard-Eskenazi, Riley at IU Health, St. Vincent's—also helped manage several of these victims. Because of our proximity and our resources, the worst injuries came to IU Health Methodist.

IU Health uses its size and scope to help further continuing education and build better relationships. IU Health recently held a training exercise at the IMS to educate first responders, increase standards of care, and build better relationships. We were able to present unique and complex cases of our Level I trauma team and better understood first responders' needs of being in the field.

IU Health is a key part of the Indianapolis and Indiana emergency network. We do things no other systems in the State can handle. We appreciate your interest and welcome your continuing support of our efforts to maintain readiness and serve fellow Hoosiers in time of crisis. Thank you.

[The prepared statement of Dr. Reed follows:]

PREPARED STATEMENT OF R. LAWRENCE REED, II

AUGUST 6, 2013

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We have the resources: 35 operating rooms; a fully-stocked blood bank and critical supplies; our LifeLine fleet of critical care transport, comprised of six helicopters and five bases throughout Indiana; senior administrators throughout the State on-call 24/7 with the infrastructure and ability to immediately call in, or send out, support from sister facilities. In the more than 100 years of Methodist history, we have never gone on diversion for trauma or emergency services, which is very unusual for a private hospital.

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But IU Health cannot do this alone. We are proud to be a part of a larger community with an established emergency preparedness system and dedication to the charge. This is where you see the community at its best, as public and private-sector resources unite to address and plan emergency preparedness. Planning and innovation has come more to the forefront for the city and State as we work with local agencies, hospitals, and Government to prepare for the event of a mass casualty—

be it a natural disaster, WMD, or other. We share a goal and collaborate rather than compete.

MESH has been a valuable partner in leading preparedness efforts, in sharing intelligence and in extending their expertise, and we are fortunate to have a National leader and partner based here in Central Indiana. IU Health is fully committed to supporting the private-sector requirements of this partnership and hopes that the funding needed for the public efforts remains in place. IU Health regularly hosts hazard vulnerability assessments, preparedness drills, and shares best practices with others in the community. After any major U.S. incident, local or National, we are privy to an after-action report and gap analysis which we can use to further refine our plans. IU Health is in constant communication with MESH, other hospitals, and partners in our immediate District V and throughout the State—all with a united goal of being prepared to offer the best unexpected medical care to patients.

KEY LEARNINGS & WHAT IS WORKING WELL

Just last week we treated an influx of patients received from an overturned bus accident that involved several fatalities; we reattached a severed hand which can be the difference between a fairly normal life or one of inconvenient and extreme handicap. Following the 2011 State Fair stage collapse, before we could even call in additional resources to prepare for the arrival of many injured patients simultaneously, our staff members were already reporting for work on a Saturday night. We did not have to activate our disaster plan. Our team knew they would be needed and they responded immediately. It was an impressive showing of dedication and commitment . . . and of typical Hoosier values . . . as we handled a serious community emergency seamlessly. Other hospitals in Indianapolis—Wishard-Eskenazi, Riley at IU Health, St. Vincent's—also helped manage several of these victims. Because of proximity and our resources, the worst injuries came to Methodist.

IU Health uses its size and scope to help further continuing education and build better relationships. IU Health recently held a training exercise at the IMS to educate first responders, increase standards of care, and build better relationships. We were able to present unique and complex cases of our Level 1 Trauma team and better understand first responders' needs of being in the field.

IU Health is a key part of the Indianapolis and Indiana emergency network. We do things no other systems in the State can handle. We appreciate your interest and welcome your continuing support of our efforts to maintain readiness and serve fellow Hoosiers in times of crisis.

Mrs. BROOKS. Thank you, Dr. Reed.

The Chairwoman now recognizes Dr. Obeime to testify.

STATEMENT OF MERCY OBEIME, DIRECTOR, COMMUNITY AND GLOBAL HEALTH, FRANCISCAN ST. FRANCIS HEALTH, INDIANAPOLIS, INDIANA

Dr. OBEIME. Good afternoon, Congresswoman Brooks, Senator Donnelly, and Congresswoman Walorski. I have lived in District V and worked in District VII since 1996. I am here today representing Franciscan St. Francis Health to discuss the ability——

Mrs. BROOKS. Excuse me. Could you pull the mic a bit closer to you? Thank you.

