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THE EBOLA CRISIS: COORDINATION OF A MULTI-AGENCY RESPONSE

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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THE EBOLA CRISIS: COORDINATION OF A MULTI-AGENCY RESPONSE

Friday, October 24, 2014

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
WASHINGTON, DC.

The committee met, pursuant to notice, at 9:30 a.m. In Room 2153, Rayburn House Office Building, Hon. Darrell E. Issa (chairman of the committee) presiding.

Present: Representatives Issa, Cummings, Mica, Turner, McHenry, Jordan, Chaffetz, Walberg, Amash, Gowdy, Farenthold, Massie, Collins, Bentivolio, DeSantis, Maloney, Tierney, Lynch, Cooper, Connolly, Cartwright, Kelly, Davis, and Lujan Grisham.

Staff present: Will L. Boyington, Deputy Press Secretary; Molly Boyl, Deputy General Counsel and Parliamentarian; Lawrence Brady, Staff Director; Ashley H. Callen, Deputy Chief Counsel for Investigations; Sharon Casey, Senior Assistant Clerk; Steve Castor, General Counsel; John Cuaderes, Deputy Staff Director; Adam P. Fromm, Director of Member Services and Committee Operations; Linda Good, Chief Clerk; Elizabeth Gorman, Professional Staff Member; Frederick Hill, Deputy Staff Director for Communications and Strategy; Christopher Hixon, Chief Counsel for Oversight; Caroline Ingram, Counsel; Michael R. Kiko, Legislative Assistant; Mark D. Marin, Deputy Staff Director for Oversight; Emily Martin, Counsel; Ashok M. Pinto, Chief Counsel, Investigations; Laura L. Rush, Deputy Chief Clerk; Jessica Seale, Digital Director; Andrew Shult, Deputy Digital Director; Katy Summerlin, Press Assistant; Rebecca Watkins, Communications Director; Tamara Alexander, Minority Counsel; Meghan Berroya, Minority Chief Investigative Counsel; Aryele Bradford, Minority Press Secretary; Courtney French, Minority Counsel; Jennifer Hoffman, Minority Communications Director; Una Lee, Minority Counsel; Juan McCullum, Minority Clerk; Suzanne Owen, Minority Legislative Director; and Dave Rapallo, Minority Staff Director.

Chairman ISSA. The committee will come to order.

Without objection, the chair is authorized to declare a recess of the committee at any time.

The Oversight Committee exists to secure two fundamental principles. First, Americans have a right to know that the money Washington takes from them is well spent. And, second, Americans deserve an efficient, effective government that works for them.

Our duty on the Oversight and Government Reform Committee is to protect these rights. It is our solemn responsibility to hold government accountable to the taxpayers. Taxpayers want to be

safe. Taxpayers want to know that our government is prepared. In this case, we leave no stone unturned in ensuring today that America is planning for tomorrow.

Beginning in March 2014, in the West African Nation of Guinea, the world first learned about yet another new outbreak of the Ebola virus. Due to poor detection, it is possible the outbreak started late last year. By August, Ebola had spread to Sierra Leone, Liberia, and Nigeria.

According to the U.S. Center for Disease Control and Prevention, the 2014 Ebola epidemic is the largest in history and, sadly, the virus has claimed at least 4,000 lives to date.

By the end of September, the CDC confirmed the diagnosis of the first travel-associated case of Ebola in the United States. The situation is rapidly developing and changing; and Americans are understandably worried, worried about their government's response to the outbreak and, in particular, the steps we are taking to contain the spread of Ebola.

With the high fatality rates—as much as 70 percent—and no FDA approved vaccines or medicines, Ebola is a serious threat to public health around the world. An outbreak in an American city or any major city of the world could be very costly to contain and could have major economic impacts. Yesterday's news was a doctor in New York City tested positive for Ebola, and this is particularly distressing.

There is certainly some good news to report on our effort to contain the outbreak. No new Ebola cases have been reported in Nigeria in 46 days. Over 40 people who came into contact with the Ebola patient, Thomas Eric Duncan, in Dallas have now gone through the 21-day monitoring period without demonstrating any symptoms. And perhaps that means that our preventive systems of those in contact is good, even though, as we will see today, not perfect.

We have the world's most advanced healthcare system undeniably in America. We spend the most money to have that system. And as long—sorry—as long as our response is well coordinated and officials use common sense, there is an ability to contain this disease, but we are not out of the woods yet.

Today we will examine efforts to coordinate Federal agencies tasked with responding to an Ebola outbreak. This examination follows a series of Statements and actions that have eroded public confidence in our response.

An infected traveler from Liberia made it through the Department of Homeland Security screening and arrived at international travelers and into the Dallas/Fort Worth area. When the same individual exhibited clear signs of Ebola—symptoms of Ebola, a hospital turned him back into the community and offered an evolving account of how this happened.

Without evidence, the director of the CDC declared that a nurse at this hospital who became infected with Ebola must have contracted it through, "a breach of protocol." Medicine is not done over the telephone. It is not done over the television. Medicine is, in fact, the business of looking at a patient, evaluating a patient, measuring a patient, and questioning a patient, not, in fact, guessing how someone became a patient.

A separate nurse who contracted Ebola at that hospital was cleared by the CDC to board a commercial airline flight, even though she reported having fever and contact with the patient, Mr. Duncan.

The news of that medical doctor returning from Guinea—the news that a medical doctor returning from Guinea now has tested positive for Ebola has raised even more questions about procedures and treating patients and risks to Americans responding with great courage and generosity from here to the infected areas.

We need to know why there have been breakdowns and if our system for responding to such serious crisis is working properly. That was a line I was supposed to read. I think we all know that the system is not yet refined to where we could say it is working properly.

How effective are our efforts at containing the disease in West Africa? Are the—are the training and equipment that frontline healthcare workers and military personnel received in the past or will receive in the future adequate? Isn't airport screening that went into effect 2 weeks ago reliable? Are government agencies doing everything they can do to foster the development of Ebola treatments? What threat does Ebola pose to international trade and America's—Americans traveling abroad?

When a situation like this arises, government is supposed to rely on prior planning and rapid, effective response that can identify mistakes quickly and correct them. Congress has recognized and considered the threat of an outbreak on a bipartisan basis. The bumbling we have seen comes despite concerted efforts by Congress to ensure protocols and funding were in place to avoid the very mistakes we have already seen.

President Obama's appointment of Ron Klain to serve as the Ebola czar sadly, in my opinion, shows the administration has, on one hand, recognized the missteps and, on the other hand, is not prepared to put a known leader in charge or, in fact, a medical professional in charge.

That does not make it a political decision, but it makes it a decision in which we have to ask and we will ask today: Is the interagency coordination already in place and he is simply overseeing it or, in fact, are we expecting Mr. Klain to put together interagency coordination to show the leadership to make it happen, to sift through conflicting claims that science and medicine have already reached conclusions versus the reality that those conclusions, at least in several cases, have proven wrong.

We did invite the President's new czar, Mr. Klain, to testify, and we are very disappointed that he was not able to. But we understand he has just started, and we do not expect that that would be repeated if there is a followup hearing.

Let me just say, in my role in this committee and others, I have traveled to the World Health Organization's headquarters. I have seen them saying to us, as visitors, that pandemics are, in fact, already planned for. And although they talk about the inevitability of a pandemic, we have also invested, as Americans, billions of dollars to, in fact, be prepared for them.

Let me just say before anyone pulls the trigger on either a political or denouncing medicine that, in fact, this is not a new problem.

Nearly 100 years ago, in 1918–1919, the influenza pandemic known as the Spanish flu killed more people than any other outbreak of disease in history. It claimed at least 20 million people—oh, thank you—around the world.

In that pandemic, an American base, one that I was stationed at, Fort Riley, Kansas, proved to be the source of the first-known outbreak. The flu spread fast around the base and other bases and eventually worldwide. Famously, "The Big Red One" is well aware that not only was the outbreak critical, but, in fact, soldiers were put on ships and sent out from there further—not recognizing that, in fact, we were simply adding to the disease and the suffering.

The Asian flu of 1957-'58, which originated in the Far East, spread to the U.S. and caused at least 70,000 deaths. The Hong Kong flu of 1968-'69 also spread to the United States and caused an estimated 34,000 deaths.

It would be a major mistake to underestimate what Ebola could do to populations around the world, and any further fumbles, bumbles or missteps or relying on postulate, certainties told to us by people who, in fact, cannot defend how that certainty came to be and when it fails to be correct how they could have been so wrong, can no longer be tolerated.

I look forward to hearing from this panel of witnesses in an effort not to solve a problem, but to take the problem appropriately seriously, recognize that what we don't know could kill us.

With that, I recognize the ranking member for his opening Statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman. And I thank you again and again for holding this hearing.

I think this is the reason why we have an Oversight Committee, to address those problems that our Nation and, in this case, the world face.

Yesterday, Dr. Craig Spencer, a physician working for Doctors Without Borders, tested positive for Ebola. We are still getting additional details.

But based on information from New York and Federal officials so far, it appears that healthcare authorities have come a long way in preparing for Ebola since Thomas Duncan first walked into a Texas hospital last month. New York had been preparing for this possibility for weeks, and about 5,000 healthcare workers were drilled on protocols and procedures just this past Wednesday.

A special team with full protective gear transported Dr. Spencer to Bellevue Hospital, which is specifically designated to handle Ebola. They placed him directly into an isolation unit. They began treating him as soon as possible. And they started tracing his contacts immediately.

As New York officials said last night, they had hoped they would not have to face an Ebola case, but they did. They were also realistic, and they worked diligently and professionally over the last month to prepare themselves for this day.

There are many questions about this new case, but we cannot assume it will be the last. And I remind all of us this is our watch. Of course, we must continue to be vigilant, and we need to continually reevaluate our protocols and training procedures to protect our healthcare workers, many of whom are here today.

And to those healthcare workers, on behalf of a grateful Congress and grateful Nation, I thank you for what you do every day.

I want to express our thanks to Nina Pham and to Amber Vinson, the two nurses from Texas who contracted Ebola when they treated Mr. Duncan. By now, we have all seen their pictures, two brave young women who risked their lives to simply do their jobs and to feed their souls, just like nurses across this country, every single day, 24/7, 365 days a year. I understand that Ms. Pham's condition has been upgraded and Ms. Vinson has now been cleared of the virus. We thank them for their bravery and their commitment.

This new case in New York should also demonstrate that we can no longer ignore the crisis in West Africa. We can no longer ignore it. Nearly 10,000 people have died from this disease or are battling with it as we speak, many in the most gruesome conditions imaginable.

I firmly believe we have a fundamental, moral, and humanitarian obligation to address the crisis in Africa. We are the richest Nation in the world, and we have the resources and expertise to make the biggest difference. However, for those who may not agree that we have a moral obligation to help, they must understand that addressing the Ebola crisis in Africa is also in our self-interest as a Nation.

Public health experts warn that, to protect Americans here at home, we need to address this outbreak at its source in Africa. The longer the outbreak continues, the more likely it will spread to the rest of the world, including more cases right here in the United States of America. And if we do not take strong action now, it will cause much, much more in the long run. The encouraging news is that healthcare experts know how to fight this disease. They know how to do that.

This week the World Health Organization declared Nigeria and Senegal free of Ebola. This is a tremendous accomplishment that was achieved through a combination of early diagnosis, contract—contract tracing, infection control, and safe burial. But we still face grave challenges in Sierra Leone, Guinea, and Liberia where the public health infrastructure is deficient and new cases are increasing at an alarming rate.

Last month the United Nations Security Council unanimously adopted a resolution declaring the Ebola outbreak "a threat to international peace and security." The U.N. established a mission for Ebola emergency response. They set forth more than a dozen mission-critical actions and they provided a 6-month budget request for $988 million.

However, they are hundreds of millions of dollars short. They definitely need funding for treatment beds, training for healthcare workers, and supplies to prevent infection. They need resources for things as basic as food and vehicles and fuel.

As the head of the United Nations mission warned the Security Council just last week, "We need to stop Ebola now or we face an entirely unprecedented situation for which we do not have a plan."

There have already been several congressional hearings on how to prepare ourselves here in the United States. So today I intend to ask our witnesses what they believe, in their expert views, are

the most significant, concrete, and constructive steps our Nation can take to address this outbreak at its source.

I am particularly grateful to Mr. Torbay from the International Medical Corps for agreeing to be here today to provide his on-the-ground assessment of what his group and others on the front lines need to stop the spread of Ebola.

Mr. Torbay, I know you must feel great empathy for Dr. Spencer, who tested positive yesterday. I have asked my staff to place your testimony on our Website. It is some of the best testimony explaining what is going on in Africa, things that work, and I think the public should have an opportunity to read all 10 pages.

He was—Mr. Spencer—Dr. Spencer was one of your compatriots, battling Ebola in West Africa, and I am sure his situation is one that all of your healthcare workers must fear on a daily basis. But the truth is that Dr. Spencer and your group and many others are doing one of the only things that will truly ensure the world will be free of Ebola. We need to support you as much as we urgently can, and we must do it forcefully. And we have to convince the rest of the world to do the same. Again, I say this is our watch.

And to my fellow committee members and the members of this great Congress, it is not a time for us to move to common ground. We have no choice but to move to higher ground.

And so, with that, Mr. Chairman, I look forward to the testimony today. And, with that, I yield back.

Chairman ISSA. I thank the gentleman.

All members will have 7 days to submit opening Statements for the record.

And, with that, we go to our panel of witnesses.

The Honorable Michael Lumpkin is the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict at the United States Department of Defense.

Major General James Lariviere—or—close enough—is the Deputy Director of Politico-Military Affairs in—let's see—Affairs in Africa at the United States Department of Defense.

The Honorable John Ross—sorry. I just got off a flight. I apologize. The Honorable John Roth is the Inspector General for the United States Department of Homeland Security.

The Honorable Nicole Lurie is the Assistant Secretary for Preparedness and Response at the U.S. Department of Health and Human Services.

Ms. Deborah Burger is the co-president of the National Nurses United.

And Mr. Rabih Torbay is the Senior Vice President of International Operations at the International Medical Corps.

Ladies and gentlemen, pursuant to the rules of the committee, would you please all rise, raise your right hands, and take the oath.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

Chairman ISSA. Please be seated.

Let the record reflect that all witnesses answered in the affirmative.

As you all can see, we have a large panel. And I know, from the dais, there will be many questions. So I would ask that you realize that your entire opening Statements will be in the record and that you limit your oral testimony in your opening to 5 minutes.

WITNESS STATEMENTS

STATEMENT OF HON. MICHAEL LUMPKIN

Chairman ISSA. With that, Mr. Lumpkin.

Mr. LUMPKIN. Chairman Issa, Ranking Member Cummings, and distinguished Members of the committee, thank you for the opportunity to be here this morning regarding the Department of Defense's role in the United States's comprehensive Ebola response effort, which are a national security priority in response to a global threat.

Due to the U.S. military's unique capabilities, the Department has been called upon to provide interim solutions that will allow other departments and agencies the time necessary to expand and deploy their own capabilities. U.S. military efforts may also galvanize more robust and coordinated international effort, which is essential to contain this threat and to reduce human suffering.

Before addressing the specific elements of DOD's Ebola response efforts, I would like to share my observations of the evolving crisis and our increasing response. After visiting Liberia, which I returned from several weeks ago, I was left with a number of overarching impressions that are shaping the Department's role supporting USAID:

First, our government has deployed a topnotch team experienced in dealing with disasters and humanitarian assistance.

Second, the Liberian Government is doing what it can with its very limited resources.

Third, the international response is increasing regionally due to our government's response efforts.

Fourth, I traveled to the region thinking we faced a healthcare crisis with a logistics challenge. In reality, what I found was that we face a logistics crisis focused on a healthcare challenge.

Fifth, speed and scaled response matter. Incremental responses will be outpaced by a rapidly growing epidemic.

Finally, the Ebola epidemic we face is truly a national security issue. Absent our government's coordinated response in West Africa, the virus's increasing spread brings the risk of more cases here in the United States.

And now I would like to turn to DOD's role of our overall whole-of-government response in West Africa.

In mid-September, President Obama ordered the Department to undertake military operations in West Africa in direct support of USAID. Secretary Hagel directed that U.S. military forces undertake a twofold mission: First, support USAID in the overall U.S. Government efforts and, second, respond to Department of State request for security or evacuation assistance if required.

Direct patient care of Ebola-exposed patients in West Africa is not part of DOD's mission. Secretary Hagel approved unique mili-

tary capabilities falling under four lines of effort: command and control, logistics support, engineering support, and training.

In the last 6 weeks, DOD has undertaken a number of synchronized activities in support of these line of efforts, to include designating a named operation, Operation United Assistance; establishing an intermediate staging base in Dakar, Senegal; providing strategic and tactical airlift; constructing a 25-bed hospital in Monrovia; constructing up to 17 Ebola treatment units, also known as ETUs, in Liberia; and preparing to train local and third-country healthcare support personnel, enabling them to serve as the first responders in these Ebola treatment units throughout Liberia.

I would like to reiterate that the U.S. military personnel will not provide direct care to Ebola patients in West Africa.

In addition to the activities of Operation United Assistance, the Department continues two enduring programs in the region: Operation Onward Liberty, partners with armed forces of Liberia to improve their professionalism and capabilities; and we are expanding the regional efforts of the Department's cooperative biological enhancement program to provide robust enhancements to biosafety, biosecurity, and biosurveillance systems in West Africa.

In all these circumstances, the protection of our personnel and the prevention of any additional transmission of the disease remain paramount planning factors. There is no higher operational priority than protecting our Department of Defense personnel.

In conclusion, we have a comprehensive U.S. Government response and, increasingly, a coordinated international response. The Department of Defense's interim measures are an essential element of the U.S. response to lay the necessary groundwork for the international community to mobilize its response capabilities. Now it is the time to devote appropriate U.S. resources necessary to contain the threat and to establish the processes for better future responses.

With that, I would like to introduce my colleague from The Joint Staff, Major General Lariviere. And we look ready to answer your questions and appreciate the opportunity to be here.

[The prepared Statement of Mr. Lumpkin follows:]

Introduction

Chairman Issa, Ranking Member Cummings, and distinguished Members of the Committee – thank you for the opportunity to testify today regarding the Department of Defense's role in the United States' comprehensive Ebola response efforts. As President Obama noted last month, the Ebola epidemic in West Africa is growing at an alarming rate. It is not only a global threat, but a national security priority for the United States. Due to the U.S. military's unique capabilities, specifically speed and scale, the Department has been called upon to provide interim solutions in support of USAID's efforts that will help give other U.S. Government departments and agencies the time necessary to expand and deploy their own capabilities. Additionally, U.S. military efforts may also galvanize a more robust and coordinated international effort, which is urgently needed to contain this threat and reduce human suffering in West Africa.

Before addressing the specific elements of the Department of Defense's (DoD) Ebola response efforts, I would like to share my observations of the evolving crisis and our increasing response. At the beginning of this month, United States Agency for International Development (USAID) Assistant Administrator Nancy Lindborg and I visited Liberia. Meeting with the country's civilian and military leaders, United Nations officials, nongovernmental organizations, and our civilian and military responders already operating in the region, I was left with a number of overarching impressions that are shaping the Department's role in our comprehensive, interagency response.

First, the United States Government (USG) has deployed a top-notch team with vast experience in dealing with disasters and humanitarian assistance. The USAID Disaster Assistance Response Team is leading the USG effort to address the Ebola epidemic abroad, and

the Joint Force Commander is in direct support of USAID's leading role. This collaborative effort is already making a difference. The interagency team has received a warm welcome from the Liberian government, and is synchronizing its activities with the local and international response efforts.

Second, the Liberian government, although significantly overburdened by this crisis, is doing what it can with every resource available at its disposal.

Third, there is little transportation or health infrastructure outside Liberia's capital, Monrovia. Moreover, the existing infrastructure is in disrepair and dangerously overstressed. With almost 200 inches of rain each year, the roads in many locations are impassible for any movement beyond foot travel and – concomitantly – the Ebola virus.

Fourth, the international response is increasing due to the USG response efforts. The USG, led by the Department of State's diplomatic efforts and USAID's engagement with international healthcare organizations, continues to see an upswing in international efforts, particularly in the wake of President Obama's remarks last month and with the advent of the United Nations Mission for Ebola Emergency Response (UNMEER).

Fifth, I traveled to the region thinking we faced a healthcare crisis with a logistics challenge. In reality, we face a logistics crisis focused on a healthcare challenge. The shortage of local transportation, passible roadways, and inadequate infrastructure to facilitate the movement of essential supplies and equipment are hindering the overall global community response to contain and combat the Ebola outbreak. This global threat, with increased international response efforts and contributions, can be overcome.

Sixth, the four lines of effort requested by USAID's Disaster Assistance Response Team (DART) – Command and Control, Training Assistance, Logistics Support, and Engineering

Support – are well within DoD's capabilities. With the proper precautions established and followed, our personnel can safely deploy to the region.

Seventh, speed and scaled response matter. Incremental responses will be outpaced by an epidemic growing exponentially.

Finally, the Ebola epidemic we face is a national security issue – one that requires coordinated domestic and international efforts. Neither the U.S. nor the international community can build a moat around this issue in West Africa, and DoD's efforts in the region are an essential component to contain and reduce the epidemic. Absent a USG response in West Africa, the virus' increasing spread brings the risk of more cases in the U.S.

Before summarizing DoD's role in the USG's USAID-led Ebola response efforts, I would like to thank the defense oversight committees for their recent decision to authorize obligation of up to $750 million of the $1 billion reprogrammed from Overseas Contingency Operations funding to DoD's Overseas Humanitarian, Disaster, and Civic Aid Program. As many are aware, deployment funding is required immediately in order to establish support contracts, move forces, and create logistics networks. This obligation authority provides DoD the latitude it needs to undertake its response in support of USAID activities necessary over the next six months.

The Department of Defense's Role in United States Government Ebola Response Efforts

In mid-September, President Obama ordered DoD to undertake military operations in West Africa to support USAID-led Ebola response efforts. The comprehensive USG response is predicated upon a strategy with four pillars: (1) control the outbreak, (2) mitigate second-order

impacts of the crisis, (3) foster coherent international leadership and response operations, and (4) improve mechanisms for global health security.

As Secretary Hagel noted at the September 26th meeting of the Global Health Security Agenda, DoD is operating in support of USAID as part of the USG's coordinated response to the Ebola Virus Disease (EVD) outbreak. The Secretary directed that U.S. military forces undertake a two-fold mission – first, support USAID in the overall USG efforts to contain the spread and reduce the threat of EVD; and, second, respond to Department of State requests for security or evacuation assistance if required. Direct patient care of Ebola-exposed patients in West Africa is not a part of the DoD mission.

In support of the mission's first element, Secretary Hagel approved military activities falling under four lines of effort: Command and Control, Logistics Support, Engineering Support, and Training.

Our first line of effort is Command and Control. On September 15th, Secretary Hagel approved a named operation, OPERATION UNITED ASSISTANCE (OUA), for U.S. military efforts in response to EVD. United States Africa Command identified Major General Darryl Williams, the Commander of U.S. Army Africa, as UNITED ASSISTANCE's initial commander. On October 25th, OUA command will transition to Major General Gary Volesky, the Commander of the Army's 101st Airborne Division.

Major General Volesky and the deploying elements of his command bring not only significant operational capabilities to support the mission's other lines of effort, but also the command-and-control structure necessary to coordinate U.S. military efforts with other entities. These include: other USG departments and agencies; the Government of Liberia and – in particular – the Armed Forces of Liberia; the United Nations, other intergovernmental

organizations, and nongovernmental organizations providing relief in the region; and bilateral partners providing a military response to the epidemic.

Our second line of effort is Logistics Support. DoD logistics activities are primarily improving transportation capabilities regionally and immediate care capabilities in Liberia. To support transportation efforts, the U.S. military has worked with regional and international partners to establish an intermediate staging base in Dakar, Senegal. U.S. military aircraft are providing strategic airlift into West Africa and tactical airlift within Liberia to move supplies and personnel. To support immediate care capabilities, U.S. military forces constructed a 25-bed hospital in Monrovia as a treatment facility for Liberia-based, non-U.S. military healthcare providers exposed to Ebola. This hospital will be manned by United States Public Health Service healthcare professionals, some of whom are already in-country. The rest will arrive in early November.

Our third line of effort is Engineering Support. In this effort, we are establishing our joint force headquarters in Monrovia, a training facility proximate to the headquarters, and up to 17 Ebola Treatment Units (ETUs) in Liberia at which non-U.S. military healthcare professionals can effectively provide care to Ebola-infected patients. U.S. military engineers are facilitating site selection and construction of the ETUs, and are working closely with Armed Forces of Liberia engineers who are committing their efforts to ETU construction.

The operation's fourth line of effort will be Training. U.S. military personnel will train up to 500 healthcare support personnel at a time, enabling the healthcare workers to serve as the first responders in ETUs throughout Liberia. Again, U.S. military personnel will not provide direct care to Ebola patients in West Africa.

In addition to OUA's four lines of effort, the Department continues two enduring programs in the region. In Liberia, OPERATION ONWARD LIBERTY, consisting of approximately 60 U.S. military personnel, partners with the Armed Forces of Liberia to improve the professionalization and capabilities of Liberia's military.

Regionally, we are expanding the efforts of DoD's Cooperative Biological Enhancement Program (CPEB) to provide robust enhancements to biosafety, biosecurity, and biosurveillance systems in West Africa. The program will also seek to leverage existing partnerships with South Africa, Kenya, and Uganda to bolster regional capacities to mitigate threats associated with the current and potential future outbreaks. As an example of these efforts, CPEB has deployed two mobile labs to Liberia that provide diagnostic capabilities essential to containing and reducing EVD. These labs augment the capacity of the Liberian Institute for Biomedical Research lab, at which CBEP has funded the work of three experts. DoD plans to deploy four additional mobile labs to Liberia the first week of November.

Throughout all of our planning and operations, the safety and well-being of our deployed forces remain of particular importance. The Department recently disseminated new policy regarding the training, screening, and monitoring DoD personnel will undergo prior to, during, and after deployments to West Africa. Before deployment, all personnel will receive a medical threat briefing covering all health threats and countermeasures. In addition, they will receive information on EVD and safety precautions, prevention/protection measures, personal protective equipment use, and symptom recognition and monitoring. DoD medical personnel will receive advanced Ebola-related training, in the unlikely event they must treat our personnel possibly exposed to the virus.

During the operation, DoD personnel will be equipped based on their mission requirements and the likelihood of interacting with local personnel. At a minimum, DoD members will have advanced protective masks, gloves, personal protective suits, and sanitizer immediately available. DoD supervisors and healthcare workers will monitor personnel for early detection of possible symptoms.

To treat DoD personnel who are injured or fall ill while deployed, we have advanced medical care capabilities deployed in Liberia, and are deploying additional capabilities to Liberia and Senegal. Should the unfortunate occur and a DoD member be exposed to Ebola, we have procedures in place to evacuate DoD patients to CDC-designated advanced care facilities in the United States.

When the mission is complete, DoD will continue to monitor the health of our personnel. Within 12 hours of departure from West Africa, trained DoD healthcare personnel will interview and assess DoD personnel to determine possible exposure. After returning from deployment, our personnel will undergo twice-a-day medical monitoring for 21 days – the maximum incubation period of EVD. In all circumstances, the protection of our personnel and the prevention of any additional transmission of the disease remain paramount planning factors for U.S. military response efforts.

Conclusion

West Africa's Ebola epidemic remains dangerous, but we have a comprehensive United States Government response and – increasingly – a coordinated international response to contain the threat and mitigate its effects. The Department of Defense's interim measures are an essential element of the U.S. response, without which it will be extremely difficult to block the

epidemic's rapid expansion. As President Obama has noted, this global threat requires a global response. He has committed U.S. leadership to international Ebola response efforts, but the United States cannot unilaterally address the situation. Now is the time to devote appropriate U.S. resources – military and civilian – necessary to contain the threat, to reduce and mitigate the suffering of the afflicted, and to establish the mechanisms and processes for better future responses.

Chairman ISSA. Thank you.

And I understand, General, you do not have a separate opening Statement.

General LARIVIERE. No, sir, I do not. But I stand ready to answer any questions you might have.

Chairman ISSA. Thank you.

Mr. ROTH.

STATEMENT OF HON. JOHN ROTH

Mr. ROTH. Good morning, Chairman Issa, Ranking Member Cummings, and Members of the committee. Thank you for inviting me to testify about DHS's management of pandemic supplies.

DHS must have the ability to continue its operations in the event of a pandemic. In 2006, Congress appropriated $47 million in supplemental funding to DHS for them to plan, train, and prepare for potential pandemic.

We recently conducted an audit of those efforts, focusing on the Department's preparations to continue operations in achieving its mission should a pandemic occur. The report of our audit is attached to my written testimony that I have submitted to this committee.

In short, our audit concluded that DHS mismanaged their program in three ways. First, we found that DHS did not adequately conduct a needs assessment before purchasing protective equipment and antiviral drugs.

As a result, we could not determine the basis for DHS's decisions regarding how much or what types of pandemic supplies to purchase, store, or distribute. As a result, DHS may have too much of some equipment and too little of others.

For example, we found that DHS has a stockpile of about 350,000 white coverall suits and 16 million surgical masks, but hasn't been able to demonstrate how either fits into their pandemic preparedness plans. It has a significant quantity of antiviral drugs. But, again, without a full understanding of the Department's needs in the event of a pandemic, we have no assurance that the quantity of drugs will be appropriate.

Second, DHS purchased much of the equipment and drugs without thinking through how these supplies would need to be replaced. The material DHS has purchased has a finite shelf life.

For example, TSA's stock of pandemic protective equipment includes about 200,000 respirators that are beyond the 5-year usability date guaranteed by the manufacturer. In fact, the Department believes that their entire stockpile of personal protective equipment will not be usable after 2015.

Likewise, the antiviral drugs DHS purchased are nearing the end of their effective life. DHS is attempting to extend that shelf life of these drugs through an FDA testing program, but the results of that are not guaranteed.

Third, DHS did not manage its inventory of drugs or equipment. As a result, DHS did not readily know how much protective equipment and drugs it had on hand or where it was being stored. Drugs and equipment have gone missing. And, conversely, our audit has

found drugs in the DHS inventory that the Department thought had been destroyed.

We visited multiple sites and found drugs that were not being stored in a temperature-controlled environment. Because DHS cannot be assured that they were properly stored, they are in the process of recalling a significant quantity of them because they may not be safe or effective.

We made 11 separate recommendations. DHS has concurred with all of them. One of those recommendations has been fully implemented, and the Department is taking action to implement the remaining ten recommendations. We will continue to keep this committee informed about the Department's progress.

Mr. Chairman, that concludes my prepared Statement. I welcome any questions.

[The prepared Statement of Mr. Roth follows:]

Good morning Chairman Issa, Ranking Member Cummings, and Members of the Committee. Thank you for inviting me to testify about the Department of Homeland Security's (DHS) management of pandemic preparedness supplies.

DHS must have the ability to continue its operations in the event of a pandemic. In 2006, Congress appropriated $47 million in supplemental funding to DHS to train, plan, and prepare for a potential pandemic. As a result, that year DHS began efforts to develop contingency plans and preparedness to be able to protect DHS personnel who may become exposed in a pandemic. Using the appropriated supplemental funding, DHS has acquired, stockpiled, and maintained protective equipment and antiviral drugs at departmental and component levels in preparation for a pandemic response.

DHS' Office of Health Affairs (OHA) and the Directorate for Management are responsible for organizing the Department's pandemic preparations. These offices provide guidance to DHS components to enable mission readiness and protect DHS personnel during a pandemic.

My statement today will focus on the results of our August 2014 audit of the Department's management of personal protective equipment and antiviral drugs as well as DHS' progress in addressing our recommendations.[1] Our audit focused on the Department's preparations to continue operating and achieving its mission should a pandemic occur. In short, our audit concluded that DHS did not adequately assess its needs before purchasing pandemic preparedness supplies and then did not adequately manage the supplies it had purchased. We made 11 recommendations to help improve the efficiency and effectiveness of the Department's pandemic preparedness.

DHS Did Not Adequately Assess Its Needs or Plan Its Acquisition of Supplies

During our audit, we found that DHS did not adequately conduct a needs assessment before purchasing protective equipment and antiviral drugs. DHS reported spending $9.5 million on pandemic protective equipment beginning in 2006, yet did not identify its needs for protective equipment. Moreover, DHS spent $6.7 million for antiviral drugs, but did not have clear and documented methodologies for determining the types and quantities of medication it should purchase. In other words, we could not determine the basis for DHS' decisions on how much or what types of pandemic preparedness supplies to purchase, store, or distribute. The balance of the funds was spent on pandemic research, exercises, and storage.

By not identifying its needs, the Department cannot be sure its protective equipment stockpiles are adequate or determine whether it has excess supplies on hand. For example:

- The DHS National Capital Region (NCR) pandemic stockpile contains about 350,000 white coverall suits. Yet DHS had no justification or related documentation to support that this quantity and type of protective equipment was necessary for pandemic response.

[1] *DHS Has Not Effectively Managed Pandemic Personal Protective Equipment and Antiviral Medical Countermeasures*, OIG-14-129, August 2014.

- The Department has a reported inventory of approximately 16 million surgical masks but did not demonstrate a need for that quantity of masks.
- The Department's NCR and component pandemic protective equipment stockpiles include expired hand sanitizer. Out of 4,982 bottles, 4,184 (84 percent) are expired, some by up to 4 years.
- TSA's stock of pandemic protective equipment includes about 200,000 respirators that are beyond the 5-year usability guaranteed by the manufacturer. TSA is sampling these to determine any specific problems with usability.

In fiscal year 2009, OHA added approximately 240,000 courses of antiviral drugs to the Department's stockpile, again without first determining the Department's pandemic needs. Only after its initial purchases did OHA prepare an acquisition management plan for antiviral drugs, which estimated its requirements, but it did not follow this plan. Instead, OHA acted on a senior-level decision to cover the DHS workforce in the event of a pandemic, but it did not provide any documentation demonstrating how the current stockpile of about 300,000 courses aligned with its pandemic needs. Without sufficiently determining its needs, the Department has no assurance it will have enough antiviral drugs to maintain critical operations during a pandemic.

DHS Does Not Adequately Manage Pandemic Preparedness Supplies

DHS did not effectively manage and oversee its inventory of pandemic preparedness supplies, including protective equipment and antiviral drugs. DHS did not keep accurate records of what it purchased and received and did not implement sufficient controls to monitor its stockpiles. More specifically, the Department did not develop and implement stockpile replenishment plans, establish sufficient inventory controls to monitor stockpiles, conduct adequate contract oversight, or ensure compliance with departmental guidelines. As a result, the Department may not be able to provide pandemic preparedness supplies that are adequate to continue operations during a pandemic.

DHS did not readily know how much protective equipment it had on hand or where the equipment was being stored. The Department also cannot be assured that the protective equipment on hand is still effective. For example, the Department's entire respirator stockpile has reached, or will soon reach, the manufacturer's date of guaranteed usability. In fact, the Department's own assessment is that the entire protective equipment stockpile will not be usable after 2015.

DHS also did not keep records of the protective equipment it purchased and received, and it has not accurately accounted for how much protective equipment it currently has in stock. There is departmental guidance on inventory management, but the Department and components did not establish and maintain accurate inventories in accordance with that guidance. This may have occurred because it did not use an inventory system to track and monitor protective equipment or perform periodic inventories of its protective equipment stockpiles. During site visits to several components, we identified inaccurate protective equipment inventories.

The Department's management of protective equipment has not been effective because it has not clearly designated department-level responsibility. For example, OHA and the Directorate for

Management interpret roles and responsibilities for administration and oversight of DHS' NCR stockpile differently. Both offices acknowledged the responsibilities were not clearly delineated to guarantee coordinated management and oversight of protective equipment.

DHS has also not effectively managed its antiviral drug stockpile. DHS decided to preposition some of its stockpile to component offices in response to the 2009 H1N1 influenza pandemic. OHA prepositioned approximately 32,000 courses of antiviral drugs to U.S. Customs and Border Protection, U.S. Immigration and Customs Enforcement (ICE), the U.S. Secret Service, and Federal Emergency Management Agency locations. OHA did not maintain complete or accurate records of the quantity and destination of antiviral drugs distributed from the stockpile, and components did not document receipt of antiviral drugs.

Based on our analysis of antiviral drugs sent to components, OHA and components did not have complete or accurate inventories of prepositioned antiviral drugs. For example:

- OHA sent more than 1,500 courses of antiviral drugs to Secret Service headquarters. OHA did not have records of any antiviral drugs at the Secret Service because it did not maintain shipment documentation.
- At three ICE field office locations, 720 courses of antiviral drugs were incorrectly reported to ICE headquarters as destroyed; yet, we identified they were still in possession of these antiviral drug courses.

Component headquarters did not issue guidance for their field offices or ensure proper controls were in place to account for the antiviral drugs after they were prepositioned. Specifically, components did not ensure antiviral drugs were consistently stored at the correct temperatures. For example, at multiple sites we visited, officials said the buildings where antiviral drugs were being stored were not temperature controlled during evenings and weekends. Antiviral drugs stored incorrectly may lose effectiveness. OHA spent about $600,000 on the antiviral drugs sent to component field offices, but because it cannot be assured that the prepositioned antiviral drugs have been properly stored, it is recalling about 32,000 courses for possible destruction because of safety and efficacy concerns.

DHS' Progress in Addressing Audit Recommendations

DHS concurred with all 11 of our recommendations and 1 recommendation has been fully implemented. The Department has agreed to make the Chief Readiness Support Officer responsible for the management and accountability of pandemic protective equipment. The Department is taking action to implement the remaining 10 recommendations. We will continue to keep the Committee informed about the Department's progress.

Mr. Chairman, this concludes my prepared statement. I welcome any questions you or other Members of the Committee may have.

Department of Homeland Security

Office of Inspector General

DHS Has Not Effectively Managed Pandemic Personal Protective Equipment and Antiviral Medical Countermeasures

OIG-14-129

August 2014

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

August 26, 2014

MEMORANDUM FOR: The Honorable Alejandro Mayorkas
Deputy Secretary
Department of Homeland Security

Dr. Kathryn Brinsfield
Acting Assistant Secretary and Chief Medical Officer
Office of Health Affairs

FROM: John Roth
Inspector General

SUBJECT: *DHS Has Not Effectively Managed Pandemic Personal Protective Equipment and Antiviral Medical Countermeasures*

Attached for your action is our final report, *DHS Has Not Effectively Managed Pandemic Personal Protective Equipment and Antiviral Medical Countermeasures.* We incorporated the formal comments from the Department in the final report. The report contains 11 recommendations aimed at improving the efficiency and effectiveness of the Department's pandemic preparations. Your office concurred with the intent of all 11 recommendations. We consider Recommendation 9 resolved and closed. Based on information provided in your response to the draft report, we consider the remaining recommendations resolved and open. Once your office has fully implemented the recommendations, please submit a formal closeout letter to us within 30 days so that we may close the recommendations. The memorandum should be accompanied by evidence of completion of agreed-upon corrective actions.

Please email a signed PDF copy of all responses and closeout requests to OIGAuditsFollowup@oig.dhs.gov. Until your response is received and evaluated, the recommendations will be considered open and resolved.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to appropriate congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact Anne L. Richards, Assistant Inspector General for Audits, at (202) 254-4100.

Attachment

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Abbreviations

CBP	U.S. Customs and Border Protection
CDC	Centers for Disease Control and Prevention
COR	contracting officer's representative
DHS	Department of Homeland Security
ECD	Estimated Completion Date
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FY	fiscal year
HHS	Department of Health and Human Services
IAA	interagency agreement
ICE	U.S. Immigration and Customs Enforcement

MCM	medical countermeasures
NCR	National Capital Region
NPPD	National Protection and Programs Directorate
OHA	Office of Health Affairs
OIG	Office of Inspector General
PPE	personal protective equipment
SLEP	Shelf-Life Extension Program
TSA	Transportation Security Administration
USCG	United States Coast Guard
USCIS	U.S. Citizenship and Immigration Services
USSS	United States Secret Service

Executive Summary

The Department of Homeland Security (DHS) supports efforts to develop and execute pandemic contingency plans and preparedness actions as part of the United States Government's pandemic preparedness strategy. A severe influenza pandemic presents a tremendous challenge, which may affect millions of Americans, cause significant illnesses and fatalities, and substantially disrupt our economic and social stability. It is DHS' responsibility to ensure it is adequately prepared to continue critical operations in the event of a pandemic.

In 2006, Congress appropriated $47 million in supplemental funding to DHS for necessary expenses to plan, train, and prepare for a potential pandemic. DHS reported that it spent this funding on personal protective equipment, pandemic research, exercises, and medical countermeasures. The Department and components purchased personal protective equipment and medical countermeasures (specifically, antiviral medical countermeasures) to reduce potential effects of a pandemic and ensure the workforce can continue operations. We conducted an audit of the DHS pandemic preparedness efforts to determine if DHS effectively manages its pandemic preparedness supply of personal protective equipment and antiviral medical countermeasures.

DHS did not adequately conduct a needs assessment prior to purchasing pandemic preparedness supplies and then did not effectively manage its stockpile of pandemic personal protective equipment and antiviral medical countermeasures. Specifically, it did not have clear and documented methodologies to determine the types and quantities of personal protective equipment and antiviral medical countermeasures it purchased for workforce protection. The Department also did not develop and implement stockpile replenishment plans, sufficient inventory controls to monitor stockpiles, adequate contract oversight processes, or ensure compliance with Department guidelines. As a result, the Department has no assurance it has sufficient personal protective equipment and antiviral medical countermeasures for a pandemic response. In addition, we identified concerns related to the oversight of antibiotic medical countermeasures.

We made 11 recommendations that when implemented should improve the efficiency and effectiveness of the Department's pandemic preparations. The Department concurred with the intent of all 11 recommendations.

Background

DHS pandemic preparedness strategy includes efforts to develop and execute pandemic contingency plans and preparedness actions. As new threats emerge, DHS must plan and prepare for possible disasters—both natural and manmade. One of these threats is a pandemic resulting from a new influenza virus. A severe influenza pandemic presents a tremendous challenge, which may affect millions of Americans, cause significant illnesses and fatalities, and substantially disrupt our economic and social stability.