Dr. OBEIME. Sorry. I am here today representing Franciscan St. Francis Health to discuss the ability of the Central Indiana community to respond to a mass casualty event. I am also here accompanied by Diana Leonard, our full-time disaster management coordinator. She is responsible for our three Central Indiana hospitals and serves as a liaison to community response partners, as well as ensures organizational preparedness through planning and training.

Franciscan St. Francis Health is one of the largest health care providers in Indiana, with campuses in Carmel, Indianapolis, and Morrisville. We are a division of Franciscan Alliance, one of the region's largest Catholic health care providers. Our mission is con-

tinuing Christ's ministry in our Franciscan tradition, and we strive to adhere to every word of the mission statement.

In order to be continuing our hospital, we must be able to continue to operate through disasters and other emergency events. We continuously strive to develop comprehensive and innovative strategies for emergency preparedness, response, recovery, and mitigation.

Since our founding, our values have been rooted in Franciscan tradition and the spirit of St. Francis of Assisi. The health care professionals at Franciscan St. Francis exhibit compassionate concern for the patients we serve and strive for Christian stewardship, a just and fair allocation of human, financial, and spiritual resources.

It is our job to help meet the basic medical needs of vulnerable populations here in Indiana. Effective health care emergency preparedness requires carefully considering the needs of vulnerable populations. Vulnerable populations can be at greater risk during disaster and crisis events. The social determinants of health, socioeconomic status, age, gender, ethnicity, education, disability, and immigration status all contribute to a lack of equity and access to opportunities and increased vulnerability to hazards.

Serving culturally-diverse populations is challenging. Our health system has a large presence on the south side of Indianapolis, which is home to a large Burmese and Hispanic population. Emergency events call for the engagement of the entire community, and we strive to break through language and other cultural barriers to meet our health care objectives.

You may recall in June 2012, dozens of Indiana children were sickened and injured when a dangerous chemical combination in a neighborhood pool created a toxic gas. Then in November, we were called to assist the victims of the Richmond Hill's explosion. Because of our hazardous materials and emergency preparedness training, as well as our partnerships with community responders, we were able to successfully manage this patient surge, care for our patients, and achieve positive health outcomes for all involved.

Franciscan St. Francis Health was an early founding member of the MESH Coalition, and we have remained a strong member. We have also leveraged social media as a source of health care intelligence and utilized platforms such as Facebook and Twitter to distribute information to our community. By collaborating with other hospitals, we can prevent redundancies in emergency planning and create an efficient response framework among area hospitals.

Chairwoman Brooks, Senator Donnelly, Congresswoman Walorski, thank you again for this opportunity to speak before your subcommittee. Emergency preparedness is vital to health care not only in Central Indiana; it is vital across the globe. We at Franciscan St. Francis Health appreciate your dedication to this important area. We stand ready to assist the community in times of need. Thank you very much.

[The prepared statement of Dr. Obeime follows:]

PREPARED STATEMENT OF MERCY OBEIME

JULY 6, 2013

Good morning Chairman Brooks, Senator Donnelly, Congresswoman Walorski, Congressman Young, and all others with us today. I'm here representing the staff of Franciscan St. Francis Health to talk to you about our mission, specifically preparing the Central Indiana community to prepare for emergencies and disasters.

Franciscan St. Francis Health is one of the largest health care providers in Indiana with campuses in Carmel, Indianapolis, and Mooresville. We are a division of the Franciscan Alliance, one of the region's largest Catholic health care providers. Our Indianapolis hospital offers cutting-edge technology and facilities, including the south side's only comprehensive cardiac and vascular care program. We have been ranked by multiple outlets as a Top 100 Hospital and have received recognition for clinical excellence and outstanding patient experience.

Since our founding, our values have been rooted in the Franciscan tradition. In the spirit of Francis of Assisi, the health care professionals at Franciscan St. Francis exhibit compassionate concern for the patients we serve and strive for Christian stewardship—a just and fair allocation of human, financial, and spiritual resources.

Since 1996, I have been fortunate to serve as the director of the Franciscan St. Francis Neighborhood Health Center at Garfield Park, where we provide primary medical care as well as health education for Hoosier families who lack access to affordable health care. Serving Indiana's underprivileged communities for the past 17 years has been a challenging but extremely rewarding experience.