According to the Centers for Disease Control and Prevention (CDC), an influenza pandemic can occur when a nonhuman influenza virus is able to transmit efficiently and sustainably from human to human and spread globally.

In the event of any emergency, Federal employees will be expected to continue operations to sustain agency functions. An influenza pandemic is not a singular event, but may come in waves that last weeks or months. It may also pass through communities of all sizes across the Nation and world simultaneously, as demonstrated with the 2009 H1N1 influenza pandemic. The mounting risk of a worldwide influenza pandemic poses numerous potentially devastating consequences for critical infrastructure in the United States.

DHS is responsible for ensuring it is adequately prepared to continue critical operations in the event of a pandemic. The Office of Health Affairs (OHA) serves as DHS' principal authority for all medical and public health issues. OHA provides medical, public health, and scientific expertise in support of DHS' mission to prepare for, respond to, and recover from all threats. OHA leads the Department's workforce health protection and medical oversight activities and provides medical and scientific expertise to support the Department's preparedness and response effort. The Directorate for Management is responsible for implementing the Departmental occupational safety and health program, as well as procurement, property, equipment, and human capital for the Department. Within the Directorate, the Departmental Occupational Safety and Health office integrates safety and health principles into the management of DHS operations, and provides direction and advice to DHS management for occupational safety and health matters.

Both OHA and the Directorate for Management are responsible for organizing pandemic preparations for the Department. These offices provide guidance to DHS components to enable mission readiness and the protection of DHS personnel during a pandemic event. Mission readiness for a pandemic includes having pandemic personal protection equipment (PPE) and antiviral medical countermeasures (MCM) to distribute and dispense during a pandemic. Pandemic PPE is a workplace control measure the DHS

workforce may use to prevent infection and reduce the spread of disease. In addition, the distribution and dispensing of antiviral MCM may protect DHS personnel, as well as critical contractors and those within DHS' care and custody who are potentially exposed in a pandemic.

In 2006, Congress appropriated $47 million in supplemental funding to DHS for necessary expenses to train, plan, and prepare for a potential pandemic. DHS reported that it spent this funding on PPE, pandemic research, exercises, and MCM. The Department and components purchased PPE and medication (antiviral MCM) to reduce potential effects of a pandemic and ensure the workforce can continue operations.

Using the appropriated supplemental funding, DHS has maintained PPE and antiviral MCM stockpiles at both the departmental and component levels in preparation for a pandemic response. Specifically, DHS has a PPE stockpile held at a Federal Emergency Management Agency (FEMA) distribution center and multiple component locations. Stockpiles of antiviral MCM are held at a Department of Health and Human Services (HHS) facility and multiple component locations.

We conducted an audit of the DHS pandemic preparedness efforts to determine if DHS effectively manages its pandemic preparedness supply of PPE and antiviral MCM. As part of this audit, we also identified concerns related to oversight of antibiotic MCM, which was outside our audit scope.

Results of Audit

DHS did not adequately conduct a needs assessment prior to purchasing PPE and MCM for pandemic preparedness. DHS did not effectively manage the inventory of pandemic preparedness supplies it purchased. Specifically, it did not have clear and documented methodologies for the types and quantities of PPE and MCM purchased for workforce protection. The Department also did not develop and implement stockpile replenishment plans, sufficient inventory controls to monitor stockpiles, adequate contract oversight processes, or ensure compliance with Department guidelines. As a result, the Department has no assurance that it has sufficient PPE and MCM for DHS employees to continue operations. DHS also has no assurance that the supplies on hand remain effective. As part of our audit work, we also identified concerns related to oversight of antibiotic MCM.

Needs Assessment for Pandemic Preparedness Supplies

DHS did not effectively determine its need for pandemic preparedness supplies prior to purchasing those supplies. Specifically, it did not identify its PPE needs or

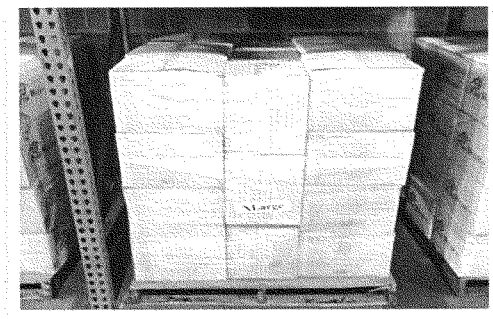
its needs for antiviral MCM, have clear and documented methodologies for the types and quantities of equipment purchased, have stockpile replenishment plans for either PPE or MCM, or implement sufficient inventory controls to monitor the stockpiles. Much of the PPE DHS purchased is past the manufacturers' date of guaranteed usability and most of the MCM purchased is now nearing the manufacturers' expiration date.[1] As a result, DHS and components may not have sufficient PPE or MCM to provide to the workforce during a pandemic.

Personal Protective Equipment Planning

Prior to purchasing PPE, the Department did not identify the type and quantity needed to continue operations during a pandemic. DHS reported spending $9.5 million on pandemic PPE beginning in 2006 for its headquarters and components, yet did not develop a life cycle management plan.[2] PPE purchases included respirators, surgical masks, gloves, goggles, hand sanitizer, and coverall suits. DHS and components did not have clear and documented methodologies for determining the types and quantities of equipment they needed. By not identifying its needs, the Department cannot be sure its PPE stockpiles are adequate or determine if it has excess supplies on hand. For example:

- The DHS National Capital Region (NCR) pandemic stockpile contains about 350,000 white coverall suits. No justification or related documentation was available to support that this quantity and type of PPE was necessary for pandemic response.

[1] Based on the manufacturer's experience, the filter media in the respirators retains its filtration performance in accordance to stated National Institute for Occupational Safety and Health certification for 5 years from the date of manufacture.
[2] A life cycle management plan is a documented process to acquire, maintain, and ultimately dispose of a product or service.



Source: OIG photo
One of 432 pallets of coverall suits at the DHS NCR PPE stockpile.

- The Department has a reported inventory of approximately 16 million surgical masks without demonstrating a need for that quantity of masks.

Source: OIG photo
An aisle of the DHS NCR PPE stockpile containing nitrile gloves, surgical masks, respirators, and coverall suits.

The Department also did not develop alternative use or rotation plans for headquarters and component PPE stockpiles. The Department's entire respirator

stockpile has reached, or will soon reach, the manufacturer's date of guaranteed usability. In fact, the Department's own assessment is that the entire PPE stockpile will not be usable after 2015. During site visits, we identified the following:

- The Transportation Security Administration's (TSA) stock of pandemic PPE includes about 200,000 respirators that are beyond the 5-year manufacturer's guaranteed usability. TSA is conducting sampling of its PPE to identify any specific problems with its usability. However, TSA officials said they will maintain existing stock and may use it for "employee comfort."

Source: OIG photo
There were 62,000 surgical masks designated for pandemic use at a TSA warehouse.

- The Department's NCR and component pandemic PPE stockpiles include expired hand sanitizer. Out of 4,982 bottles, 4,184 (84 percent) are expired, some by up to 4 years.

Source: OIG photo
Pallet in DHS NCR stockpile of hand sanitizer that expired in February 2010.

Antiviral Medical Countermeasures Planning

In fiscal year (FY) 2009, OHA purchased approximately 240,000 courses of antiviral MCM on behalf of the Department, without first determining the Department's pandemic needs.[3] After its initial purchases, OHA prepared an acquisition management plan for antiviral MCM, which estimated its requirements. However, OHA did not follow this plan. Instead, OHA acted on a senior-level decision establishing 110 percent coverage of the DHS workforce.[4] The Department has not provided any documentation demonstrating how the current stockpile of approximately 300,000 courses aligns with its pandemic needs.

Since FY 2009, OHA has purchased additional antiviral MCMs without reevaluating the stockpile quantity for reasonableness. OHA conducted periodic data calls to components to identify mission-critical employees. However, OHA did not document how the information was used to ensure its stockpile of antiviral MCM would be sufficient to meet its needs.

[3] A course is a series of doses administered to a single individual over a designated period. The DHS antiviral MCM stockpile contains Tamiflu and Relenza.
[4] The DHS workforce includes critical contractors and people under DHS' care and custody. It does not include the United States Coast Guard (USCG) because the USCG maintains its own MCM program and stockpile.

Without sufficiently determining its needs, the Department has no assurance it will have an adequate amount of antiviral MCM to maintain critical operations during a pandemic. Also, it cannot ensure previous and future purchases of antiviral MCM are an efficient use of resources. DHS acquired most of its stockpile of antiviral MCM in FY 2009, but did not implement an acquisition management plan that included a strategy for replenishment. Having an acquisition management plan would ensure its stockpile continued to meet its needs. As a result, about 81 percent of its stockpile will expire by the end of 2015 (shown in table 1). DHS recently spent about $760,000 on an additional purchase of 37,000 antiviral MCM courses, yet had still not demonstrated how that purchase met its needs.

OHA is applying for a shelf-life extension with the Food and Drug Administration (FDA) to extend the expiration dates on the antiviral MCM expiring in 2015, specifically Tamiflu, in the DHS stockpile. We applaud their effort and encourage this process, as it reduces the resources needed to replace expiring drugs and would extend their Tamiflu stockpile expiration until 2018. However, OHA has not yet been granted an extension. Even with the extension, this may not fulfill the DHS requirements if a pandemic event occurs.

Table 1. Courses of DHS Antiviral Medical Countermeasures Expiring in 2015

Antiviral MCM	Current Antiviral MCM Stockpile	Antiviral MCM Expiring in 2015	Percent of Antiviral MCM Expiring in 2015
Tamiflu	192,272	192,272	100%
Relenza	103,734	47,472	46%
Totals	**296,006**	**239,744**	**81%**

Source: OIG analysis

Management of Pandemic Preparedness Supplies

DHS did not effectively manage and oversee its inventory of pandemic preparedness supplies, including PPE and antiviral MCM. Specifically, DHS did not keep accurate records of what it purchased and received and did not implement sufficient controls to monitor its stockpiles. As a result, DHS may not be able to provide sufficient pandemic preparedness supplies to its employees to continue operations during a pandemic.

Personal Protective Equipment Oversight

DHS did not have proper oversight of its pandemic PPE supplies. It did not keep records of what it purchased and received, and it has not accurately accounted for how much PPE it currently has in stock. There is departmental guidance on inventory management; however, the Department and components did not establish and maintain accurate inventories in accordance with that guidance. This condition may have existed because the Department and components did not use an inventory system to track and monitor PPE or perform periodic inventories of their PPE stockpiles. For example, the Department lost a secondary PPE stockpile, once located in Washington, DC, containing 25,000 surgical masks and hand sanitizer. A Federal Government office building in Washington, DC received this stockpile in 2009, but officials were unable to locate the stockpile for this audit and reported it as lost. Additionally, at a site visit to the DHS NCR stockpile at a FEMA distribution center, we found inventory discrepancies as seen in table 2.

Table 2. Analysis of DHS National Capital Region Stockpile

Personal Protective Equipment Item	FEMA Distribution Center Inventory Aug. 2013	OIG Verified Count Aug. 2013	Discrepancy
Model 9210 Respirators	Not on Inventory	4,800	4,800
Model 1860 Respirators	919,080	928,320	9,240
Coverall Suits	367,800	356,400	-11,400
Hand Sanitizer (8 oz.)	Not on Inventory	784	784
Protective Goggles	23,214	20,312	-2,902

Source: OIG analysis

We also identified inaccurate inventories at component offices. United States Immigration and Customs Enforcement (ICE), National Protection and Programs Directorate (NPPD), and TSA did not establish an inventory of the initial stock they received from the Department. Subsequent attempts to inventory their pandemic PPE were not accurate. ICE and TSA officials reported unknown quantities of PPE may have been disposed of, but we could not verify this report since the components had not performed an earlier inventory. In fact, at some ICE and United States Secret Service (USSS) locations, PPE was distributed to employees without any tracking or record keeping.

Management of the Department's pandemic PPE has not been effective because responsibility at the departmental level has not been clearly designated. The Directorate for Management and OHA have different interpretations regarding

the roles and responsibilities for administration and oversight of DHS' NCR stockpile. Both offices acknowledged that there is no clear delineation of responsibilities necessary to guarantee successful coordination of the management and oversight of pandemic PPE. They have agreed to clarify their roles. Without delineated roles, proper management, accountability, and oversight of the Department's pandemic PPE cannot occur.

Antiviral Medical Countermeasures Inventory Management

DHS decided to pre-position some of its stockpile to component offices in response to the H1N1 influenza pandemic in 2009. OHA pre-positioned approximately 32,000 courses of antiviral MCMs to U.S. Customs and Border Protection (CBP), ICE, USSS, and FEMA locations. OHA did not maintain complete or accurate records of the quantity and shipped location of MCM distributed from the stockpile, and components did not document receipt of MCM.

In 2010, OHA requested component inventories, but did not validate the reported information. OHA cannot account for nearly 6,200 courses of antiviral MCM pre-positioned with the components (see table 3). During our review, we were able to locate more than 4,000 courses of antiviral MCM; however, more than 2,000 courses remain missing.

Table 3. Analysis of OHA and Component Antiviral Medical Countermeasures Inventories

Component	Courses Shipped by HHS	Courses Reported to OHA by Components	Net Adjustments from OIG Validation	Courses Missing
CBP	24,192	20,275	2,040	1,877
FEMA	144	144	0	0
ICE	6,240	5,496	696	48
USSS	1,536	0	1,406	130
Grand Total	**32,112**	**25,915**	**4,142**	**2,055**
Total Unknown to OHA			**6,197**	

Source: OIG analysis

Based on our analysis of antiviral MCM sent to components, OHA and components did not have complete or accurate inventories of pre-positioned antiviral MCM. Specifically, we identified the following:

- OHA sent more than 1,500 courses of antiviral MCM to the USSS headquarters. OHA did not have records of any MCM at USSS because it did not maintain shipment documentation.
- OHA sent 590 courses of antiviral MCM to eight CBP field offices, of which CBP headquarters was unaware because it did not monitor antiviral MCM until 2012.
- At two CBP locations, we found inventory discrepancies including one location that reported 90 courses, but actually had 1,344; and another location reported 330, but actually had 528.
- At three ICE field office locations, 720 courses of antiviral MCM were incorrectly reported to ICE headquarters as destroyed; yet, we identified they were still in possession of these MCM courses.

Interagency Agreement Oversight

OHA had interagency agreements (IAA) with HHS for the storage and logistics of the majority of its antiviral MCM. However, OHA did not ensure proper contract administration and oversight. Specifically, there was no documentation that the contract performance was routinely monitored. Only one inspection was documented during the entire contract period. The most recent contracting officer's representative (COR) was unaware of his appointment and did not fulfill his duties for more than 7 months. This occurred because the program office responsible for designating the COR did not notify the COR of his appointment and responsibilities.

COR oversight is essential to ensuring that goods are received and services are performed in accordance with the statement of work. However, OHA has paid HHS without ensuring it received goods and services. We notified OHA of this problem, and OHA has since designated a COR and issued an appointment letter outlining COR duties and responsibilities.

Antiviral Medical Countermeasures Guidance and Monitoring

OHA issued guidance that pre-positioned antiviral MCM was to be securely stored in remote locations with limited or no immediate access to medical care, properly dispensed, and kept in a temperature-controlled environment. However, CBP, ICE, and USSS did not follow OHA's guidance on pre-positioning antiviral MCM in remote locations, and OHA did not enforce this requirement. Instead, OHA allowed components to store antiviral MCM in major metropolitan areas like Boston, MA; Chicago, IL; Denver, CO; Miami, FL; and Washington, DC. For example, ICE requested that OHA send an equal amount of antiviral MCM to

locations nationwide, regardless of the size of the office or of its remote location.

Neither OHA nor components provided documented guidance regarding how to properly secure the antiviral MCM. This contributed to the ineffective management of the antiviral MCM and diminished the Department's ability to continue critical operations during a pandemic. For example, ICE was missing 48 courses of antiviral MCM at two of its locations. ICE headquarters cannot account for what happened to the missing courses of antiviral MCM. We visited one of these offices and found that the medication was in an unsecured office storage room.

In addition to missing antiviral MCM, USSS may have improperly dispensed 130 courses of antiviral MCM to its employees to treat influenza in 2009. USSS could not provide any documentation, as required, to show they were dispensed. OHA officials said components were not authorized to dispense the antiviral MCM. OHA did not maintain records of MCM at USSS, and it may not have provided guidance on proper dispensing protocols to USSS.

OHA also had no assurance that components stored antiviral MCM at the proper temperature and did not monitor components to ensure MCMs were stored in continuously temperature-controlled environments. OHA's 2009 guidance for antiviral MCMs outlined the requirements for storage temperature, but it did not have monitoring requirements for components to ensure the antiviral MCM were stored properly.

Additionally, component headquarters did not issue guidance for their field offices or ensure proper controls were in place to account for the antiviral MCM after it was pre-positioned. Specifically, components did not ensure antiviral MCM were consistently stored at the correct temperatures. For example, at multiple sites we visited, officials said the buildings where antiviral MCM were being stored were not temperature controlled during evenings and weekends. OHA spent approximately $600,000 on the antiviral MCM sent to component field offices. OHA does not have assurance that the pre-positioned antiviral MCM have been properly stored. Therefore, it is in the process of recalling approximately 32,000 courses of antiviral MCM for possible destruction due to concerns about safety and efficacy.

Additional Observation

Although antibiotic MCM was outside the scope of our audit, we have similar concerns regarding the effectiveness of CBP's monitoring of its antibiotic MCM.

During four of our CBP site visits, we observed antibiotic MCM stored alongside antiviral MCM. CBP MCM monitoring relies on the self-reported inventories, which do not contain storage conditions at field offices. This monitoring is insufficient to ensure pre-positioned antibiotic MCM are being stored according to requirements. As a result, the usability of its stockpile of more than 88,000 courses of antibiotic MCM, valued at $5 million, may be questionable.

OHA has agreements in place with most components giving them the responsibility to properly store antibiotics and outlining requirements to maintain the antibiotics. During our audit, we observed inadequate monitoring of storage conditions only at CBP. However, we urge OHA to ensure there is proper management and oversight of the Department's pre-positioned antibiotic MCM and that components comply with all storage requirements.

Recommendations

We recommend that the Deputy Secretary:

Recommendation #1:

Identify and designate an office responsible for the management and accountability of pandemic PPE.

We recommend the office designated for the management and accountability of pandemic PPE:

Recommendation #2:

Develop a strategy for management, storage, and distribution of pandemic PPE.

Recommendation #3:

Implement an inventory system for the current inventory and future inventories of pandemic PPE.

Recommendation #4:

Work with components to establish a methodology for determining sufficient types and quantities of pandemic PPE to align with the department-wide pandemic plan.

Recommendation #5:

Have components implement inventory control procedures for pre-positioned pandemic PPE to monitor stockpiles, track shipments, and ensure compliance with departmental guidance.

We recommend the DHS MCM Working Group and OHA:

Recommendation #6:

Determine requirements of antiviral MCM for the Department to maintain critical operations during a pandemic.

We recommend OHA:

Recommendation #7:

Create an antiviral MCM Acquisition Management Plan to include:

a) a methodology for determining the ideal quantity of antiviral MCM OHA will stockpile and how frequently it will be reevaluated;
b) a replenishment plan; and
c) inventory tracking, reporting, and reconciliation procedures for existing stockpile and new antiviral purchases.

Recommendation #8:

Revise procedures to ensure proper contract oversight by government employees for management of its MCM support service contracts and ensure the contracting officer's representatives follow procedures.

Recommendation #9:

Finalize and issue antiviral MCM guidance on the storage conditions, security, and distribution for antiviral MCM for all components.

Recommendation #10:

Finalize the antiviral MCM recall it has initiated on the CBP, ICE, FEMA, and USSS inventories.

Recommendation #11:

Collaborate with CBP to determine the safety and effectiveness of the antibiotic MCM that have been stored alongside their antivirals.

Management Comments and OIG Analysis

In its response to our draft report, the Department concurred with the intent of all 11 recommendations. It identified issues it believed were not appropriately characterized, which are addressed below. The Department expressed concern that we overemphasized the role of PPE and MCM, which they view as the last in a hierarchy of controls. During the audit, we did review the hierarchy of controls including engineering controls, administrative controls, PPE, and MCM. The audit focuses on PPE and MCM due to the extensive governmental resources dedicated to purchasing materials and drugs in both areas. In addition, according to the DHS Chief Medical Officer, "the MCM Program plays a vital role in protecting our workforce and ensures that the Department's operational and headquarters components have the capability and the resources to continue to fulfill our mission during a major incident." We were unable to include information on engineering controls because the Department could not provide documentation to demonstrate this control was used. According to DHS officials, no funding has been allocated for engineering controls, such as physical barriers. We also considered the potential impact of administrative controls, specifically telework. At the time of our audit, less than 5 percent of DHS employees actually teleworked and approximately 30 percent of DHS employees were in positions that are capable of telework. Many of DHS employees conduct operations, such as passenger screening, that are not suitable for telework. Therefore, while there are alternative controls, we chose to focus on where DHS has invested its resources and on the controls within the hierarchy that would be critical in allowing DHS operations to continue during a pandemic.

In auditing PPE and MCM, the OIG relied on HHS, FDA, CDC, manufacturer information, and DHS's medical, safety and health professionals as outlined in the report. The Department headquarters' entire respirator stockpile has reached, or will soon reach, the manufacturer's date of guaranteed usability. According to a Departmental safety and health official, "although periodic sampling by DHS professional occupational safety and health personnel could establish whether it remained usable, Management has determined the best alternative is to standardize the pandemic PPE supply chain and discontinue headquarters' reliance on current stockpiles and dispose of them by the end of 2015." At the time of the audit, DHS provided no documentation on plans to replace their current PPE stockpile by 2015 and the funding to accomplish such a

task. The audit found that DHS and components do not know where PPE is located, how much it has, and the usability of the stockpiles that exist. Although DHS has identified PPE and MCM as the least effective controls, it has invested millions in purchasing these resources without determining the quantities needed for a pandemic response. According to DHS, it is not required under the Occupational Safety and Health Administration to provide PPE supplies to its personnel; however, it has elected to do so in its own planning requirements. DHS should ensure it has sufficient supplies to fulfill its requirements and that the supplies are in working condition.

In addressing MCM, OHA has taken steps with the FDA to use the Shelf-Life Extension Program (SLEP), which can save valuable resources by extending expiration dates on drugs still found to be effective. We applaud their effort and encourage this process, as it reduces the resources needed to replace expiring drugs. However, OHA needs to ensure that it properly identifies the drugs that receive such an extension. OHA improperly identified in its response that it had been granted an FDA extension for its antiviral MCM. The FDA has not approved the specific drugs OHA has in its strategic stockpile that are due to expire next year. During meetings with the Department, they confirmed they did not have an FDA extension for their stockpile.

The plans in place when the audit was initiated were the 2009 H1N1 plans for both the Department and the components. The Department was in the process of updating its pandemic plans, so we were unable to review those as part of this initial audit. The Department's pandemic planning efforts will be addressed in an upcoming audit.

Recommendation #1: Concur. The Office of the Under Secretary for Management designated the DHS Office of the Chief Readiness Support Officer as being responsible for the management and accountability of pandemic PPE effective January 2014. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides evidence that the Chief Readiness Support Officer has been designated as being responsible for the management and accountability of pandemic PPE effective January 2014. The Department should also provide a copy of the new policy memo, once implemented.

Recommendation #2: Concur. The DHS Chief Readiness Support Officer issued a Pandemic Logistics Support Plan Charter on May 30, 2014. This charter

establishes the framework for the development of a Department pandemic logistics support plan for pandemic PPE. A Pandemic Logistics Integration Team (iTeam) has also been established with representation from DHS Components and pandemic PPE requirements have been drafted. Estimated Completion Date (ECD): September 30, 2014.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the strategy for management, storage, and distribution of pandemic PPE developed by the Pandemic Logistics Integration Team. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #3: Concur. Members of the Pandemic Logistics iTeam are reviewing the application of the Department's existing personal property inventory management systems for establishing management and inventory controls for pandemic PPE. The current pandemic PPE inventories are being distributed within DHS where operational requirements can be augmented; remaining items will be surplused in accordance with Federal and Department requirements and standards. ECD: September 30, 2014.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the implementation plan including the inventory system for the current inventory and future inventories of pandemic PPE developed by the Pandemic Logistics Integration Team. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #4: Concur. Work is underway. A workgroup has been established under the Pandemic Logistics iTeam to develop PPE requirements using an employee risk based approach supporting work place controls. ECD: September 30, 2014.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the workgroup's plan establishing a methodology for determining sufficient types and quantities of pandemic PPE to align with the department-wide pandemic plan. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #5: Concur. This is in the planning stage. A policy and standards workgroup is being established under the Pandemic Logistics iTeam to establish PPE control procedures and standards. ECD: September 30, 2014.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the workgroup's plan implementing inventory control procedures for pre-positioned pandemic PPE to monitor stockpiles, track shipments, and ensure compliance with departmental guidance. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #6: Concur. Concur. OHA continues to solicit, receive, and address DHS component MCM needs and requirements as a standing agenda item during the monthly MCM Working Group meeting, and as a key element of the MCM Quarterly Reports, OHA prepares and distributes as part of the MCM program. Additionally, DHS is working with CDC on an interagency process to define antiviral stockpiling needs on behalf of the entire Federal Government. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the workgroup's plan outlining the determination of requirements of antiviral MCM for the Department to maintain critical operations during a pandemic. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #7: Concur. An MCM Integrated Logistics Support Program has been drafted and is currently in DHS clearance. Completion of the MCM Integrated Logistics Support Program will address all three elements of this recommendation. ECD: September 30, 2014.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the Integrated Logistics Support Program addressing all three elements of this recommendation. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #8: Concur in principle. Existing procedures as described in the Homeland Security Acquisition Regulation, Homeland Security Acquisition

Manual, the DHS Office of Procurement Operations contracting officer's representative guidebook and component-specific procedures addressing contracting officer's representative duties and responsibilities are adequate for ensuring proper contract oversight, but these procedures were not followed consistently in the administration of MCM support service contracts. Since OIG identified findings concerning inadequate oversight, OHA has taken steps to ensure that highly qualified contracting officer's representatives are assigned to all MCM support service contracts. These employees provide direct and comprehensive oversight of each aspect of the MCM project including detailed governance over all related contract support. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy of the revised procedures to ensure proper contract oversight by government employees for management of its MCM support service contracts and ensure the contracting officer's representatives follow procedures. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #9: Concur. Storage and security guidance MCM standard operating procedures initially released in 2010 have been updated and expanded, and provided to component MCM planners. They have also been posted to the DHS Connect Intranet MCM page. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. The Department provided supporting documentation on storage and security guidance MCM standard operating procedures that have been updated and expanded, and provided to component MCM planners. This documentation was sufficient to close this recommendation. This recommendation is resolved and closed.

Recommendation #10: Concur. The recall is complete. OHA recently received a confirmation letter, dated July 7, 2014, from the HHS storage facility advising that all antiviral lots had been returned. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides a copy that all antiviral MCM shipped to the

field locations has been returned. There are still 1,071 courses of antiviral MCM sent from the field that have not been returned to the HHS facility. There were five locations that did not return any of the antiviral MCM they were shipped, and there were eight locations that did not return the full amount of the MCM that was originally shipped. This recommendation cannot be closed until OHA locates the remaining courses or documents that those courses have been lost and provides documentation in either case. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Recommendation #11: Concur. OHA continues to collaborate with all DHS Components to include U.S. Customs and Border Protection, through the MCM Working Group, to validate the safety and effectiveness of MCM. DHS employs the approved SLEP in close coordination with the FDA and the U.S. Department of Defense. To date, ten lots of antibiotic MCM have been submitted to SLEP for testing and of those for which testing has been completed all have been found to remain efficacious resulting in a cost avoidance of $5.1 million to the Department.

In addition to extending the shelf life, the SLEP testing verifies the safety/efficacy of MCM that may have been stored improperly (outside of the manufacturer's temperature range). In one instance, 5,450 bottles of antibiotics were exposed to a temperature spike over 100 degrees Fahrenheit for an unknown duration. The lot was submitted to SLEP to test for continued efficacy. It was found to be still safe and effective for use, and it was returned to the DHS stockpile.

Additionally, on July 7, 2014, OHA provided procedural guidance to DHS Components regarding MCM on measures to ensure the safety and effectiveness of medications, including antibiotics, in the MCM Program. We request that OIG consider this recommendation resolved and closed.

OIG Analysis: The Department's response to this recommendation addresses the intent of the recommendation. This recommendation is resolved and will remain open until the Department provides documentation on how it is validating the safety and effectiveness of the MCM. We will close this recommendation upon determining that the evidence provided meets the intent of this recommendation.

Appendix A
Objectives, Scope, and Methodology

The DHS OIG was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the Department.

We conducted an audit of the DHS pandemic preparedness efforts to determine if DHS effectively manages its pandemic preparedness supply of PPE and antiviral MCM. To achieve our audit objective, we identified and reviewed applicable Federal laws, regulations, and DHS policies and procedures regarding pandemic preparedness. The audit covered DHS pandemic efforts from FY 2006 through April 2014.

We interviewed DHS officials within the Directorate for Management, the Office of Operations Coordination and Planning, OHA, and some components responsible for pandemic preparedness planning, administration, oversight, and management. Specifically, we met with component officials from CBP, FEMA, ICE, TSA, USCG, NPPD, U.S. Citizenship and Immigration Services (USCIS), and USSS. We also interviewed personnel at HHS.

We met with Department officials to determine which offices were responsible for pandemic preparedness planning, management, and oversight to ensure workforce protection. We interviewed DHS officials within the Directorate for Management, the Office of Operations Coordination and Planning, and OHA responsible for pandemic preparedness planning, administration, oversight, and management. We also met with HHS personnel who conduct the storage and logistics of the DHS antiviral MCM stockpile as part of the IAA. Finally, we interviewed DHS employees from component headquarters and field offices of CBP, FEMA, ICE, TSA, the USCG, NPPD, USCIS, and USSS.

To determine if DHS effectively manages its pandemic PPE, we reviewed what plans and guidance DHS had for the types and quantities of PPE, for the alternative use or rotation of the equipment, and for distribution of PPE to components. We assessed the accuracy of DHS inventories by conducting a judgmental sample of site visits and a physical verification of onsite equipment. Specifically, we visited pandemic PPE stockpiles for the NCR at a FEMA distribution center and at ICE, USSS, TSA, and NPPD locations and documented storage conditions and discrepancies between inventories and quantities onsite. We assessed DHS oversight of its pandemic PPE stockpile by determining how DHS tracked and monitored PPE, conducted periodic inventories of their PPE stockpiles,

and delineated the roles and responsibilities between DHS offices. See table 4 for the offices we visited that possessed PPE.

Table 4. Personal Protective Equipment Site Visits

Component	Number of Locations
FEMA	4
ICE	5
NPPD	2
TSA	5
USSS	3

Source: OIG

To determine if DHS effectively manages its pandemic preparedness supply of antiviral MCM, we determined whether OHA created plans for its acquisition and inventory management. We evaluated the guidance OHA issued on appropriate storage and distribution of antiviral MCM. We assessed OHA oversight of its antiviral MCM stockpile by determining how OHA tracked and monitored antiviral MCM, conducted inventories of the antiviral MCM stockpiles, and ensured performance of COR responsibilities. We assessed the accuracy of OHA and component antiviral MCM inventories by comparing their inventories with the shipping data from HHS. In addition, we reviewed the accuracy of component headquarters' inventories of antiviral MCM stockpiled at their offices by conducting a judgmental sample of site visits and a physical verification of the medication on site. Specifically, we visited antiviral MCM stockpiles at an HHS storage facility and at ICE, CBP, NPPD, and USSS locations, and documented storage conditions and discrepancies between inventories and quantities on site. See table 5 for the offices and locations we visited.

Table 5: Medical Countermeasures Site Visits

Component	Number of Locations
CBP	14
FEMA	1
ICE	12
NPPD	1
TSA	1
USCG	1
USCIS	1
USSS	2

Source: OIG

We relied on components and DHS headquarters to provide us counts of their pandemic PPE and antiviral MCM stockpiles, which were not complete and accurate. We

performed physical verification by sampling inventories at the headquarters level, as well as at component headquarters and field office locations selected. We also compared original order and shipment information for antiviral MCM with OHA and component inventories and were able to identify quantities that were in undocumented locations or missing. The evidence from testing the inventories through our physical verification during site visits and analysis of data was sufficient and adequate for the purposes of meeting our audit objective and supporting our audit findings.

We conducted this performance audit between July 2013 and April 2014 pursuant to the *Inspector General Act of 1978*, as amended, and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.

Appendix B
Management Comments to the Draft Report

U.S. Department of Homeland Security
Washington, DC 20528

Homeland Security

July 18, 2014

MEMORANDUM FOR: The Honorable John Roth
Inspector General
Office of Inspector General

FROM: Jim H. Crumpacker, CIA, CFE
Director
Departmental GAO-OIG Liaison Office

SUBJECT: OIG Draft Report: "DHS Pandemic Preparedness"
(Project No. 13-155-AUD-DHS)

Thank you for the opportunity to review and comment on this draft report. The U.S. Department of Homeland Security (DHS) appreciates the Office of Inspector General's (OIG's) work in planning and conducting its review and issuing this report.

DHS agrees with the intent of all 11 recommendations outlined in the draft report. However, the Department is concerned that OIG has not appropriately characterized a number of issues discussed in the report, resulting in a misrepresentation of the information and evidence that DHS program officials and subject matter experts provided to the auditors during the audit, and of the DHS pandemic preparedness program in general. Specifically:

1. **The OIG seems to have overemphasized the final level of controls rather than viewing them in their role as last in a hierarchy of controls.** Personal protective equipment (PPE) and medical countermeasures (MCM) are the final levels of control available to the Department and are one part of a multi-level hierarchy. This hierarchy is a state-of-the-art occupational health principle, captured in American National Standards Institute (ANSI)/American Industrial Hygiene Association (AIHA) Z10-2012, "Occupational Safety and Health Management Systems," and summarized in Figure 1 below.[1] The concept is fundamental to Occupational Safety and Health Administration (OSHA) regulations and National Institute of Occupational Safety and Health training programs. This fundamental principle was utilized by the DHS Occupational Safety and Health Office and the DHS Office of Health Affairs (OHA) medical and occupational health professionals in developing pandemic response actions.

[1] MCM is equated to PPE in relative effectiveness and as a protective measure because it is administered AFTER a person actually is infected with a disease.

There are three applicable controls for the purpose of pandemic planning. These controls focus on limiting exposures first – by distancing personnel from sources of infection and using mechanical means such as barriers and ventilation to reduce potential contact with the infectious agent (known as engineering controls). The second level uses administrative controls including telework, shift rotation, vaccination programs, among other things, to reduce and provide a degree of protection to the population that may be exposed to infected co-workers or the public. The final level of controls, and least effective, from a business standpoint, as well as exposure reduction perspectives, includes PPE and MCM; sometimes these are all that can be reasonably provided for personnel that must perform higher-risk activities or who have become infected. There is not a single mention in the report of the two most important levels of controls and the effort the Department devoted to developing them, despite repeated discussions with OIG personnel in meetings and conversations. Exclusion of this principle overemphasizes the relative importance of the PPE and MCM controls.

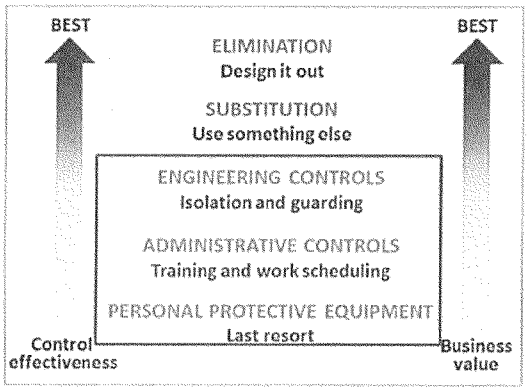


Figure 1: General Hierarchy of Controls, ANSI/AIHA Z10-2012, Occupational Safety and Health Management Systems. Controls applicable to pandemic planning are highlighted.

2. **OIG concluded that the Department has "no assurance it has sufficient personal protective equipment and antiviral medical countermeasures for a pandemic response" thus inhibiting DHS's ability to continue operations during a pandemic or ensure compliance with Department guidelines.** In fact, the Department is assured that it has sufficient PPE and antiviral MCMs. The OIG's conclusion seems to be reached by relying on the manufacturers' information rather than the judgment of published peer reviewed research, and DHS's highly experienced medical, safety, and health professionals with concurrence of subject matter experts from the U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC).

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Both the PPE and MCM in the stockpiles audited have been tested and determined to be useable by DHS professional staff; this should not lead to the conclusion that there is no assurance that they are currently useable, and plans to replace these in upcoming years indicate the stocks are being managed, not allowed to become obsolete.

The PPE stockpile is very simple in nature: surgical-style nitrile gloves, surgical masks, and filtering facepiece disposable respirators. When these products were purchased, there were no established or published shelf life data, nor was shelf-life stated on the box or in the literature. When asked, the manufacturers stated that they tested them for five years, and as a result certified/guaranteed them for five years, but owners were told they could examine the products and determine if they were still useable based on visual inspection. The parts of these products that are most at risk are any flexible components; with exposure to heat, ultraviolet rays, and oxidation, the gloves, elastic headbands, and valves can become brittle or non-elastic. Filters and filter media are the most stable component of most filter facepiece respirators. Testing them is simply a matter of examining a random sample from stock in the same storage conditions and determining if they retain their flexibility.

The current PPE inventory is in useable condition at the time of this report, but with further aging it may not be useable in coming years. The manufacturers recently started placing firm 5-year expiration dates on respirator packaging; in the past users were told the respirators could be used after five years if they were inspected. Replacing the PPE by 2015 addresses concerns about it becoming unusable and also prevents regular trips to the warehouse to verify it is still intact. During a recent (spring 2014) inventory evaluation of the pandemic PPE stockpile, DHS offered this PPE to Components who use it regularly in daily operations, but little was requested; therefore most of these supplies must be placed in surplus when replaced. After this supply is replaced with new, there will be no inspection allowance and the PPE will have to be replaced after five years.

For MCM, the authority and expertise of the Food and Drug Administration (FDA) appears not to have been considered. The current stockpile of MCMs is part of an aggressive shelf-life extension program used by the FDA to analyze "outdated" MCMs and extend the original manufacturer's shelf life when they are shown to be still useable. This process conserves Departmental resources and establishes that the on-hand MCM are currently useable. Further, the Department provided DHS Components a copy of the most recent and relevant HHS guidance documenting that one or two courses of MCM were considered reasonable. Combined with coverage for the entire DHS workforce, critical contractors, and those in the Department's care and custody, it is unclear what the OIG considers sufficient.

Furthermore, the state of PPE and MCM supplies is not an appropriate indicator of pandemic readiness. As the last tools in a systematic hierarchy of controls, they are not the most efficient or effective means of maintaining workforce health. Despite this fact, PPE and MCM are commonly and erroneously viewed as the primary means of workforce protection, likely because they are more familiar to laypersons and they are more tangible and easily accounted for. The use of PPE also shifts much of the burden of

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protection from the employer to the employee. Using PPE stock levels as an indicator of preparedness is based on a misconception that during a pandemic, the entire workforce should wear PPE, when in fact it will be determined by risk assessments and feasibility of other control methods.

OSHA requires agencies to perform pandemic risk analyses on their workforce and establish (due to work-related exposures) which risk level they fall under, ranging from low to very high. A risk analysis was completed by DHS during the H1N1 pandemic response and has recently been updated due to the new DHS plan. Based on risk assessments, DHS has only a limited number of personnel with risk assessments that recommend "mandatory PPE use" during a serious pandemic. Use is linked to specific activities that increase risk. The majority of these personnel already wear PPE regularly while performing their duties, so they are not expected to rely on pandemic stockpiles of PPE. The remaining employees, including almost all at the DHS Headquarters served by the PPE stockpile at the Federal Emergency Management Agency (FEMA) Cumberland warehouse, are termed by OSHA as "voluntary users," the lowest risk group. Employers are not required to provide any PPE to personnel in this low-risk group, and when they do, it is recognized in the standards that it is done both to help prevent a possible, but unlikely, exposure to the disease and to provide a degree of reassurance and comfort to the employee.

Similarly, the antiviral medications in the DHS stockpile are not vaccinations and do not prevent infection; they reduce the symptoms of an infected person and allow them to return to work earlier and provide an additional means of intervention when vaccines may not yet be developed or available in sufficient quantities. In cases where they are appropriate and effective for a given disease, they can provide a significant benefit when applied to a large workforce at times of high absenteeism and help ensure workforce coverage to continue mission essential functions. However, while employers were encouraged to stockpile antiviral MCM when used within the context of a broader occupational health strategy, there is no interagency mandate to provide antiviral MCM, but rather a determination of the Department leadership to enhance workforce availability and protection. Considering this, the on-hand goal of ensuring availability of MCM for all employees, contractors and those in the care and custody of DHS and the fact that the supplies available are currently useable do not support an implication of a readiness failure.

3. **The OIG incorrectly states that "about 81 percent of its [antiviral] stockpile will expire by the end of 2015 (shown in Table 1 of OIG's draft report)."** The Department provided OIG emails documenting that by July 1, 2013, the expiration dates of most of the current stockpile of antiviral MCM had already been extended according to criteria defined by the FDA, so that only 15 percent of DHS's antiviral stockpile is set to expire in 2015—an amount that DHS has budgeted to replace through purchase. An additional small percentage of antiviral stocks that have been returned from DHS Components following their deployment in response to the 2009 H1N1 Influenza pandemic may also be retired in 2015 because the small lot sizes do not meet the fiscal threshold for testing. The current stockpile of MCM is part of an aggressive shelf-life extension program

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(SLEP) managed by OHA to analyze MCM and extend the original manufacturer's shelf life when they are determined to be still effective. Extending the shelf life of MCM is a responsible use of departmental resources providing significant cost deferrals and valuable time to smooth out replacement for the initial large MCM purchases made with one-time supplemental funding.