It is our job to help meet the basic medical needs of vulnerable populations here in Indiana. Effective health care emergency preparedness requires carefully considering the needs of vulnerable populations. Social factors often cause populations to be at greater risk during disaster and crisis events. Not unlike the social determinants of health, socio-economic status, along with age, gender, ethnicity, class, disability, and immigration status, all these factors determine lack of equity in access to opportunities and increased exposure to hazards. During Hurricane Katrina in 2005, for example, and most recently following Hurricane Sandy, this social vulnerability to disasters was widely evident as children, women, minorities, and the poor were disproportionately affected. Serving culturally-diverse populations also presents challenges. Our health system has a large presence on the south side of Indianapolis, home to a large Burmese population. Emergency events call for the engagement of the entire community, and we strive to break through language and other culture barriers to meet our health care objectives.

Like most hospitals, we have not been strangers to emergencies. Last summer, dozens of Indiana children were sickened and injured when a dangerous chemical combination in a neighborhood pool created a toxic gas. Our acute care hospital in Indianapolis received 25 patients, all of whom required decontamination due to chemical exposure. Because of our hazardous materials and emergency preparedness training, as well as the partnerships with community responders, staff was able to successfully manage the surge in patients, while achieving positive health outcomes for those affected by the incident.

Additionally, Franciscan St. Francis Health—Indianapolis was called to assist the victims of last fall's Richmond Hills home explosion. Among the items lost in the event were the medications of numerous neighborhood residents. Our hospital offered its services to provide a mobile clinic, working with a local pharmacy to meet the need for maintenance medications for the residents of Richmond Hills. While the mobile clinic was never deployed, Franciscan St. Francis stood ready to assist the community in its time of need.

The mission of Franciscan St. Francis is continuing Christ's ministry in our Franciscan tradition, and we strive to adhere to every word of the mission statement. In order for our work to be "continuing," our hospitals must be able to continue to operate through disasters and other emergency events. Franciscan St. Francis Health—through individual and collaborative efforts—continuously strives to develop comprehensive and innovative strategies for emergency preparedness, response, recovery, and mitigation. We maintain a full-time disaster management coordinator for our three Central Indiana hospitals who serves as a liaison to community response partners, as well as enhance organizational preparedness through planning and training. Having this resource has allowed us to conduct full-scale emergency drills and streamline our emergency response plans into operational checklists. We conduct an annual Hazard Vulnerability Analysis, a method used to identify the most likely potential dangers to specific health care providers and to provide action plans for mitigating and responding to those vulnerabilities. We have

upgraded our equipment, including a robust communications system that operates across our three campuses. All campuses are also in the process of becoming certified as "storm-ready" by the National Oceanic and Atmospheric Administration.

While Franciscan St. Francis Health takes the initiative in creating comprehensive disaster management policies for our hospitals, we realize that true emergency preparedness cannot exist in a vacuum. We engage with other health care providers and public safety officials in order to create an efficient, collaborative emergency management system. Franciscan St. Francis Health—Indianapolis was an early, founding member of the MESH Coalition, and we have remained a strong partner since. MESH is a health care non-profit organization focused on giving hospitals the accurate information and resources to respond to emergency events and remain viable through recovery, promotes collaboration between Marion County hospitals in the area of emergency management, and provides invaluable resources we could not afford individually. Our membership with MESH has proven to be very beneficial over the years, allowing St. Francis to participate in many community initiatives, including the Super Care Clinic during the 2011 Super Bowl in Indianapolis, as well as hosting Nationally-recognized emergency management professionals in the MESH Grand Rounds Series.

Another significant area in which MESH provides assistance is health care intelligence. During mass casualty incidents, MESH helps us better manage patient surge by notifying our emergency department how many patients are being transported to our hospital. MESH serves as the Medical Multi-Agency Coordinating Center (MedMACC) for Marion County, providing hospitals with real-time intelligence, including news and weather, public safety radio traffic, information from restricted homeland security portals, and social media. Franciscan St. Francis has also leveraged social media as a source of health care intelligence, and utilizes platforms such as Facebook and Twitter to distribute information to our community.