Additionally, many steps have been taken since the 2006 pandemic planning supplemental appropriation of $47 million to improve on the initial MCM planning. Specifically:

a. OHA has conducted five separate data calls from 2006 to 2013 to DHS Components to determine their specific MCM and PPE needs. DHS has used the results of these data calls to assess needs and make effective program management and purchasing decisions.
b. OHA developed methodologies for determining the MCM needs identified in the data calls, to include the amount of MCM needed to provide coverage, at the direction of the DHS Secretary's office, for the DHS workforce and all critical contractors and those in DHS care and custody.
c. OHA has conducted replenishment planning which has been captured in the budgeting process and other activities, such as pursuing shelf life extension opportunities.

DHS is more prepared than most federal agencies to provide MCM protection for its workforce. As the sole civilian Department with the only mature antiviral stockpile and dispensing program, DHS is working closely with CDC on the development of updated guidance for all federal departments and agencies.

4. **The report does not acknowledge the current state of affairs of DHS pandemic planning.** Beginning in March 2013, a working group consisting of DHS Headquarters and Operational Component representatives spent a significant amount of time and effort writing a Departmental Pandemic Workforce Protection Plan (PWPP). This PWPP, signed by the DHS Secretary in October 2013 – and subsequently provided to the audit team – outlines the total pandemic policy for DHS – from readiness measures including risk assessments and supply to actual response such as implementing the hierarchy of controls. This successful effort, along with the Component-specific plans and analyses it generated, should have been acknowledged in the audit report, as they were completed prior to the initiation of the audit, addressed many of the issues outlined in the report, and have a far greater effect on current DHS pandemic preparedness than irregularities in the stockpiles of PPE and MCM may have.

The draft report contained 11 recommendations with which the Department concurs. Specifically, OIG recommended:

Recommendation 1: That the Deputy Secretary identify and designate an office responsible for the management and accountability of pandemic PPE.

Response: Concur. The Office of the Under Secretary for Management designated the DHS Office of the Chief Readiness Support Officer as being responsible for the management and accountability of pandemic PPE effective January 2014. We request that OIG consider this recommendation resolved and closed.

Recommendation 2: That the Deputy Secretary develop a strategy for management, storage, and distribution of pandemic PPE.

Response: Concur. The DHS Chief Readiness Support Officer issued a Pandemic Logistics Support Plan Charter on May 30, 2014. This charter establishes the framework for the development of a Department pandemic logistics support plan for pandemic PPE. A Pandemic Logistics Integration Team (iTeam) has also been established with representation from DHS Components and pandemic PPE requirements have been drafted. Estimated Completion Date (ECD): September 30, 2014.

Recommendation 3: That the Deputy Secretary implement an inventory system for the current inventory and future inventories of pandemic PPE.

Response: Concur. Members of the Pandemic Logistics iTeam are reviewing the application of the Department's existing personal property inventory management systems for establishing management and inventory controls for pandemic PPE. The current pandemic PPE inventories are being distributed within DHS where operational requirements can be augmented; remaining items will be surplused in accordance with federal and Department requirements and standards. ECD: September 30, 2014.

Recommendation 4: That the Deputy Secretary work with components to establish a methodology for determining sufficient types and quantities of pandemic PPE to align with the department-wide pandemic plan.

Response: Concur. Work is underway. A workgroup has been established under the Pandemic Logistics iTeam to develop PPE requirements using an employee risk based approach supporting work place controls. ECD: September 30, 2014.

Recommendation 5: That the Deputy Secretary have components implement inventory control procedures for pre-positioned pandemic PPE to monitor stockpiles, track shipments, and ensure compliance with departmental guidance.

Response: Concur. This is in the planning stage. A policy and standards workgroup is being established under the Pandemic Logistics iTeam to establish PPE control procedures and standards. ECD: September 30, 2014.

Recommendation 6: That the DHS MCM Working Group and OHA determine requirements of antiviral MCM for the Department to maintain critical operations during a pandemic.

Response: Concur. OHA continues to solicit, receive, and address DHS component MCM needs and requirements as a standing agenda item during the monthly MCM Working Group

meeting, and as a key element of the MCM Quarterly Reports, OHA prepares and distributes as part of the MCM program. Additionally, DHS is working with CDC on an interagency process to define antiviral stockpiling needs on behalf of the entire federal government. We request that OIG consider this recommendation resolved and closed.

Recommendation 7: That OHA create an antiviral MCM Acquisition Management Plan to include:

a) A methodology for determining the ideal quantity of antiviral MCM OHA will stockpile and how frequently it will be reevaluated;
b) A replenishment plan; and
c) Inventory tracking, reporting, and reconciliation procedures for existing stockpile and new antiviral purchases.

Response: Concur. An MCM Integrated Logistics Support Program (ILSP) has been drafted and is currently in DHS clearance. Completion of the MCM ILSP will address all three elements of this recommendation. ECD: September 30, 2014.

Recommendation 8: That OHA revise procedures to ensure proper contract oversight by government employees for management of its MCM support service contracts and ensure the contracting officer's representatives follow procedures.

Response: Concur in principle. Existing procedures as described in the Homeland Security Acquisition Regulation, Homeland Security Acquisition Manual, the DHS Office of Procurement Operations Contracting Officer's Representative guidebook and component specific procedures addressing Contracting Officer Representative duties and responsibilities are adequate for ensuring proper contract oversight, but these procedures were not followed consistently in the administration of MCM support service contracts. Since OIG identified findings concerning inadequate oversight, OHA has taken steps to ensure that highly qualified contracting officer's representatives are assigned to all MCM support service contracts. These employees provide direct and comprehensive oversight of each aspect of the MCM project including detailed governance over all related contract support. We request that OIG consider this recommendation resolved and closed.

Recommendation 9: That OHA finalize and issue antiviral MCM guidance on the storage conditions, security, and distribution for antiviral MCM for all components.

Response: Concur. Storage and security guidance MCM standard operating procedures initially released in 2010 have been updated and expanded, and provided to Component MCM planners. They have also been posted to the DHS Connect Intranet MCM page. We request that OIG consider this recommendation resolved and closed.

Recommendation 10: That OHA finalize the antiviral MCM recall it has initiated on the CBP, ICE, FEMA, and USSS inventories.

OFFICE OF INSPECTOR GENERAL
Department of Homeland Security

Response: Concur. The recall is complete. OHA recently received a confirmation letter, dated July 7, 2014, from the HHS storage facility advising that all antiviral lots had been returned. We request that OIG consider this recommendation resolved and closed.

Recommendation 11: That OHA collaborate with CBP to determine the safety and effectiveness of the antibiotic MCM that have been stored alongside their antivirals.

Response: Concur. OHA continues to collaborate with all DHS Components to include U.S. Customs and Border Protection, through the MCM Working Group, to validate the safety and effectiveness of MCM. DHS employs the approved SLEP in close coordination with the FDA and the U.S. Department of Defense. To date, ten lots of antibiotic MCM have been submitted to SLEP for testing and of those for which testing has been completed all have been found to remain efficacious resulting in a cost avoidance of $5.1 million to the Department.

In addition to extending the shelf life, the SLEP testing verifies the safety/efficacy of MCM that may have been stored improperly (outside of the manufacturer's temperature range). In one instance, 5,450 bottles of antibiotics were exposed to a temperature spike over 100 degrees Fahrenheit for an unknown duration. The lot was submitted to SLEP in order to test for continued efficacy. It was found to be still safe and effective for use, and it was returned to the DHS stockpile.

Additionally, on July 7, 2014, OHA provided procedural guidance to DHS Components regarding MCM on measures to ensure the safety and effectiveness of medications – including antibiotics – in the MCM Program. We request that OIG consider this recommendation resolved and closed.

Again, thank you for the opportunity to review and provide comments on this draft report. Technical comments were previously provided under separate cover. Please feel free to contact me if you have any questions. We look forward to working with you in the future.

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Appendix C
Major Contributors to This Report

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Appendix D
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The OIG seeks to protect the identity of each writer and caller.

Chairman ISSA. Dr. Lurie.

STATEMENT OF HON. NICOLE LURIE, M.D.

Dr. LURIE. GOOD MORNING, CHAIRMAN ISSA, AND RANKING MEMBER CUMMINGS, AND OTHER DISTINGUISHED MEMBERS OF THE COMMITTEE.

I am Dr. Nicole Lurie, the Assistant Secretary for preparedness and response at the U.S. Department of Health and Human Services. I am also a primary care doctor.

I appreciate the opportunity to talk with you today about the steps that HHS and other agencies have taken since the Ebola outbreak began in West Africa. We are working 24/7 to control the epidemic there and to ensure that we are prepared to prevent and curtail the spread of disease here at home.

Thanks to the foresight of the Congress, the leadership of this and prior administrations, the dedicated work of HHS and the interagency whole-of-government approach we are taking, we are better positioned than ever before to respond to Ebola as well as a range of other threats that may affect this country.

I serve as the Assistant Secretary. I serve as the principal advisor to the Secretary on all matters related to public health and medical preparedness in response to emergencies. Since my confirmation in 2009, we have worked hard to ensure that we have the tools necessary to prepare for and respond to any disaster with public health consequences.

I have led the modernization of the Medical Countermeasure Enterprise, created new opportunities for coordination among State and local public health and healthcare systems, and strengthened our ability to make better decisions before, during, and after an emergency. Our all-hazards approach allows us to be flexible and nimble in response to known and unknown threats.

As you know, four cases of Ebola have been detected in the United States. Our hearts go out to the family of Mr. Duncan, the nurses who have been infected, as well as the physician in New York. We are pleased that the nurses are doing so well and wish them and the physician a speedy recovery.

We are extremely serious in our focus on protecting America's health security. The best way to do that is to end Ebola epidemic in West Africa. At the same time, we are expediting the development of medical countermeasures and preparing our systems to deal with any potential cases in this country.

So, not long after this epidemic began, I convened the Federal medical countermeasures stakeholders to see what could be accomplished as quickly as possible. Thanks to past investments, we have leveraged U.S. Government-wide assets to urgently speed the development and testing of vaccines and therapeutics for Ebola. These advances are allowing us to create Ebola countermeasures in record time so that we will have products to use as soon as we have the necessary proof of efficacy.

Our strategic investments in the countermeasure infrastructure, including our Centers for Innovation in Advanced Development and Manufacturing established in 2012 and newly established Fill Fin-

ish Manufacturing Network, will be used to get Ebola vaccines and therapeutics into vials for use. We are also leveraging our strong, ongoing relationships with industry and public-private sector partners to scale up vaccine manufacturing.

In addition, our public health and healthcare systems must be prepared to deliver safe care at a moment's notice. Investments in the hospital preparedness program and the public health emergency preparedness program have meant that healthcare systems and State and local public health departments are prepared to respond to public health emergencies.

Since the epidemic began, we have been using these programs to educate healthcare systems stakeholders and ensure surveillance in laboratory capacities were in place. We have launched a very aggressive national outreach and education program to promote the safe and effective detection, isolation, treatment of Ebola patients.

The system we now have in place is based on changes and lessons learned from each emergency, including those I have confronted, as the Assistant Secretary.

Based on the first U.S. Cases, HHS has already made adjustments to minimize the spread of Ebola. These include tightened guidance for the use of personal protective equipment, an expanded aggressive national education campaign for healthcare workers, and screening and active monitoring of passengers entering the United States now funneled through five airports.

We have been working collaboratively with our interagency partners, including on transport of contaminated waste with the Department of Transportation, medical evacuation with the Department of State, deployment of military personnel with the Department of Defense, and worker and workplace safety with OSHA and NIOSH.

Mr. Chairman and Members of the committee, I understand why you and yours constituents are concerned. We take domestic preparedness very seriously. Our top priority is protecting the health of Americans.

I can assure you that my team, the Department and our partners have been working and continue to work long hours to prepare our Nation for threats like this. With lessons learned from this new challenge, we are making efficient use of the investments provided and we have made tangible, meaningful progress since you first created this office in 2006. As a result, HHS has been able to provide crucial health and medical support to our States and communities.

I thank you again for this opportunity to address these issues and welcome your questions.

[The prepared Statement of Dr. Lurie follows:]

Good morning, Chairman Issa, Ranking Member Cummings, and other distinguished Members of the Committee. I am Dr. Nicole Lurie and I serve as the Assistant Secretary for Preparedness and Response (ASPR) at the U.S. Department of Health and Human Services (HHS).

I appreciate the opportunity to talk to you today about the aggressive steps that HHS and other Federal Agencies have taken since the first cases of Ebola were identified in West Africa. By all accounts, the spread of this deadly disease in West Africa is unprecedented and we continue to work diligently, as part of the global community, to support the response and make necessary preparations in this country. The likelihood of a significant Ebola outbreak in the United States is remote, but ASPR, other HHS components, and other agencies are moving forward with preparedness planning to be ready for any contingency.

As the ASPR, I serve as the principal advisor to the Secretary on all matters related to Federal public health and medical preparedness and response for public health emergencies. Since my confirmation as the ASPR in 2009, I have created cross-Department policy group, the Disaster Leadership Group, which is comprised of leadership from my HHS counterparts at the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Food and Drug Administration (FDA), to advise on critical preparedness matters, address ongoing response activities, and mitigate lasting effects of disasters. I also led the modernization of the medical countermeasure enterprise; created opportunities for new coordination among state and local health care systems; strengthened our systems for response; and advanced a science base to strengthen decision-making processes before, during, and after emergencies. Our all-hazards approach, a shift from individual planning efforts to a more comprehensive approach to all

public health and medical emergencies, allows us to be flexible and nimble to both known and unknown threats, including the current Ebola crisis in West Africa that has challenged the entire global response capacity.

As part of the HHS leadership team responding to Ebola, I lead coordination activities supporting the HHS policy team managing critical issues including: international engagement for HHS; establishing technical assistance for state and local health care providers; the development of medical countermeasures, vaccines, and treatments for Ebola as well as testing and possible use; and preparation of Federal personnel. I coordinate daily with the Secretary and other key HHS leadership to address Ebola. I engage on an ongoing basis with the Departments of Transportation (DOT), State, Defense (DOD), and Homeland Security (DHS), as well as the Department of Labor's Occupational Safety and Health Administration (OSHA), the U.S. Agency for International Development, and others, to share information and align activities. I also communicate regularly with the Assistant to the President for National Security Affairs and other White House leadership. My staff and I work aggressively to keep leadership well-informed of ASPR's engagement, needs, and priorities related to the ongoing Ebola epidemic in West Africa and our Nation's domestic preparedness. For HHS to be successful, each element of the Agency must be fully engaged in its mission space.

Recognizing the potential impact of the many threats we face, ASPR has sought to build relationships within and outside the Federal Government and internationally to enhance coordination; make improvements in planning, logistics, and personnel management for responses to emergencies within the United States; maximize coalition building under the

Hospital Preparedness Program; and coordinate efforts within the Public Health Emergency Medical Countermeasures Enterprise. Over the past five years, we have worked to create an infrastructure capable of developing, testing, producing, and deploying medical countermeasures for the range of threats we face. Even as we continue to learn from the outbreak in West Africa and the current situation in the United States and to make adjustments, that infrastructure serves us well as we develop Ebola countermeasures, ensure that our health care system is prepared, and make decisions based on the best available science.

As you know, three cases of Ebola have been detected in the United States—an individual who was infected in Liberia and two nurses who attended to him. Our hearts go out to them and their families. Mr. Duncan's death is a tragic loss. We wish the health care workers a speedy recovery as they fight this terrible illness. I understand why you and your constituents are concerned. We are extremely serious in our focus on protecting America's health security. The best way to do that is to support the response to the Ebola epidemic in West Africa to get infection and spread under control as quickly as possible. At the same time, thanks to the preparedness work and planning that has taken place over the past several years, we are speeding the development of medical countermeasures and preparing our public health and health care systems to deal with any further cases in the United States.

Let me pause here and provide an assessment of where we are today thanks to past investments. Thanks to the support of the Congress and feedback from critical stakeholders at all levels of government, we have made significant improvements in preparedness, response, and recovery at the Federal, state, and local levels. We have strengthened our medical countermeasures

enterprise to respond to chemical, biological, radiological, or nuclear (CBRN) threats. State and local partners are more prepared than ever before due to enhanced response capabilities, improved coordination, and enhanced awareness among the public health and medical communities.

HHS has made progress in preparing the Nation for the range of CBRN threats we face by creating a flexible capacity capable of developing and producing novel safe and effective medical countermeasures faster than ever before. Elements of this infrastructure are being used right now to develop countermeasures against the Ebola virus. In 2012, HHS established the Centers for Innovation in Advanced Development and Manufacturing, public-private partnerships that provide a significant domestic infrastructure in the United States to produce medical countermeasures to protect Americans. These Centers are now positioned to expand the production of Ebola monoclonal antibodies, like those in ZMapp, into tobacco plants and mammalian cells. The Fill Finish Manufacturing Network established last year will be used to formulate and fill Ebola antibody and vaccine products into vials for studies and other uses. With respect to vaccines, HHS is working to scale-up to commercial scale the manufacturing of promising investigational Ebola vaccine candidates with funds provided by the FY 2015 continuing resolution.

The Congress provided critical authorities and appropriated billions of dollars for development and procurement of CBRN medical countermeasures that have been turned into real products by the combined efforts of ASPR's Biomedical Advanced Research and Development Authority, NIH, FDA, and CDC. Despite some of the challenges that dealing with a serious illness such as

Ebola can have on even the most advanced health care system, I can say with certainty that we are now more prepared for the range of CBRN threats and other emerging infectious diseases, such as pandemic influenza, than at any point in our Nation's history. We have gone from having very few products in the medical countermeasure pipeline to funding over 80 candidate products. If successfully transitioned to procurement contracts and inclusion in the Strategic National Stockpile, we anticipate having the following new medical countermeasures available in the next five years: an entirely new class of antibiotics; anthrax vaccine and antitoxins; smallpox vaccine and antivirals; radiological and nuclear countermeasures, including candidates to address the hematopoietic, pulmonary, cutaneous, and gastrointestinal effects of acute radiation syndrome; pandemic influenza countermeasures; and the first set of chemical antidotes to chemical threats. Furthermore, in demonstration of our end-to-end approach to development, we have successfully moved a product through all phases of the medical countermeasure pipeline—from discovery to procurement—and have begun manufacturing a new smallpox vaccine (Modified Vaccinia Ankara).

Related to state and local preparedness, HHS has also utilized and strengthened two critical tools to support community preparedness and resilience. Both the ASPR-led Hospital Preparedness Program (HPP) and the CDC-led Public Health Emergency Preparedness (PHEP) cooperative agreement grant programs have advanced our preparedness agenda within the health care and public health infrastructure as well as throughout a number of communities. HPP and PHEP support efforts at state and local public health departments and medical facilities to ensure that communities are prepared to respond to public health emergencies. With HPP grants, we made great strides in the ability of the predominantly private-sector health care system to surge to

provide medical care to a large number of patients. PHEP funding has fostered an increased level of preparedness throughout communities and contributed to state and local governments' decreased reliance on Federal aid following disasters. Specifically, since 2002, state and local health departments have used HPP grants to allow hospitals and health care coalitions to purchase equipment and supplies; exercise and train for a number of different emergency scenarios, including highly infectious diseases; and develop partnerships and coalitions across regional health care systems to address situations like Ebola. More recently, HPP has moved towards a community-based preparedness approach to build resiliency and encourage the creation of health care coalitions. Health care coalitions are collaborative networks of hospitals, health care organizations, public health providers, emergency management, emergency medical services, and other public and private sector health care partners within defined regions. The HPP program seeks to build capabilities for hospitals and health care coalitions, such as the ability to surge and manage infectious diseases.

Building on past successes, these programs are proving critical in preparedness activities for Ebola. HHS has a number of specific activities underway to support national health security and preparedness. These efforts benefit and support broader preparedness initiatives and will strengthen the national health care infrastructure going forward. CDC, in coordination with OSHA, has issued updated infection-control guidance for health care workers caring for patients with Ebola in the United States to ensure there is no ambiguity with respect to the use of personal protective equipment (PPE). In addition, HPP began informing awardees on October 1, 2014, that funds may be used to prepare for suspected or known Ebola patients. This includes developing action plans, purchasing supplies for health care facilities, including PPE, and

training personnel. Also, in emergency circumstances, HPP awardees may request, and in some cases already have requested, approval to use grant funds for activities outside the currently approved scope of work. HHS is also using these networks to disseminate educational materials on awareness and response regarding potential Ebola patients, such as checklists to prepare health care providers, hospitals, emergency medical services, and community health care coalitions. The checklists provide practical and specific suggestions to ensure health care workers, facilities, and coalitions are able to detect possible Ebola cases, protect their employees, and respond appropriately.

HHS has also organized a number of training opportunities, in coordination with other Federal partners, to ensure quick and accurate identification of persons with Ebola, including training to support ongoing screening activities at domestic airports. HHS is also supporting efforts to develop protocols for waste management, something that has been a key concern for health care providers, hospitals, and political leadership at state and local levels. For example, HHS developed Ebola Medical Waste Management guidelines with input from DOT, the Environmental Protection Agency, and OSHA. These guidelines provide hospitals and health care providers with key information about the safe handling, transport, and disposal of waste generated from the care of persons diagnosed with or suspected of having Ebola. CDC also will be coordinating with OSHA and other Federal Agencies to develop guidance that is relevant to other occupations—such as employees of the transportation industries—to address potential exposure to persons with Ebola.