MESH also assists Franciscan St. Francis with emergency planning by serving as a liaison with non-traditional emergency responders as well as researching real-world emergencies in order to identify strategies and tactics that were successful. We also participate in MESH's Hospital Preparedness Officers Working Group, where emergency management professionals meet to collaborate on Best Practices for training, education, emergency planning, and exercises. By collaborating with other hospitals we can prevent redundancies in emergency planning and create an efficient response framework among area hospitals.

Chairman Brooks, Senator Donnelly, Congresswoman Walorski, and Congressman Young, thank you again for the opportunity to speak before this subcommittee today. Emergency preparedness is vital to health care here in Central Indiana and across the country. We at Franciscan St. Francis Health appreciate your dedication to this important area. I am happy to respond to any questions this subcommittee might have.

Mrs. BROOKS. Thank you, Dr. Obeime.

At this time, I will recognize myself to begin the line of questioning.

As we have learned in the aftermath of the Boston bombing, the Boston EMS utilized the Metro Boston Central Medical Emergency Direction System to alert area hospitals of the mass casualty event and route patients, and this coordinated response between EMS medical personnel along that marathon course and area hospitals undoubtedly saved many lives.

In Central Indiana, what I would like to hear is: How are we coordinating? Are we holding exercises for a large-scale event, either individually in your own hospitals or collectively? I think I would like to hear from each of you very briefly in how are we working together on a day-to-day basis before any mass incident.

We will go ahead and start with you, Mr. Priest.

Mr. PRIEST. In Central Indiana, in partnership with Marion County and some regional areas as well, the Indianapolis Fire Department, the Indianapolis EMS, and MESH, we operate the Marion County Medical Multi-agency Coordinating Center. It is a mouthful. We call it the MedMACC. The MedMACC's job is to facilitate communication from scenes, such as the bus accident that

was discussed today, and local hospitals. As I think Dr. Reed mentioned, surge management does start in the field, and that means that we need to be able to tell our responders which hospitals have availability, leaving the decisions to transport in the hands of those professionals.

Mrs. BROOKS. Thank you.

Dr. Caine, coordination among, or training?

Dr. CAINE. We originally did a training with the 1,000 U.S. postal workers in Indianapolis with the fire department and a number of our hospital partners just recently. We also, about 2 years ago, did a partnership looking at the chemical and biological threats in our community, as well as we have had exercises with the hospitals looking at radiological threats, and we have been fortunate enough to have some of our Federal agencies come down, the U.S. Army, helping to support some of our exercises.

So we have numerous training and exercises that we try to do with the various Governmental agencies, as well as our hospitals and community partners.

Mrs. BROOKS. Thank you.

Dr. Profeta.

Dr. PROFETA. In regards to coordinating with a lot of the hospitals directly, we really don't do that much coordination. To be honest, we make sure that we are prepared no matter what. Methodist I don't think calls us to ask us what our capacity is. I don't recall ever calling Methodist or IU, and vice versa. We certainly should be doing it more if we need to, but I have no doubt that I can pick up the phone and talk to any emergency department, the personnel at any of those institutions, and they would gladly be able to communicate, and vice versa with us.

We do a lot of internal training. We run our own drills. We do a lot of tabletop exercises, active-shooter scenarios, fire exercises, how do we evacuate the hospital, how do we evacuate the emergency department and mobilize pharmacy. We take part in the District V drills, HAZMAT training. We work with Lighthouse Readiness Group to further train our faculty, and overall we try to be real active in doing at least two drills a year with patients, and tabletop drills continuously, and drills at the safety huddles at the beginning of each day.

Mrs. BROOKS. Thank you.

Dr. Knight.

Dr. KNIGHT. Thank you. Some different drills that we participate in, I got to witness a drill that was done at MESH recently. They have a command center where they do keep track of surge capacity in each of the emergency departments around the city. So if there were an event, MESH can act as a centralized coordinator to identify the capacity in each of the different emergency departments. So the emergency departments don't need to call each other and find out how much space there is in each of those.

Mrs. BROOKS. To clarify, are you all involved in MESH? Are all of the hospitals here at this table partners in MESH?

[Chorus of ayes.]

Mrs. BROOKS. Okay.

Dr. KNIGHT. Within our facilities, we have facility-specific training drills on at least an annual basis. For example, in our emer-

gency departments, we have decontamination showers. We want to make sure that folks really know how to use those when the time comes, so they will actually go through the motions of using those, as well as tabletop exercises for leadership to make sure we know how to deploy personnel appropriately throughout the facilities. Then we do participate within our district along with other emergency preparedness exercises that are done.

Mrs. BROOKS. Excellent. Thank you.

Dr. Reed.

Dr. REED. Yes. Sometimes it seems like we are in a drill every day. Our emergency department sees somewhere on the order of 300 patients daily. During the summer surge, we sort of prepare, as trauma is seasonal, and disease. So from May through October, we are at full heat handling things. But we do have internal drills, coordinated drills with outside facilities, EMS, MESH, other facilities throughout the State.

The thing that we also have at IU Health that is a little unique is this bridgeline process, that when there is some event within the health care system, the downtown facilities and IU Health, there is an immediate linkage between administrators and directors and executives about the situation and what is going to be done to solve those issues, anything from steam factories blasting to electrical problems to internet situations. So there are a lot of resources, and usually they are in practice sometime during the week, if not daily.

Mrs. BROOKS. Okay, thank you.

Dr. Obeime.

Dr. OBEIME. At St. Francis, we collaborate with our community partners. Since I started working at St. Francis, part of my FTE was assigned for me to be able to work with Dr. Caine and the Marion County Health Department. We have also worked with MESH. We know that the people who may be most hurt will be the vulnerable who need the most help. We also do a lot of internal training for HAZMAT, mass casualty, active-shooter. We also have WMD exercises. We do all of these on both a local and regional basis.

Mrs. BROOKS. Thank you very much.

I now yield 5 minutes to the gentleman from Granger.

Senator DONNELLY. Thank you, Madam Chairwoman.

Mr. Priest, the Super Care Clinic was pretty much the first of its kind for a mass gathering like that. What is your biggest challenge to re-creating that at other events here in Central Indiana or throughout our entire State?

Mr. PRIEST. Thank you for acknowledging that. It was the first of its kind. I don't know that we have a biggest challenge to re-creating it. I think the biggest challenge is to get another big event so we can do it. Producing that sort of fan-facing health and wellness program, which really for fans looked like a clinic but for us was an emergency management strategy, is something we are prepared to do.

Senator DONNELLY. Well, let me ask you this. Eighty-five thousand people go to a football game in one part of the State, 65,000 in another part of the State, 58,000 in another part of the State on any given weekend. Do the lessons of MESH translate to those events?

Mr. PRIEST. They do. In fact, I have been fortunate enough to work with my colleague, Dr. Dan O'Donnell, with Indiana University to actually look at their football program and how to adopt if not exactly a Super Care Clinic model, something that is similar, again looking at fan-facing health care.

Senator DONNELLY. This is not Indiana-specific, but obviously there will be another Super Bowl next year. I think it is in New York. Have you had any conversations with those people about the things you have learned so that our fellow citizens of this country have the same benefit of the talents that all of you brought to our Super Bowl?

Mr. PRIEST. Senator, New Jersey personnel came to the Super Bowl here to observe our operations, and we certainly will make ourselves and have indicated we will make ourselves available to help them re-create this. We would certainly like to be helpful.

Senator DONNELLY. Thank you.

Dr. Reed, your network goes across the State, from one end to the other, and in many cases when you look, Methodist is the final trauma center. That is where some of the very, very most difficult cases occur. Do you work together with your fellow—not only IU locations, but other hospital unit locations in places like Terre Haute and Richmond, Fort Wayne, to try to provide best practices and to coordinate with them?

Dr. REED. Yes, we do. We communicate with them when they have patients to transfer to us on a fairly consistent basis. Terre Haute is one of our big providers for that kind of service, as well as Reed Hospital in Richmond. I am also on the Governor's trauma care committee, where all the trauma directors in the State, as well as their administrative staff and people within the State, the Departments of Health and Homeland Security, interact to help develop an actual trauma system within the State of Indiana. We are actually one of only three States that doesn't have a formal trauma system. We are about halfway through putting things together.

But it is a significant need that is increasingly recognized, because by getting trauma care not just something that can be delivered at Methodist's doorstep but something that can be out there in the community where the patient can get care faster, or even faster, is very beneficial. We are actually starting to build our own IU Health trauma system within the State. We have had consultations and site visits from the American College of Surgeons for IU Health in Lafayette and IU Health——

Senator DONNELLY. That was the other question I was going to ask you. Are the lessons that you have learned here being transported to not only the IU network but to all health care providers throughout the State?