Thanks to a number of new authorities provided by the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), ASPR stands ready to support a response to such events as the current Ebola incidents. One specific provision of that Act allows the Secretary to authorize a state or Indian Tribe to temporarily reassign health personnel funded through HHS programs under the Public Health Service Act to augment resources for a declared public health emergency. In addition, PAHPRA gave the Secretary the authority to declare that circumstances exist to justify the authorization of emergency use of certain medical products, which, under certain circumstances, enables FDA to issue an Emergency Use Authorization (EUA) when appropriate. The Secretary issued a declaration for in vitro diagnostic devices for detection of Ebola virus on August 5, 2014, which was based on an existing Ebola virus Material Threat Determination issued by DHS. The HHS EUA declaration was then used to support FDA issuance of an EUA for an Ebola diagnostic test developed by DOD and two EUAs to permit distribution and use of Ebola diagnostic tests developed by CDC.

Understanding today's global community, HHS has strengthened international partnerships. HHS now has a number of international relationships designed to better support information sharing, leverage critical assets, and help one another in times of need. Through a variety of initiatives, plans, and strategic capacity building programs, in response to the current Ebola outbreak, HHS—in coordination with other Federal Departments and Agencies—has been able to rapidly engage with international partners in communications and collaborations, including the Ministers of Health of the G7 countries, Mexico, the European Commission, the World Health Organization (WHO), the Institute Pasteur and its affiliates in West Africa, to discuss countries' domestic preparedness activities and policies. These activities include border protocols, mutual

notifications of imported cases, support for medevac capabilities, and coordination of activities to develop and manufacture medical countermeasures among developed countries (mainly Canada, UK, and France) and the WHO, and overall support for West African countries. In its coordination role for the medical portion of the U.S. response effort, HHS convenes weekly U.S. Government and WHO clinical conference calls with physicians in developed countries who treat patients with Ebola to facilitate information-sharing and diffusion of best practices. In addition to coordinating with international partners, HHS is working to support the deployment of U.S. Public Health Service (PHS) officers to West Africa.

Throughout the Federal Government, we are all working together to ensure we are safer going forward and protecting against the growing number of threats to public and medical health. Mr. Chairman and Members of the Committee, I understand why you and your constituents are anxious and concerned. There is good reason for concern. Ebola is a dangerous disease, but there is hardly a reason for panic. There is an epidemic of fear, but not of Ebola, in the United States. We always can, and do, learn from experience, and we are making adjustments moving forward based on the first U.S. cases. I can assure you that my team, HHS, and our interagency partners have worked long hours to prepare our Nation for threats like Ebola. We are making efficient use of the investments provided and we are far better off than we were ten years ago following the anthrax attacks and the Hurricane Katrina response. As a result, HHS stands ready to provide health and medical support to our states and communities. I thank you again for this opportunity to address these issues and welcome your questions.

Chairman ISSA. Ms. Burger.

STATEMENT OF DEBORAH BURGER, R.N.

Ms. BURGER. Thank you, Mr. Chairman and Members of the committee. I am Deborah Burger, a registered nurse and——

Chairman ISSA. Could you pull the mic just slightly closer. Thank you.

Ms. BURGER. Thank you.

—and co-president of the National Nurses United, representing 190,000 members in the largest organization of nurses in the United States.

The Ebola pandemic and the exposure of healthcare workers to Ebola in Texas and the real threat that it could occur elsewhere in the U.S. represent a clear and present danger to public health.

Every R.N. Who works in a healthcare facility could be Nina Pham or Amber Vinson, both of whom contracted Ebola while treating Thomas Eric Duncan at Texas Presbyterian Hospital in Dallas. One patient diagnosed and dead in this country. Two nurses infected so far.

And our survey of over 3,000 nurses from over 1,000 hospitals in every State, D.C., and the Virgin Islands reveals 85 percent of the nurses say they are not adequately trained and the level of preparation for Ebola in our facilities is insufficient.

68 percent of R.N.s still say they have not—their hospital has not communicated any policy for admission of a potential Ebola patient. 84 percent still say their hospitals have not provided Ebola education with the opportunity to interact and ask questions.

44 percent say their hospitals lack sufficient supplies of eye protection now. 46 percent say there are insufficient supplies of fluid-resistant impermeable gowns in their hospital. 41 percent say their hospitals do not have plans to equip isolation rooms.

Initially, the nurses who interacted with Mr. Duncan wore non-impermeable gowns, three pairs of gloves with no taping around the wrists, surgical masks with the option of N95s and face shields, leaving their necks exposed. Two of them became infected. This is what happens when guidelines are inefficient and voluntary.

The new CDC guideline that protective equipment leave no skin exposed is a direct testament to the courage of Dallas whistleblower Briana Aguirre who first spoke to us.

We have called on President Obama to invoke his executive authority and urged Congress legislatively to mandate uniform optimal national standards.

These include full-body HazMat suits that meet the ASTM F1670 standard for blood penetration and the ASTM F1671 standard for viral penetration, which leaves no skin exposed or unprotected; NIOSH-approved air-powered purifying respirators with an assigned protection factor of at least 50 or higher standard as appropriate; at least two direct-care R.N.s for each Ebola patient and the additional—and no additional patient care assignment; continuous onsite interactive hands-on teaching with the R.N.s and updates responsive to the changing nature of the disease.

The precautionary principle must be utilized when developing public health policy designed to protect patients, the public, nurses, and all healthcare workers who may be exposed to potentially infectious patients.

Lest we forget the risk of exposure to the population at large starts with the frontline caregivers. It does not end there. As we have seen with school closures in Ohio and Texas and the quarantining of airline passengers, improper protection and inadequate protocols in hospitals can lead to public exposure.

The response to Ebola from U.S. hospitals and governmental agencies has been dangerously inconsistent and inadequate. The lack of mandates and shifting guidelines from agencies and reliance on voluntary compliance has left caregivers uncertain, severely unprepared, and vulnerable to infection.

Our experience with U.S. hospitals is they will not act on their own to secure the highest standards of protection without a specific directive from our Federal authorities by an act of Congress or potential Presidential executive order.

The new CDC guidelines represent progress with improved standards for training, as we have been demanding for months. The CDC guidelines are still unclear on the most effective protective equipment, specifically allowing hospitals to select protective equipment based on availability and other factors.

We are your first line of defense. No nation would ever contemplate sending soldiers into the battlefield without armor and weapons. Give us the tools we need. All we ask from President Obama and Congress is not one more infected nurse. Thank you.

[The prepared Statement of Ms. Burger follows:]

Testimony by Deborah Burger, RN
Co-President, National Nurses United
Committee on Oversight and Government Reform
U.S. House of Representatives
October 24, 2014

Thank you, Mr. Chairman and members of the Committee on Oversight and Government Reform. My name is Deborah Burger, I am co-President of the Nurses United and a registered nurse, representing 190,000 members in the largest organization of nurses in the United States.

Every RN who works in a hospital or healthcare facility could be Nina Pham or Amber Vinson, both of whom contracted Ebola while treating Thomas Eric Duncan at Texas Health Presbyterian Hospital in Dallas, Texas.

One patient diagnosed on U.S. soil, two infected nurses. So far.

In many ways, all nurses work at Texas Health Presbyterian. In a survey done by National Nurses United 85% of RNs say they have not been adequately trained and the level of preparedness for Ebola in our facilities is woefully insufficient. Specifically, the survey done by National Nurses United of over 3,000 nurses from over 1,000 hospitals in every U.S. state, the District of Columbia and the Virgin Islands reveals that:

- 68 percent still say their hospital has not communicated to them any policy regarding potential admission of patients infected by Ebola
- 84 percent say their hospital has not provided education on Ebola with the ability for the nurses to interact and ask questions
- 44 percent say their hospital has insufficient current supplies of eye protection (face shields or side shields with goggles) for daily use on their unit; 46 percent say there are insufficient supplies of fluid resistant/impermeable gowns in their hospital – significantly, these percentages have been rising
- 41 percent say their hospital does not have plans to equip isolation rooms with plastic covered mattresses and pillows and discard all linens after use;

only 8 percent said they were aware their hospital does have such a plan in place

A Texas Health Presbyterian Hospital nurse, Briana Aguirre, told NBC's "Today" show Thursday, October 16, 2014, that nurses did not have mandatory Ebola training, except for an optional seminar that didn't allow them any hands-on practice.

"We never talked about Ebola. We never had a discussion," Briana Aguirre said. Training for Texas Health Presbyterian's nursing staff amounted to "just information," she said. "We were never told what to look for." "All I know for sure is that he (Duncan) was put into an area where there are around seven other patients," she said.

"We took around three hours to make first contact with CDC to let them know what we had of our suspicion. There were no special precautions other than basic contact precautions. No special gear." She said the hospital did not know what to do with one of his lab specimens. A lab technician told Aguirre the specimen was "mishandled," she said. "It was a chaotic scene."

Ms. Aguirre said there was an effort to contact the hospital's infectious disease expert to determine the correct Ebola treatment protocol. Their answer was, 'We don't know. We will have to call you back,' " she said.

On CNN Ms. Aquire said, "And the most outrageous part about it is, is that every time I think about the facts that I'm saying right now, I just know that the nurses that have been infected . . . They were dealing with an Ebola positive patient with copious secretions of diarrhea, vomiting, continuous dialysis, you know, mechanical ventilation, all these dangerous, dangerous medical procedures and they put their life on the line and without the proper equipment. . . .

Anderson Cooper asked her:

"You believe Nurse Pham was wearing that kind of equipment when she was exposed?"

Ms. Aquire's powerful response was: I know she was because the equipment we needed was still on order."

These heroic nurses had to interact with Mr. Duncan with whatever minimal and woefully inadequate protective equipment was available, at a time when he was unfortunately most vulnerable with diarrhea and vomiting, and therefore most contagious.

Initially the nurses who interacted with Mr. Duncan wore a non-impermeable gown front and back, three pairs of gloves, with no taping around wrists, surgical masks, with the ***option*** of N-95s, and face shields. Some supervisors even told the nurses the N-95 masks were not necessary.

This is what happens when guidelines are insufficient and voluntary.

The porous gowns and eventual suits they were given also left their necks exposed, in other words, the part closest to their face and mouth.
The nurses had to innovate and use medical tape in a futile attempt to cover their dangerously exposed necks. The medical tape was not impermeable and has permeable seams, but the nurses had no other choice. And as if this weren't bad enough, in their effort to protect themselves, they also were forced to put the tape on and take it off, all on their own, which is counter-productive and increases the likelihood of spreading contaminants.

We note that the new CDC guideline that any protective equipment leave 'no skin exposed,' is a "direct testament to the courage of Briana Aguirre. Briana first spoke to National Nurses United with several others of her Texas Health Presbyterian colleagues whose joint statement we released publicly a day before Briana's appearance on NBC.

A hospital in the Bay Area last week provided nurses with a so-called "Ebola tool kit" that contained a gown similar to what was used at Texas Health Presbyterian, with no neck or full head covering. In southern California, a patient claiming Ebola infection presented at an ER where there had been no prior Ebola training and no appropriate Personal Protective Equipment. At a Florida hospital where the RNs had not been provided with any Ebola information or preparedness training, an understandably concerned nurse called the CDC. And how was her initiative and

concern for her patients met by the hospital at which she worked? Her hospital management suspended her without pay.

I offer these examples to illustrate the importance of the federal government mandating utilization of the highest, uniform optimal level of Personal Protective Equipment and the highest optimal uniform level of interactive hands on education and training for nurses and other caregivers.

We have called upon President Obama to invoke his executive authority, and have urged Congress legislatively to mandate uniform optimal national standards. That should include:

• Optimal personal protective equipment for Ebola that meets the highest standards used by the University of Nebraska Medical Center, including:

• Full-body hazmat suits that meet the American Society for Testing and Materials (ASTM) F1670 standard for blood penetration, the ASTM F1671 standard for viral penetration, and that leave no skin exposed or unprotected and National Institute for Occupational Safety and Health-approved powered air purifying respirators with an assigned protection factor of at least 50 — or a higher standard as appropriate.

• At least two direct care registered nurses dedicated to caring for each Ebola patient, with no additional patient care assignments. Additional RNs shall be assigned as needed based on the direct care RN's professional judgment.

• Continuous on-site interactive training with the RNs who are exposed to patients along with updates responsive to the changing nature of disease.

• If any Employer has a program with standards that exceed those used by the University of Nebraska Medical Center, the higher standard should be used. The "Precautionary Principle" must be utilized and adhered to when determining and developing public health policy designed to protect patients, the public, nurses and all healthcare workers who are directly interfacing with potential infectious patients.

Simply put – not one more nurse, not one more hospital worker, not one more patient should become infected with Ebola. Not one more community should

have fear of Ebola being spread in their neighborhoods. The only effective way to stop the spread of fear is to ensure full preparedness in every U.S. hospital.

And our long experience with U.S. hospitals is that they will not act on their own to secure the highest standards of protection without a specific directive from our federal authorities in the form of an Act of Congress or an executive order from the White House.

The response to Ebola from US hospitals and governmental agencies has so far been dangerously inconsistent and woefully inadequate. The lack of mandates in favor of shifting guidelines from multiple agencies, and reliance on voluntary compliance, has left nurses and other caregivers uncertain, severely unprepared and vulnerable to infection.

Regarding the new guidelines issued by the CDC, these represent progress particularly in the area of improved standards for training – as our members and organization have been demanding for two months.

But serious questions remain. Perhaps most important, the CDC guidelines remain unclear on the most effective protective equipment, and, significantly, have their own gaping hole in the option offered to hospitals to select which protective equipment to use "based on availability" and other factors.

The CDC identifies diarrhea, vomiting, and unexplained hemorrhage as signs and symptoms of Ebola.[1] Moreover, although the CDC refers in its guidance to the possibility of "an unexpected aerosol generating procedure" it does not acknowledge the very real possibility of unexpected diarrhea, vomiting and hemorrhage, as well as coughing or sneezing, that can generate aerosols which contain Ebola. So:

- Why do the updated guidelines issued this week by the CDC allow "fluid-resistant" gowns and aprons rather than specifying a full-body hazmat coverall impermeable to all body fluid, blood, and viral agents to ensure optimal protection of healthcare workers?
- Why didn't the CDC specify an assigned protection factor (APF) for respirators?

[1] http://www.cdc.gov/vhf/ebola/symptoms/index.html,

- Finally, given that the CDC leaves open the possibility that hospitals will not provide the same level of PPE to all nurses, when does the CDC recommend that healthcare workers immediately begin donning PPE when caring for patients identified as potentially exposed to Ebola? If not, at precisely what point does the CDC recommend the use of PPE for healthcare workers?

Granted, there is new information, and conditions can change. This is all the more reason however, to mandate measures based on the precautionary principle. Any lack of certainty does not justify inaction, but rather, points toward an approach that calls for taking the highest level of precautions.

The Ebola pandemic and the exposure of health care workers to the virus in Texas and the real threat that it could occur elsewhere in the US, represent a clear and present danger to public health.

We know that unless uniform optimal standards are universally required for all health care facilities, we are putting registered nurses, physicians and other healthcare workers at extreme and unnecessary risk.

And lest we forget, the risk of exposure to the population at large merely starts with frontline caregivers like registered nurses, physicians and other healthcare workers – it does not end there. As we've seen with school closures in Ohio, and quarantining of airline passengers, improper protection and inadequate protocols in hospitals can lead to public exposure outside of healthcare facilities.

Indeed, a critical lesson we should have learned from the horrifying Ebola outbreak in West Africa is what the World Health Organization has called an "unprecedented" infection rate of nurses, physicians and other frontline healthcare workers – and a record death rate for them. In Liberia, our sister union informed us this disease is not even called Ebola, it is called the "nurse killer disease."

If we cannot protect our nurses and other healthcare workers, we can not protect anyone.

We are your first line of defense. No leader would ever contemplate sending soldiers into the battlefield without armor and weapons. Why would we send

nurses into the battle with Ebola and other infectious diseases without the protection, training, and treatment protocols necessary to defeat this enemy?

You should not expect RNs to treat any highly infectious disease without optimal preparation and protection. Give us the tools, we will contain Ebola.

All we ask from President Obama and this Congress is: Not one more infected nurse.

Chairman ISSA. Thank you.
Mr. TORBAY.

STATEMENT OF RABIH TORBAY

Mr. TORBAY. Chairman Issa, Ranking Member Cummings, and distinguished Members of the committee, on behalf of International Medical Corps, one of the few agencies in the world to be treating Ebola patients, I would like to thank you for inviting me to testify today and for your leadership in convening this critically important hearing. We would also like to express our appreciation to the U.S. Government for their pivotal action and generous support for the response.

Our response to the Ebola outbreak has been robust. By the end of November, I anticipate we will have a total of about 800 staff in Liberia and Sierra Leone. Approximately 70 of these will be expatriots. International Medical Corps has been operational in West Africa since 1999.

Our Ebola response started in late June with community education and sensitization in Sierra Leone. In late July and after we realized the epidemic has reached out-of-control levels, we deployed our emergency response teams to both Sierra Leone and Liberia and decided to get involved in treatment of Ebola cases.

When our emergency teams arrived in Liberia in August, what we found on the ground confirmed that urgent action was required. In a few short months, fallout from the Ebola outbreak had brought the country's already fragile healthcare system to the brink of collapse.

Many were dying. Most were afraid. Previously busy hospitals and clinics were empty, with both staff and potential patients too frightened to go there for the fear of being infected with the virus.

Rather than risk infection, mothers shunned lifesaving vaccinations for their children and, if their child became ill, even seriously ill, all too many believed the safer option was not to seek treatment at all.

With funding from USAID, we opened up our first 70-bed Ebola treatment unit in Bomi County in Liberia as we admitted our first patients on September 15. Currently, we have 53 beds occupied and staffed by a team of 17 ex-patriots and 161 Liberian nationals. To date, this issue remains one of just two in Liberia operating outside of Monrovia.

Within the next 6 weeks, we expect to open three additional Ebola treatment units, one in Liberia in Margibi County and two in Sierra Leone's Northern Province, specifically in Lunsar and Makeni.

Within the next 3 weeks, we expect to open a training center in Bung County to train other NGO staff on case management protocols. In this center, which will be adjacent to our Ebola treatment unit, we will offer a fast-paced, 7-to 12-day training for those that will be involved in the treatment of Ebola patients.

We will open a similar center in Sierra Leone in the near future as well. Such hands-on training is the key to protecting healthcare workers who must operate in an environment where all know the

Ebola virus is present. Strong guidelines and regulations are important, but they must be combined with hands-on training to be truly effective.

Mr. Chairman, I would like to briefly share some of what we know works. This will help highlight several key areas to focus as well as what is needed going forward.

First and foremost, we need to contain the disease at its source. For that to happen, we have learned that several factors need to be in place.

This includes having operational Ebola treatment units that are staffed by well-trained health professionals, a robust referral system between community care centers and Ebola treatment units as well as between Ebola treatment units themselves to take advantage of available bed capacity in certain areas.

Limiting the spread of the virus in the community is essential to containment plan. Therefore, the focus on community sensitization, including education, awareness, and outreach are critical. Finally, contact tracing and burial teams are critical to limit transmission.

I would like to conclude by offering some recommendations to the committee for consideration. More detailed recommendations can be found in our written testimony.

First, one of the most critical lessons learned from this response has been the importance of having the human resources ready and prepared to address an outbreak of infectious disease.

Cadres of healthcare workers need to be well trained and supported to staff the treatment units and care centers in the affected countries, as well as to prepare other countries in the region for any potential future outbreaks.

Second, ensure availability of appropriate personal protective equipment.

Third, ensure clear protocols for evacuating healthcare workers. This is essential for our recruitment, training, and retaining of health staff in Liberia and Sierra Leone.

Fourth, open air space to and from the Ebola-affected countries must be maintained. The growing restrictions on travel to and from West Africa will only isolate the affected countries further, compromise the supply chain, and inhibit efforts to recruit qualified staff. These factors will further enable the severe outbreak to continue.

Fifth, we need to accelerate and support the production of vaccines and innovative technologies.

Finally, in developing and implementing recovery efforts and a long-term strategy, we must focus on building stronger healthcare systems in the region.

Mr. Chairman, there is no doubt that we will stop this outbreak and the death and, if done correctly, build the tools to prevent another outbreak of such proportions. International Medical Corps looks forward to working with you to make this happen.

Once again, thank you, Mr. Chairman and Ranking Member Cummings, for allowing me to present this testimony. I would be glad to answer any questions the committee might have.

[The prepared Statement of Mr. Torbay follows:]

International Medical Corps

Statement of Mr. Rabih Torbay
Senior Vice President for International Operations
On Behalf of
International Medical Corps
Before the
House Committee on Oversight and Government Reform
The Ebola Crisis: Coordination of a Multi-Agency Response

October 24, 2014

Chairman Issa, Ranking Member Cummings, and distinguished members of the Committee. On behalf of International Medical Corps, one of only a small handful of international NGOs in the world to be treating Ebola patients, I would like to thank you for inviting me to testify today and for your leadership in convening this critically important hearing. We would also like to express our appreciation to the U.S. government for their pivotal action and generous support for the response.

International Medical Corps is a global, humanitarian, nonprofit organization dedicated to saving lives and relieving suffering through health care training and relief and development programs. Its mission is to improve the quality of life through health interventions and related activities that build local capacity in underserved communities worldwide. By offering training and health care to local populations and medical assistance to people at highest risk, and with the flexibility to respond rapidly to emergency situations, International Medical Corps rehabilitates devastated health care systems and helps bring them back to self-reliance.