Dr. REED. Yes. A number of other hospitals are looking at becoming trauma centers, Level III or Level II trauma centers, not that they necessarily need to ramp up their resources. They already are seeing these trauma patients coming into their facilities. But by being a verified center, that ensures that not only do you have the resources but they work well, because it is a process of managing the patients. It is actually reviewed in the act of obtaining verification. So that gets that quality level of care closer to the patient.

Senator DONNELLY. Dr. Knight, what is the thing we need to do better the most right now as you look at the scenarios that we have to deal with on a regular basis? For want of a better way to put it, what keeps you up at night?

Dr. KNIGHT. Well, I think that the more we can cooperate and work together in preparedness, the better off we all are, because if we can share those expenses of the training and education and share that preparation, then as a community we do a better job when those times come. So things like the MESH Coalition, the Indianapolis Coalition for Patient Safety, and our district preparedness are all very important so that we are working more in a coordinated fashion than as individual health care systems. So I think the more we can do to emphasize that, the better off our patients are and the communities are that we serve.

Senator DONNELLY. Thank you.

Thank you, Madam Chairwoman.

Mrs. BROOKS. Thank you.

Now, if the gentlelady from Jimtown has any questions.

Mrs. WALORSKI. Thank you, Madam Chairwoman.

I am interested in, obviously, the concept of this MESH at events, but I am also very aware of the fact—and you are all saying the same thing. The difference between a planned event versus an element of surprise, like the bus turnover just a few weeks ago, where all eyes are on the Super Bowl, the 500, and the plan is there, and it all comes together.

But, for example, with the bus rollover, which was unexpected. Nobody knew, thought, or ever conceived that that was going to happen 5 minutes away from the designation, back to the church. So when that happens, who takes over then? Dr. Profeta, when you talked about there was a place right here, who takes over and says——

Dr. PROFETA. At the scene?

Mrs. WALORSKI. At the scene. Who takes over?

Dr. PROFETA. The first responder, whoever is the first responder at the scene.

Mrs. WALORSKI. Right. Then do all the hospitals immediately engage with the first responders?

Dr. PROFETA. Not necessarily. I mean, if they call, we engage. But we go ahead and just engage on our own. We activate the plan. We get things moving.

When the State Fair collapse took place, the same thing happened to us. People and doctors started coming in. We didn't have to call and respond to them. But we have three systems set up in our emergency department in case each one of them fails to notify mass numbers of people. Obviously, we monitor social media, just like anybody else.

But in terms of who initiates the communications at the scene, it can be variable depending on who shows up. There can be breakdown. The more levels of interference you have between a mass casualty event and the hospital that is nearest to that event, the greater likelihood you have of people being routed to the wrong facility, deferred to preferential facilities, or not reaching the location they need to be.

Also, think about it, a vast majority of people, especially in a mass casualty event, they are not going to come by ambulance. History shows that they are going to self-transport, and there is no way of controlling that flow of people. They know where the emergency departments are. They don't know where the MESH tent is. They don't know where the secondary command center is. They know where their local emergency departments are, and they are going to throw their kids in the car and they are going to go driving there. That is what we are prepared for.

Mrs. WALORSKI. My second question is this: I just want to kind of throw out to the panel. In my previous tenure as a State representative, we were briefed at one point—this is a couple of years ago—on global pandemic of bird flu and what the State of Indiana was going to do, and it was the first chance I had to actually look at a State-wide comprehensive plan of exactly how county facilities, county fairgrounds were going to be used to operate.

Is there, for this issue of a bioterror attack, a mass casualty attack on the State of Indiana, does that State matrix exist where in the event that our entire State, outside even of the population of Marion County, does that plan exist where we know exactly who is doing what?

Dr. CAINE. Yes. I am also actually a practicing physician. I am in the Division of Infectious Diseases at Indiana University School of Medicine. Yes, there is a State plan that exists. It was actually established by the Indiana State Department of Health. It was broken down into 10 districts that we had to prepare for avian flu, and I want to say that for our H1N1 event that happened, we were able to vaccinate over 200,000 children in the City of Indianapolis and hundreds of thousands of adults only through the collaboration of all of our hospital partners and a lot of our contracting agencies that we use in order to do this.

We have a number of pre-prepared, established sites that are already designated. We have to inspect them every year with our security police, even the FBI, in terms of having the preparation for all of our governmental efficiencies, who is going to do those vaccinations and at what point.

Mrs. WALORSKI. So my final question is this: In the event of an unanticipated mass casualty event like that, and even aside from just pandemic types of flus and those kinds of things, the rule of thumb is our country and our State has about a weekend's worth of groceries for people to buy and gasoline for people to consume.

What is the rule of thumb in the hospital networks State-wide? How long can you go before there would absolutely have to be Federal intervention at a level higher than what you all can do?

Dr. PROFETA. Can I——

Mrs. WALORSKI. Yes.

Dr. PROFETA. I always get amazed every year when we start talking about influenza. If we look at last year's influenza outbreak, the vaccine conferred maybe a 50 percent immunity to the people that were exposed to it. Fortunately, the flu was not that virulent.

But if you want to say what keeps me up at night, it is not nuclear weapons or an anthrax exposure. It is influenza. If we have an outbreak with a serious strain of influenza, a one-protein

change, and the vaccine does not confer immunity to the vast majority of people and it is highly infective, we are going to have 50-plus percent of our health care providers sick, and that includes in nursing homes. I mean, do you think our support teams or people like our porters and housekeeping and food services and all those people that end up being sick are going to show up to work, especially if you have something with a high mortality ratio?

So I think the entire infrastructure collapses under that situation. Again, when you have a virulent strain of flu with a vaccine that does not confer high immunity and a high fatality ratio, a lot of people are going to refuse to come to work. No matter how well you think you are going to prepare for an event like that, it is not going to happen. The system is going to break down.

Mrs. WALORSKI. Thank you, sir.

Dr. PROFETA. So make sure you have enough food to feed people out in the community.

Mrs. WALORSKI. I appreciate it.

Thank you, Madam Chairwoman.

Mrs. BROOKS. Okay, thank you.

As we gave the last panel, we would love the opportunity to hear from you in a little bit of a lightning round, a bit. As you have Members of Congress here from both the Senate and the House, what is it that Congress can do to ensure that we can be as ready as we possibly can for a mass casualty event?

I think we will start this way and work our way back this time, to wrap up, and if we could just be very brief. We really appreciate all of you incredibly busy professionals running major hospital systems and important systems like MESH, we appreciate that we have kept you longer than we thought that we might, but this is so very important.

What can Congress do? What can we do to help?

Dr. OBEIME. I will make two comments. The first one is we cannot forget those who cannot take care of themselves. The system is set up, if you listen to what everybody has said—the people who do not understand the language, who cannot read, who cannot write, they will not be able to do anything for themselves. We need to make sure everybody in their local community knows who their neighbors are, knows who is going to take care of them.

The second point is I work for a private institution, I have for almost 18 years, and I think we have done a wonderful job of taking care of a lot of people. Every day we hear about cuts in reimbursement. We hear about cuts in a whole lot of things. We can work by faith, but we also know that we need money to take care of people. We need money to pay for things.

If we continue to have cuts, that makes it impossible for organizations like ours to do the work that we do. Many people will suffer because we can no longer provide the services that we provide for them now. I know that the Affordable Care Act is active and everybody is talking about it, and I know it does not include everybody. We need to make sure we are looking out for everyone. It takes only one apple to spoil everything, and we cannot leave anyone behind.

Mrs. BROOKS. Thank you, Dr. Obeime.

Dr. Reed, thank you.

Dr. REED. Yes. Refraining from further reimbursements and health care cuts would be the No. 1 priority. As you know, in order for us to maintain an infrastructure, we have to have revenue in excess of what it costs us to take care of the patients because there is no mechanism to provide for infrastructure like preparedness, and if we are not prepared, we really don't have a system.

So our system right now is totally based upon how much extra revenue we were able to generate from the payments we received over the cost it took us to take care of the patient. So further reductions in those reimbursements for the care are going to lead to cuts in places we can cut. We can't really cut while taking care of a patient, but a lot of those excesses may disappear, and that leads to infrastructure reductions.

So refraining from further cuts in health care reimbursement is critical.

Mrs. BROOKS. Thank you.

Dr. Knight.