My remarks today will largely be confined to our operations in Liberia and Sierra Leone—where the overwhelming majority of Ebola cases have been reported.

The Outbreak and Our Response

Our response to the Ebola outbreak has been robust. By the end of November, I anticipate we will have a total staff of about 800 in Liberia and Sierra Leone. Approximately 70 of these will be expatriates.

I would like to take you through the response of my organization to the Ebola outbreak. International Medical Corps has operated health care and humanitarian assistance programs in West Africa since 1999.

When the first Ebola cases were detected in the region in late 2013, we were operational in Sierra Leone, providing community level health care, mental health care, and support in the fight against malnutrition. Because of our longstanding work and familiarity with the West Africa region, we learned of the Ebola outbreak almost immediately, at the end of December 2013, and we continued to monitor the pace of the disease.

In March 2014, Liberia's Ministry of Health and Social Welfare provided details on suspected and confirmed cases of the Ebola Virus Disease (EVD) to the World Health Organization (WHO). Two months later (May 2014), the first case of Ebola was reported in the Kailahun District of Sierra Leone, about 270 miles east of the capital, Freetown.

Between mid-June and mid-July, the number of confirmed cases of Ebola in Sierra Leone spiked from fewer than 20 per week to more than 50. During the second half of July, the number of confirmed cases reported in Liberia also increased. After immediate discussions in the field and with partner agencies at headquarters to assess needs and gaps, we realized the epidemic had reached out of control levels.

By this time, we had already deployed teams to Sierra Leone to work with local NGOs as part of a community-level campaign to raise awareness about Ebola. On July 31st, Sierra Leone President Ernest Bai Koroma declared a state of emergency. The following day, we ordered a rapid assessment of the local conditions and triggered our highest category of emergency response. We also determined the more urgent task was treatment of those who had contracted the virus. Our Emergency Response Team arrived in Sierra Leone on August 9th. Since then, we have begun construction on—and will staff—a 50-bed Ebola Treatment Unit (ETU) in the town of Lunsar, a commercial hub with a population of more than 35,000, about 60 miles northeast of Freetown. The projected date of completion of this unit is November 7th and we anticipate receiving our first patient by November 15th. We plan to operate a transportation service for the ETU that will include minibuses, ambulances and hearses.

We also expect to manage a second 50-bed ETU in Makeni, a city of over 100,000 about 110 miles northeast of the capital. The locations of these two treatment units were chosen because they are in areas with the highest concentration of new cases in Sierra Leone in addition to the country's capital. Throughout this process, we have coordinated closely with the Sierra Leone Ministry of Health and Sanitation, with donors, including USAID, Britain's Department for International Development, the European Commission's Humanitarian Aid and Civil Protection department (ECHO), Irish Aid, WHO, the CDC and other International NGOs.

In Liberia, we trigged our highest category of emergency response and need for a rapid assessment of conditions on August 2, 2014. Five days later (on August 7th), Liberian President Ellen Johnson declared a

state of national emergency in the country. Our Emergency Response Team arrived in Monrovia 72 hours later to begin its assessment. What our team found on the ground in Liberia confirmed that urgent action was required. In a few short months, fallout from the Ebola outbreak had brought the country's already fragile health care system to the brink of collapse. Many were dying. Most were afraid. Previously busy hospitals and clinics were empty, with both staff and potential patients too frightened to go there for fear of being infected with the virus. Rather risk infection, mothers shunned life-saving vaccinations for their children, and if their child became ill—even seriously ill—all too many believed the safer option was to not seek treatment at all.

For us, coordination in emergency response is critical. In these critical circumstances, we reached out to key actors, such as WHO, the CDC and USAID even before the deployment of our team. We were also in regular communication with Médecins Sans Frontières (MSF) in Brussels. Once on the ground in Liberia, we immediately began coordinating our work with other groups involved in the response of the Ebola crisis, particularly Liberia's Ministry of Health and Social Welfare, as well as the representatives of USAID's Disaster Assistance Response Team (DART), WHO, the CDC and MSF. As part of an Incident Management System established to tackle the Ebola outbreak, International Medical Corps quickly agreed to manage and provide the necessary staff for an ETU being built by Save the Children in the Suakoko District of Bong County, about a four-hour drive north of the capital, Monrovia. MSF graciously offered training for our key staff who would be operating the ETU. The Ministry of Health provided us with a cadre of national health workers that would staff the ETU, and the management of Cuttington University provided us with their dormitories to house our staff, as well as other administrative buildings. We are thankful to all for their support.

We admitted our first patients to the Bong county ETU on September 15th. Currently, we have 53 beds occupied and staffed by a team of 17 expatriates and 161 Liberian nationals. We are gradually building up to 70 beds and a staff of around 230. I would like to take a moment to acknowledge the dedicated and courageous staff working in our treatment center. They have come from inside Liberia and outside – including physicians and nurses from many parts of the United States, Europe and Africa. Our staff is comprised of doctors, nurses, technicians, specialists in water, sanitation and hygiene, logisticians, mental health professionals, custodial workers, and members of burial teams.

To date, this ETU remains one of just two in Liberia operating outside of Monrovia. Our operations there involve isolating and treating patients, providing them with counseling, caring for the remains of those who succumb to the disease, operating ambulance service dedicated to transporting suspected Ebola patients to the ETU and returning those home who have either been cured or tested negatively for the virus, assisting in the reintegration of those returnees to communities that may be anxious about their return, and working with local NGOs on patient referrals.

After discussions with the Ministry of Health, WHO, the CDC, DART and the U.S. military, the U.S. Navy established a laboratory at Cuttington University, adjacent to our ETU. The presence of this laboratory and its ability to turn around the results of blood test for Ebola quickly has made a major difference to our work. It has also saved many lives by allowing those who test negative for the disease to leave the ETU far sooner than they did previously—from as long as five days to a matter of 5-7 hours. I want to take this opportunity to express my personal thanks to the U.S. military for establishing the laboratory in Bong.

In both Liberia and Sierra Leone, we are preparing to manage a second Ebola Treatment Unit—a 70-bed unit in Margibi County, Liberia and a 50-bed unit in Makeni, Sierra Leone. Approximately within the next three weeks, with funding from USAID, we expect to open a training center in Bong County to pass on the knowledge we have gained to members of other NGOs who want to join in the effort to stem the current outbreak. In this center, which will be on the grounds of Liberia's Cuttington University, adjacent to our ETU, we will offer a fast-paced 7-12 day training course for those arriving on the frontlines of the fight against this disease.

Physicians and nurses coming into direct contact with Ebola patients will receive up to 12 days training, while other essential skilled technical staff, such as logisticians and water and sanitation engineers, will receive 7-10 days. Among the individuals we plan to train are members of a U.S. Public Health Service team that will staff a 25-bed Ebola Treatment Unit in Monrovia dedicated to treating health workers who have been infected with the disease during the course of their work treating others. A similar training center will be established in Sierra Leone as well.

Such hands-on training is the key to protecting health workers who must operate in an environment where all know the Ebola virus is present. Strong guidelines and regulations are important, but they must be combined with hands-on training to be truly effective.

Procedures, Protocols and Practice

In its 30 years of providing humanitarian assistance to those in need, International Medical Corps has worked in more than 70 countries in some of the world's toughest, most dangerous environments, but had not previously encountered the Ebola virus or treated patients infected with it. However, our experience of working consistently in challenging, high-risk conditions taught us to move carefully, expect the unexpected and to err on the side of caution when weighing risk as we prepared to open our first treatment center. We consulted with staff from Médecins Sans Frontières to draw on the depth of their experience and the guidelines and protocols they had developed in treating Ebola patients during previous outbreaks in Africa. We also reviewed guidelines and protocols from the CDC and WHO.

We learned quickly that treating Ebola patients is a labor-intensive endeavor that demands very strong logistics to maintain the flow of large quantities of supplies, including personal protective equipment (PPE) for the staff, bedding and medications for patients, as well as disinfectant and water to keep the treatment

unit safe and clean. For example, most PPEs can be used only once, then are incinerated to prevent possible infection. We require approximately 840 PPEs per week to comply with the established guidelines to ensure the safety of our staff. We follow a ratio using 3 expatriate doctors per 50 patients, 8 expatriate nurses per 50 patients, 4 local physician assistants per 50 patients, 24 local nurses per 50 patients, and 2 consumable PPEs per patient.

To treat Ebola patients effectively, we require a staff of about 230 to operate a 70-bed treatment unit. This is a staff per patient ratio of over 3:1. At our Bong County, Liberia treatment unit, we currently have a staff of 178 serving 53 beds. Ebola treatment requires higher than normal staff levels to reduce the risk of mistakes that could potentially endanger both patients and staff. One common practice in our ETUs is for members of our teams to work in pairs—what we call a "buddy system." For example, two physicians or two nurses make every decision that in a regular setting would be made by one on their own. Each "buddy" is constantly checking the personal protective equipment of the other and that the delivery of care is running correctly. The "buddy system" is also used when removing a PPE, a procedure that can carry a high risk of infection if not done properly. To further diminish risk, we have also added one more Shift Supervisor, whose task is to make sure each "buddy team" is following the prescribed protocols and to monitor the overall movement of the team and the treatment it is delivering to our patients. Our staff follow very specific and meticulous, step-by-step donning and doffing protocols.

These protocols are demanding and arduous, requiring personal discipline, concentration and patience on the part of all involved to follow. They are needed because the danger to staff can be very high. We are painfully aware that as of middle of this month, more than 400 health workers had been infected with Ebola in the course of their work. In fact, Ebola has been nicknamed "the nurse killer" in Liberia.

I am pleased to report the strict guidelines and protocols we have implemented have been successful. We have been able to both protect and treat health workers at the Bong facility. Actually, one of the patients we admitted, treated and cured was a Liberian nurse infected while caring for Ebola patients at another facility.

Our protocols require that PPEs worn by our staff cover the entire body. No skin can show. We quickly learned that wearing a bulk, impermeable PPE with as many as three layers of protection in West Africa's high humidity with temperatures of 95 degrees means that staff can only work relatively short periods of time—usually between 1 and 2 hours maximum—inside the unit's restricted area before being rotated and replaced by another team.

In addition to the ETUs, a new approach is to be implemented in Liberia and Sierra Leone that is hoped to help contain the virus. Community Care Centers are to be established where suspected Ebola patients could be removed from their homes and relocated into a center in the community where they could be isolated and provided with palliative care. These would be centers with approximately 10 beds where patients could await testing. A patient testing positive for Ebola could be transferred to an ETU for treatment while those who test negative would be allowed to return home. An advantage of such centers

would be to protect families attempting to care for a loved one from being exposed to the virus. We would support this concept as long as the health workers serving in such centers receive both full training and are equipped with the same PPEs as those used in ETUs. The centers should also need to be linked to—and supported by—an ETU, acting as de facto satellites to that ETU.

Funding, Needs and Support

We are grateful for the timely and generous funding we have received from USAID's Office of Foreign Disaster Assistance, which has enabled us to open the ETU in Bong County and to prepare our staff training facility nearby. It has also funded the ETU nearing completion in Lunsar, Sierra Leone. Other government donors have also come forward to address the crisis, as have some private foundations and corporations. However, generating public donations, which are also necessary to support our efforts to fight Ebola, has been a challenge.

As we continue the scale-up in both Liberia and Sierra Leone for what we believe will be a prolonged fight to contain the Ebola virus in West Africa, the needs will grow accordingly. Put simply, we need three things: people, commodities, and money. We need to continue the recruitment and training of staff and to build a "human resource" pipeline. Conditions to facilitate this—which include travel to and from the affected countries, procedures and systems to protect and treat health workers—must be ensured and implemented as soon as possible.

By commodities, I mean everything from PPEs to disinfectant, to vehicles for transportation, mattresses and bed clothing. Many of these items can only be used once to contain the spread of the disease.

The fight to contain Ebola will be costly. Assuming there are 27 ETUs regionally, and 120 Community Care Centers, we anticipate it would require about $1.6 billion for the next 6 months to bring the disease under control. We will also need to consider the secondary impact of the outbreak—the added costs of food, security, and loss of economic activity are estimated at $500 million. Rebuilding the health care system and maintaining an adequate disease surveillance system could run an additional $600 million.

What Works

Mr. Chairman, I would now like to briefly share some of our lessons learned of what we know works. I believe this will help highlight several key areas of focus as we move forward.

First and foremost, we need to contain the disease. For that to happen, we have learned that several factors need to be in place. This includes having operational ETUs that are staffed by well-trained health professionals.

Community Care Centers, if well-staffed and equipped, could help limit the transmission. A robust referral system between the care centers and ETUs, as well as between ETUs to take advantage of available bed capacity in certain areas to alleviate pressure of overloaded ETUs can help reduce the wait, time, transmission rate and mortality rates. Furthermore, a smart and efficient coordination mechanism at the national level is critical for effectiveness of the response. Limiting the spread of the virus in the community is essential to the containment plan. Therefore, a focus on community sensitization, including education, awareness and outreach to build a trusting environment are of utmost important.

Second, building local capacity by carrying out training and supervision of personnel provides countries with the needed tools and mechanisms to be prepared to respond during outbreaks.

And third, we must focus on strengthening coordination of efforts. To turn the tide of this epidemic, we need to work together and use the strengths of all stakeholders involved. For instance, data analysis and sharing information about what is currently happening and where the gaps are is critical.

What is Needed Going Forward

As we have stated above when describing our response, the most critical challenge is the scarcity of health workers to treat patients and staff the treatment centers that are currently in operation and those being built and planned.

We are facing a severe shortage of adequately trained health professionals, both national and international. The difficult work environment, the personal risk, the need for 21 day self-isolation in some circumstances, all make it difficult for us to recruit volunteers. Health care workers also want to be assured that there are clear plans and procedures in place for possible evacuation and treatment should they fall ill. This has been slow in coming. The growing restrictions on travel to and from West Africa will only isolate the affected countries further, compromise the supply chain and inhibit efforts to recruit qualified staff. These factors will further enable the severe outbreak to continue.

Training of health workers and first responders continue to be a major need. This includes training of staff working in a treatment units, at community care centers, burial teams, ambulance attendants, community workers and educators. The training being conducted by the CDC, the training to be conducted by the U.S. military, training being led by other NGOs, as well as International Medical Corps needs to be supported. We, at International Medical Corps, are willing to train ETU staff, both in Sierra Leone and Liberia, to help contain the virus.

I would also like to underscore how vital has been and continues to be the availability of and proper usage of PPEs during the Ebola response. To this end, it is important to note that acquiring appropriate protective equipment has represented another challenge given the numbers required to effectively implement

treatment centers and protect workers, as well as the limited number of available qualified suppliers. The current demand far exceeds the supply. There are currently two main manufacturers for our "acceptable" coveralls (a key component of the PPE), and they are producing at full capacity. We estimate that, at the current stage, they will meet around 35 percent of the demand. Those manufacturers need to be supported and encouraged to increase their production capabilities to meet the demand.

I would like to conclude by offering some recommendations to the Committee for consideration.

First, one of the most critical lessons learned from this response has been the importance of having the human resources ready and prepared to address an outbreak of infectious disease. Cadres of health workers need to be well-trained (and supported) to staff the ETUs and care centers in the affected countries, as well as to prepare other countries in the region for any potential future outbreaks. This epidemic has very visibly demonstrated that it is communities, civil society - including NGOs - and government health workers at the local level who carry out the majority of the response related to treatment, patient care and case management, and community outreach. To be truly effective, it is important that training and supervision of personnel be led by entities with hands-on experience in treatment and management to undertake this task, which should involve actual practical training and not be limited to didactic methods. A comprehensive approach to the training that includes all aspects of addressing the outbreak should include case management and treatment, contact tracing, dead body management, as well as psychosocial support, community outreach and awareness, and social mobilization.

Second, we need to accelerate the construction and staffing of ETUs and community care centers to break the chain of transmission. We must also improve coordination among the centers so that beds are available to patients who need them. Today, some ETUs have many empty beds while others are at full capacity, forcing staff to turn suspected Ebola patients away.

Third, we must improve surveillance and referral systems that will help individuals access treatment quickly and strengthen the link between community-based and referral-systems.

Fourth, we need to establish clear and understandable linkages among various coordination structures that are now in place such as the UN Mission for Ebola Emergency Response and country coordination bodies. Such clarity is especially critical for NGOs who are closest to the ground and doing service delivery, as well as national governments and their agencies. Efficient coordination would also aid in supply chain and logistics issues.

Fifth, while we welcome the advances that have been made over the past few weeks in establishing procedures to evacuate and treat health workers who might contract Ebola, we recommend that the systems

being put in place now be institutionalized and made part of the global preparedness planning in the event of future epidemics.

Sixth, we need to maintain an open airspace to and from the Ebola-affected countries. This is critical for the humanitarian response, to get staff and supplies in and out of the region. It is critical for our recruitment and for the well-being of our staff. We need to contain this virus at the source and we cannot do this without the ability to get much-needed staff and supplies to and from the affected countries. As InterAction, a coalition of over 190 member organizations stated in their recent letter to Congress: "Without the NGO community and its supported health workers on the ground treating patients in West Africa, it will be very difficult to end this crisis."

Seventh, we need to accelerate and support the production of vaccines. The human and economic consequences of this outbreak are disastrous and an investment in vaccines would help mitigate future outbreaks.

Eighth, we need to invest in preparedness in the region at large to ensure these countries have the needed resources, proper training and systems in place to respond to possible future outbreaks. Also, as we have learned over the past few months, the virus does not recognize international borders and could affect other West African Countries with devastating effects.

Finally, in developing and implementing recovery efforts and a long-term strategy, we must focus on building stronger health care systems in the region. Some of the most serious side effects stemming from the Ebola outbreak have occurred within the countries' health care systems. Health centers have closed, emergency and maternity wards are not functioning, hospital staff have stopped coming to work, all of which has had a severe impact on the already dire circumstances facing these countries. As a consequence of the current situation, Sierra Leone and Liberia, which already experienced some of the highest burden of maternal and child deaths, are now facing conditions where there are no available places for women to have C-sections, for children to be immunized, trauma centers to go to after car and other accidents, as well as continue to manage the ongoing severe health problems affecting the countries such as high rates of malaria, pneumonia, and a wide range of chronic conditions. As a result, the mortality rate is expected to increase to higher levels.

Addressing these challenges will require increased financial investments and the engagement of other countries and various stakeholders working in tandem. At the same time, we need to consider the secondary and tertiary impacts of this outbreak such as its impact on economic conditions, livelihoods, food security, and vaccination coverage.

There is no doubt that we will stop this outbreak, end the deaths, and - if done correctly - build the tools to prevent another outbreak of such proportions. We look forward to working with you to make this possible.

Once again, thank you, Mr. Chairman and Ranking Member Cummings for allowing me to present this testimony before your very distinguished committee and for holding this timely hearing. I would be glad to answer any questions the Committee may have.

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Chairman ISSA. Thank you. I would like to thank all our witnesses.

I am going to withhold my questioning at this time and go—let Mr. Turner go first.

The gentleman from Ohio is recognized for 5 minutes.

Mr. TURNER. Mr. Chairman, I greatly appreciate that. I am under a time constraint, having to return back to my district, and I greatly appreciate the Chairman doing that.

Tuesday I had the opportunity to talk to Secretary Hagel about the Ebola mission. And I believe that he takes this very seriously and he is very concerned both about the effects on our men and women in uniform and, also, on the effects of protecting the American public.

I am very concerned about the protocols of protecting the American public. And since I only get one question, my question is going to be about that, although I, too, am very concerned, as all the American public is, about the protection of our men and women in uniform.

I am very skeptical of the DOD protocols, and I think the American public is very skeptical. We have basically two threats: one, Ebola coming here; or two, individuals who have been exposed to Ebola falling ill to Ebola.

We have had four cases. Two came here. Two are the result of people being exposed to Ebola here and then falling ill. Three were healthcare providers.

Now, the American public is very concerned that individuals who have been exposed to the Ebola virus have had significant public access after being exposed. This is during a period while they were falling ill to Ebola.

Now, on October 10, Ebola came to visit Ohio. Amber Vinson traveled from Dallas, Texas, to Cleveland. While she was in Cleveland, she visited local businesses. Of course, she flew on a flight there. Almost 300 people had contact with her while she was falling ill to Ebola.

Fortunately, Ohio doesn't have a report at this time of a case of Ebola. But on October 20, the entire Ohio congressional delegation, on a bipartisan basis, sent a letter to the CDC challenging their protocols with respect to people who have been known to have been exposed to Ebola.

Now, we all know the stories: trying on wedding dresses, flying, going on a cruise, bowling, riding the subway. Although some of these issues are personal responsibility, they do go to the issue of protocols.

And if you look at the October 10 Department of Defense guidelines, in paragraph 4, it says that a commander has authority, which means they may—they don't have to—quarantine someone up to 10 days if they are concerned about an individual who has been exposed. Now, we all know that the doctor in New York fell ill, apparently, after 11 days.

And then it goes on to say that no known exposure—now, it doesn't mean they weren't exposed—it means no known exposure—that there is a 21-day monitoring period, but it suggests that the individuals return to routine daily activities. Well, those routine

daily activities would include going on cruises, flying, wearing wedding dresses, bowling, and riding the subway.