Dr. KNIGHT. I have two things. One is, again, sort of on my theme I guess of coalition and working together. The MESH Coalition, the Indianapolis Coalition for Patient Safety, and the work we do with the district in preparedness, especially the two coalitions, MESH and the Indianapolis Coalition for Patient Safety, those are subscription memberships. We pay to be part of those coalitions as hospital systems, and I think it really helps us as a community. So any grant funding that could go to support MESH and the Indianapolis Coalition for Patient Safety, I think that makes us better prepared as a community for those sorts of things.

The second thing is echoing what you have heard, and that is when we train and educate our staff, that is a fixed cost. That is an expense that there isn't any reimbursement attached to. As we continue to be pushed to be more and more efficient in health care, our fixed costs are what we are having to cut out. So if we don't have some scholarships or something like that that we can use for education and training for our staff, those are the sort of things that are going to be cut out.

Mrs. BROOKS. Thank you, Dr. Knight.

Dr. Profeta.

Dr. PROFETA. The grants, the money is like $20,000 per year per hospital. The Carmel Marching Band I think can make that in a bake sale in a week.

You know, the infrastructure, when we talk about accommodating these huge surges in patients, any of our hospitals, if we have to accommodate 500 or 1,000 patients that require beds, not the walking wounded, our infrastructure is going to break down. If you go to Rambam Hospital, for example, in Haifa, it is a hospital the size of St. Vincent's Hospital, they have the ability to move 2,000 extra patients into their parking garage, which becomes a state-of-the-art hospital complete with operating suites, infrastructure built for oxygen suction, electronic monitoring.

We are going to be putting people in the hallways. We constantly are looking for waiting rooms where we can stack patients. We don't have a comprehensive—none of the hospitals really do—a comprehensive, well-thought-out location that is completely wired from a computer standpoint, from a life services standpoint. If

there was any place where money could go, it is building out that infrastructure at all the individual hospitals, especially the major hospitals like St. Vincent's, Methodist, IU Health, St. Francis, and Community. Start there, increase the capacity to expand to 500 or 1,000 patients that require in-patient management, and then we can work out into the periphery.

Mrs. BROOKS. Thank you.

Dr. Caine.

Dr. CAINE. I just want to also encourage that we continue to have our Federal funds that go to the Department of Homeland Security, primarily UASI, but also the MMRS. That is the Medical Metropolitan Response funding that goes to local health departments, as well as State health departments. It is so critical for our training, and I don't want us to also forget Wishard Hospital and Eskenazi Hospital that primarily focuses on the vulnerable populations.

Mrs. BROOKS. Thank you, Dr. Caine.

Mr. Priest.

Mr. PRIEST. I think you have heard from the panel that a lot of the problems we are facing are related to the grant funding. As you know, the grant funding is not sustainable. It has not been responsive to communities such as ours, where it has gone up and down, and now in many cases eliminated. I think as stewards of public resources, we have to get a little creative, and I think there are some opportunities in health care to do that, particularly when we are being asked to respond to issues of National significance.

I think one of the things to think about is using models such as pay-for-performance models, incentive payment systems that exist in our current medical reimbursement system, to fund this important work that is not merely accruing to the benefit of hospitals but that truly is part of our community's preparedness structure.

Mrs. BROOKS. Well, thank you all so very much. This has been valuable testimony, again not just for Central Indiana. But because it has been webcast, hopefully many other communities around our country will think about the medical preparedness of their own communities.

I might remind you that the Members of the subcommittee may have additional questions. I know that I had several, and we will ask you to respond to those in writing, and the hearing record will be open for 10 days.

I just want to thank you all so very much. I want to thank the City of Carmel. I want to thank Commissioner Altman, who is here; Chief Green, who is here from Carmel Police Department, all of your assistance in helping us put this incredible hearing on.

I want to thank everybody who came and listened and learned, from the first responders that you heard from on the first panel, from the medical professionals.

I certainly believe, as I started out this hearing, that failing to prepare is preparing to fail, and these are all professionals that work day in and day out trying to ensure that we do not fail in the critical issue of keeping our communities safe. So I just want to thank you all so very much.

This subcommittee stands adjourned.
I thank my colleagues for joining me today. Thank you.
[Whereupon, at 12:36 p.m., the subcommittee was adjourned.]

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