So I think I am very concerned, as the American public is, as to the multiplier effect of the contacts that could occur in the public. And as we are learning, as we have looked at, in light of what has happened, I believe that both the CDC rules and perhaps the DOD guidance should be revised.

General, in light of what we now know and what we are seeing and our concerns of the multiplier effect, again, of three healthcare providers who had significant public contact while falling ill to the Ebola virus, do you believe that this October 10 DOD guidance should be revised?

And, Mr. Lumpkin, I would like your answer, too.

Mr. LUMPKIN. I think the first thing I would like to say is to make sure—as I mentioned in my opening Statement, is that we at DOD in West Africa are not doing direct patient care. So our operations in support of USAID are focused on those lines of effort of the command and control, the logistics, the——

Mr. TURNER. But, Mr. Lumpkin, as you know, that does not mean that no one is going to be exposed to the virus. I mean, I understand what you are saying about the distinction between healthcare providers and non-healthcare providers. But the gentleman who flew here first, Patient 1 in the United States, was not a healthcare provider either.

Mr. LUMPKIN. Very true.

But I want to make sure you understand that, because we are not—we have different categories of risk. And I would like to turn it over to my Joint Staff colleague here to explain the risk categories and the mitigation strategies for each one of them.

General LARIVIERE. Mr. Turner, thank you for the question.

The protocols that we have put in place, we think, exceed the CDC standard. As you mentioned, we will be testing personnel twice a day while they are deployed, take their temperature, and to ensure that they—that, if they were exposed and they did become infected, we could isolate them effectively.

The 0-to 10-day timeline that you discussed is the timeline that will take place in country. Commanders will have the authority to remove their personnel,——

Mr. TURNER. But, General, as we already know from the doctor in New York, he indicated, if the news reports are correct, that his symptoms occurred at 11 days.

General LARIVIERE. Yes, sir.

Mr. TURNER. So is it you are 10 days too short?

General LARIVIERE. Yes, sir. Well, the 10 days were in country. The 21 days can't start until they are actually out of the affected area. So the 21-day monitoring period will take place——

Mr. TURNER. Which means they could be traveling on day 11 and no longer isolated?

General LARIVIERE. They could be traveling on day 11, but they will—the 21——

Mr. TURNER. Which would result in additional exposure?

General LARIVIERE. No, sir. We will try to limit their exposure prior to their departure. But the 21-day timeline won't start until they are back in the United States——

Mr. TURNER. Well, my time is up.

But I want to indicate I am highly skeptical. The American public is worried. I believe these need to be revised. The Ohio delegation sent to CDC, they believe theirs need to be revised.

The American public is concerned that people who are exposed are having too much contact with the American public and raising the risk to the United States citizens.

Thank you, Mr. Chairman. I appreciate it.

Chairman ISSA. Thank you.

And, General, I just want to make sure, as the ranking member—I just want to make sure that you are clear in what you are saying and what Mr. Turner was asking.

If someone like the doctor in New York who just tested positive is, in fact, held for 10 days, leaves on a commercial airplane—if one of your gunnery sergeants leaves on an airplane, arrives in New York and on the 11th or 12th day goes positive, your 10 days will have done nothing and you won't get that opportunity to have them outside—you know, in other words, the quarantine of 21 days after you get back doesn't matter.

And I think that is what Mr. Turner was very much asking, is the example he gave of a doctor from just yesterday tells, I think, all of us that 10 days isn't long enough if that person then travels on a commercial airplane where they then can infect the passengers on the airplane.

Is that your question, Mr. Turner?

Mr. TURNER. Correct, Mr. Chairman.

Chairman ISSA. Thank you.

Do you have any further clarification?

General LARIVIERE. Perhaps I am—perhaps I am not being clear. The 10 days is to attempt to limit their possibility for exposure while they are in country in Liberia.

They will then be screened for temperature and possible exposure prior to getting on a government contract or U.S. military aircraft to be returned to their unit back in the United States.

Once they have flown back to their unit in the United States, they will be given a 21-day monitoring period where they will be required to come into the unit twice a day for medical checks by U.S. military medical personnel at their unit where they will have their temperature taken and looked in the eye by a medical professional to see how they are doing. That will take place for 21 days back—back in the rear area to ensure they that do not become infected.

They will never be more than 12 hours from possibly spiking a fever. If they did exhibit symptoms and spike a fever once they were back in the United States during one of those medical checks, they would immediately be taken to a treatment facility and begin the isolation process.

Chairman ISSA. Mr. Cummings.

Mr. CUMMINGS. Yes.

Mr. Torbay, I want you to remember what was just Stated and I want you to comment on that in a minute. I am going to—I am really curious as to what you—you deal with this every day. So—what you think of it. But I want to go through some other things first.

I know your organization is incredibly busy, but your input is very crucial. In addition to your very detailed written Statement, you provided some pictures, and I am hoping you can explain what we are seeing.

First, I believe this picture is an Ebola treatment center. Can you briefly describe what we have seen here. And where is that?

Mr. TORBAY. Absolutely. This is in Bomi County in our Ebola treatment unit. This is the isolation unit. What you see, the two health workers in yellow suits with a hood and a mask are actually inside the restricted area. Nobody is allowed to go in there without full personal protection, equipment, and training.

And outside they are taking notes. There is a supervisor to make sure that proper protocols are taking place as they are entering the Ebola treatment unit.

Mr. CUMMINGS. And, in your testimony, you said you need about 840 of these suits every week. You also said this, "The current demand far exceeds the supply. There are currently two main manufacturers for our acceptable overalls, and they are producing at full capacity." You go on to say, We estimate that at the current stage, they will meet around 35 percent of the demand. Is that right?

Mr. TORBAY. That's correct.

Mr. CUMMINGS. And so what can we do to help provide more protective gear?

Mr. TORBAY. Absolutely. First of all, I would like to clarify that it is 840 PPEs for a 60-bed hospital. That is for one Ebola treatment unit; it is not for the entire operation. What we need to do is encourage those manufacturers to increase the supply line and make sure that anybody who has the capacity or has some of those PPEs in stock to release them, because a lot of them are in stock in areas that are not actually endemic, and they need to be released for those that are treating patients.

Mr. CUMMINGS. Now going back, let me go to another picture.

Mr. Torbay, in this picture there is a little truck in the background, and it has some kind of tarp on a flatbed. Can you tell us what the truck is used for?

Mr. TORBAY. This is a makeshift ambulance. There is a lack of ambulances in Liberia. So we took a flatbed truck, we put a mattress in it, and we covered it with a tarp. And this is what we take to get patients from the community to the Ebola treatment unit.

Mr. CUMMINGS. In your written Statement. You said, "Put simply, we need three things, people, commodities, and money. By commodities, I mean everything from PPEs, to disinfectant, to vehicles for transportation, mattresses and beds and clothing." So is this what you are talking about in additional vehicles to transport patients? Is that what you are talking about?

Mr. TORBAY. Absolutely. To transport patients. Additional vehicles for burial teams. Ambulances that could go out to the communities, to the community care centers and transfer patients to the Ebola treatment unit for treatment.

Mr. CUMMINGS. Now let me go to the next picture. This is not a picture you provided, but one from a hospital in Sierra Leone. There are people on the floor. There is fluid everywhere. And there is a team of people in full protective suits that appear to be remov-

ing a dead body. Can you please explain why it is so important to have proper burial procedures?

Mr. TORBAY. Absolutely. The viral load in a dead body is at its highest. This is when it is most contagious. So it is extremely important to have proper burial procedures. The way we go about it, when a person succumbs to the disease, we spray them with disinfectant, chlorinated water. We put them in a body bag; we spray them again. We spray the body bag again. We put them in a second body bag', we spray the body bag again. And a third body bag, and we spray them before we transfer them to the burial ground. So it is extremely important that proper burial procedures are followed all the time.

Mr. CUMMINGS. And would more resources help with that process that you just described?

Mr. TORBAY. Absolutely, sir.

Mr. CUMMINGS. And how so?

Mr. TORBAY. We need more burial teams. The burial teams on the ground in the three countries are not enough. They possibly contribute probably a third of the need. We need body bags. We need training for the burial teams, as well as vehicles for transportation of dead bodies.

Mr. CUMMINGS. Mr. Chairman, with the committee's indulgence, I would like to play a very short video clip, showing how the final stage of this process, the burials, is currently being handled.

[Video shown.]

Mr. CUMMINGS. Thank you, Mr. Chairman.

Mr. Torbay, right now there are a lot of people watching this hearing. And many of them do not know the extent of the crisis in West Africa. They do not know the urgency of the need. You have a microphone in front of you. You have an opportunity to reach millions of people this morning. If there is one thing you want to tell the American people, what would that be?

Mr. TORBAY. Thank you, Mr. Cummings, for giving me this opportunity. We need to deal with the Ebola virus at its source in West Africa. Steps can be taken in order to deal with this. We need to immediately increase treatment capacity by deploying and training proper health personnel. We need commodities, as we discussed, PPEs, ambulances. We need financial resources. We need further containment at the community level as well. It is not just about treatment; we need to contain it at the community level. This is a global issue. It is not just a West Africa issue. We all need to work together as one team to tackle this deadly disease and put an end to this outbreak.

Once we do so, we need to continue the investment in rebuilding the health care system in West Africa, as well as preparedness in other countries. We need to make sure that this outbreak doesn't reoccur. The U.S. has and is playing a pivotal role. I am proud to say that the U.S. has led the way and continues to answer the call, and other countries are following the lead of the U.S.

Mr. CUMMINGS. Just one last thing. Mr. Turner asked, I thought, a great question. And the chairman tried to get some clarification about military folks. What was your reaction to—you deal with this disease. We have got health care workers in the back of you, and the American people are looking on. I mean, do you feel that that

is an appropriate way to address this? And should the American people be concerned? I mean, we have got people going over to Africa to try to help out.

Mr. TORBAY. I would like to clarify one thing. If there are no symptoms, there is no transmission. That is the first thing. Unless the patient develops symptoms, the patient cannot transmit the Ebola virus. So monitoring temperature is critical, because as long as the patient is asymptomatic, there is no risk of transmitting the disease. We follow a slightly different protocol, but it is very much in line with what the General said, as well as with the CDC.

There is no risk, which means somebody who hasn't been exposed to the Ebola virus; he hasn't been in contact with somebody—in fact knowingly infected with Ebola. We bring them on a commercial airline. They monitor their temperature for 21 days twice a day. We contact them to make sure it happens.

There is low risk or some risk. And those people, we do not allow them to actually travel on commercial airlines. We ask them to stay out of the risk area, even in West Africa, but out of the risk area for 21 days to make sure that actually they have no symptoms before we allow them back.

And there is high risk. Those are people that have knowingly been exposed to the virus. Those will be quarantined and monitored. And the minute they develop symptoms, they will be tested for Ebola and admitted.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

And I want to followup on the ranking member at that point. So if I heard you correctly, the fact is the 10-day waiting period has absolutely no value, that, in fact, the only real question, the only real way to ensure that someone is not contagious or not going to become contagious is for them to be outside the risk area for 21 days, not exposed to other people who exhibit symptoms for 21 days. Is that correct?

Mr. TORBAY. I think where the 10 days comes from is that the majority of symptoms appear within 7 to 10 days after——

Chairman ISSA. Or 11 in the case of the gentleman from New York.

Mr. TORBAY. Absolutely. I said majority. There are exceptions. The incubation period is 2 to 21 days. That is why it is important to wait for 21 days after the last known exposure to the virus.

Chairman ISSA. Again, known exposure. That is correct.

Now, General, you are going to be operating some seven labs. You said you are not doing medicine, but anyone who works in those labs, takes materials out of those labs, has secondary exposure to, if you will, liquids and so on, in fact, is in a direct risk, aren't they? The testing labs, because we have already had that in Dallas, is, in fact, a point of transmission. It's not just the individual, but, in fact, the materials that come out of that individual. Isn't that correct?

General LARIVIERE. So the military personnel who are working in the labs are infectious disease specialists who do this——

Chairman ISSA. I don't want to know who they are. I want to know are they exposed.

General LARIVIERE. They are considered actually low risk because they actually have the entire suite of protective equipment and the extensive training.

Chairman ISSA. You know, one of my problems, General, very little time, and I want to be pleasant through this whole thing. But we have the head of CDC, supposed to be the expert, and he has made Statements that simply aren't true.

Doctor, you can get Ebola sitting next to someone on a bus if they, in fact, throw up on you. Can't you? That is reasonable.

Dr. LURIE. The way you get Ebola is by exposure to body fluids, yes.

Chairman ISSA. OK. So when the head of the CDC says you can't get it with somebody on the bus next to you, that is just not true.

When the head of the CDC says you cannot in fact—that we know what we are doing, but, in fact, health care professionals, wearing what they thought was appropriate protective material, got it, then that means he is wrong. When the head of the CDC goes on television and says, sometimes less protection is more—is better, and then has to reverse the protocols so that we no longer have nurses, Ms. Burger, who have their necks exposed, that was just wrong, isn't it? Ms. Burger?

Ms. BURGER. That their necks were exposed?

Chairman ISSA. I mean the fact is the head of the CDC gave false information, basically saying it was OK to have your neck area exposed, when, in fact, if somebody threw up on you that could be——

Ms. BURGER. I honestly don't know that those nurses were instructed that their necks were OK to be exposed. I know that——

Chairman ISSA. The head of the CDC, when asked about whether you had to have full body suits versus simply the mouth, said sometimes less is—you know, more is not necessarily better. So the head of the CDC was wrong. We are relying on protocols coming from somebody who has been proven not to be correct. Isn't that true?

Ms. BURGER. Those nurses were not protected. Correct.

Chairman ISSA. Mr. Roth, I don't want to belabor waste, fraud, and abuse at this hearing, even though that is a lot of what this committee looks for. But if I understand correctly, you have—your report shows that they didn't know what they were buying and why particularly well. They bought large amounts without a recognition that it was going to essentially expire and without a plan to rotate it or in some other way put those materials into good use the way DOD normally does in order to prevent items from expiring that have secondary use. Is that all correct?

Mr. ROTH. That's correct.

Chairman ISSA. And although I know you can't reach every conclusion, in your material, did you discover that, for example, the face masks, that instead of buying them they simply could have had a rotating inventory that they could have drawn from that would have allowed the vendor to maintain a stockpile but rotate it so they would only take possession—which is also done at DOD on occasions—they would only take possession when they need it, and, in fact, they wouldn't have to buy it but rather rent the avail-

ability of it. Did you look into that at all or did they look into that at all?

Mr. ROTH. They did not look into that at all. Certainly when we make our recommendations, one of the things that we ask them to do is explore the types of options that you talk about.

Chairman ISSA. So all of those options are going to need to be looked at, evaluated, and available to Members of Congress before we start writing checks for large stockpiles. Wouldn't that be correct?

Mr. ROTH. That's obviously up to Congress to decide. And certainly now the Department is starting to do the kinds of planning that we had recommended.

Chairman ISSA. I will close with Mr. Torbay. The pictures that the ranking member showed and the situation in Africa is certainly desperate. And I know my constituents are most worried about what comes here. But realizing that 4,000 there versus less than one handful here certainly shows us where the problem is. And I think you said that very well. But, in fact, medical personnel that are dispatched from here go there and, in more than a few cases, find themselves infected. Isn't that true?

Mr. TORBAY. Correct.

Chairman ISSA. So I want to just ask—it might be both—but is that primarily because of the conditions under which those doctors and nurses and other health care professionals find themselves working, or is it for lack of training? Is it more one or the other?

Mr. TORBAY. Mr. Chairman, it is a combination of both. Our medical staff, they are heroes, doctors and nurses. They work in probably 95-degree temperature wearing those PPEs that you have seen. Our rotations are every hour. We get them out every hour because they are dehydrated.

Chairman ISSA. So they are capable of not getting infected if they were in a good facility dealing with one patient rather than questionable facilities, endlessly, for 24 hours a day, trying to deal with an onslaught of patients. Is that correct?

Mr. TORBAY. I would say in our facility—it's a 70-bed facility—we have 230 staff members. And their only job is actually to look after the patients that are infected with Ebola.

Chairman ISSA. To the greatest extent possible, I am going to ask one last question that I would like to have people say a yes or no. Ebola is a 35-year-old disease. It is not new. It was discovered a long time ago. And we have spent money looking into it, planning for it. The various flus, the influenzas, going back to at least 1918, are not new, and they have a similarity in that they can be transmitted and they kill. Since this is a hundred-year-old process of dealing, at least, with modern infectious diseases, is there inherently a similarity in that, whether it's Ebola or, in fact, a pandemic, that we in Congress should be looking at the planning and the prevention and the training somewhat homogenously?

In other words, today we are looking at Ebola. Should we be looking at infectious diseases, the training, the prevention, the handling, the emergency? Should we on this side, the nonmedical professionals, look at this as a failure of not just Ebola, but infectious diseases of this entire sort that we could have and should have

been more prepared for? And to the extent you can, I would appreciate a yes or no. Doctor?

Mr. TORBAY. Yes.

Chairman ISSA. Ms. Burger.

Ms. BURGER. Yes.

Chairman ISSA. Doctor?

Dr. LURIE. It is a somewhat more complicated question. Ebola and flu are very different. And they are spread very differently.

Chairman ISSA. Well, I was using infectious diseases and the isolation, the maintenance, and so on. I wasn't trying to say that those which can be aspirated or in some other way transmitted. The point, though, is AIDS and lots of other diseases—AIDS being much more similar to Ebola as far as fluid transmission—we have had these for a long time. We are now seeing failures.

In your opinion, Doctor, are these failures to a certain extent the fact that we said we were planning to deal with infectious disease, prepare our health care system, and our doctors and nurses, and, in fact, it appears as though we trained them but not trained them to the level we should? Yes or no.

Dr. LURIE. I think that our failures largely relate to the fact that we are learning some new things about Ebola. Ebola has never been in this hemisphere before. And as we are learning those things, we are tightening up our policies and procedures as quickly as possible.

Chairman ISSA. Mr. Roth.

Mr. ROTH. To the extent that the viruses transmit in the same way, when we looked at the logistics, the acquisition management, I would say the answer would be yes.

Chairman ISSA. Doctor? Or Mr. Lumpkin.

Mr. LUMPKIN. This is outside of our purview and lane.

Chairman ISSA. OK.

With that, I will go to the gentlelady from New York.

Mrs. MALONEY. Thank you.

And I first would like to thank all of our distinguished panelists for coming today during what is a critical time in the Federal Government's response to an urgent global crisis.

First, I would like to take a moment to commend the health care professionals in New York City for their outstanding response yesterday to our first case of Ebola. New York City has been working with New York State, the Centers for Disease Control, to prepare for this. And our Nation's largest city, based on what we know now, I believe they have responded and done absolutely everything right. A young physician had returned from West Africa 10 days ago, where he had been working on the Ebola crisis with the Doctors Without Borders. Upon arrival into the United States, the doctor was flagged by the CDC and Customs and Border Patrol, and reported to New York City health officials. Yesterday, when he reported he had a 103-degree temperature and was experiencing pain and nausea, the New York City health care system sprang into action. The patient was immediately transported to a specially trained Haz-Tac Unit, wearing personal protective equipment, to Bellevue Hospital. The hospital had previously been designated for the isolation, identification, and treatment of potential Ebola patients by the city and State officials.

Governor Cuomo has designated eight special hospitals in New York City. Earlier this week, a specially trained CDC team visited Bellevue and determined that the hospital has been trained in proper protocols and is well prepared to treat patients.

I must say that I respond to your concerns about nurses. And at the hospital, there were clear protocols in place established by the health department to ensure that nurses and all staff caring for the patient followed the strictest safety guidelines and protocols. Contact teams were ready to quickly identify, notify, and, if necessary, quarantine any contacts the patient may have had on his three trips on subway, visit to a restaurant, and a ride in a taxi cab. The health department is now working with the HHC leadership, Bellevue's clinical team, and the New York State Department of Health. And the CDC is assisting us daily in this effort. They are in close communications with the New York City Health Department, Bellevue Hospital, I would say all elected officials, and they are providing technical assistance and resources.

The CDC already had a team of Ebola experts in New York City. They were already there to help. Three members I am told were flown in last night from the CDC's so-called CERT team to join their colleagues already on the ground. And we are told that more CDC professionals will come in if needed. The CDC Ebola Response Team will arrive within 24 hours to any location in the United States where a case is reported. And so far, this is absolutely true, it is what has happened in New York City.

This week, CDC named New York City and State as one of six States who will begin active post-arrival monitoring of travelers whose travel originates in either Liberia, Sierra Leone, or Guinea, and arrive at one of the five airports in the United States doing enhanced screening. Active post-arrival monitoring means that travelers without fever or symptoms consistent with the Ebola symptoms will be followed up daily by State and local health departments for 21 days from the date of their departure from West Africa. And active post-arrival monitoring will begin on Monday, October 27.

I want to reiterate that Ebola is not airborne. Someone infected with Ebola can only transmit the virus if they are experiencing symptoms, bodily fluids in direct contact, vomiting, blood, saliva, diarrhea. There are over 9,000 reported cases and over 4,000 deaths. I am told that the American health system is now actively reviewing two vaccines. They are in clinical trials. And we are responding.

My question really is to you, Dr. Lurie, about the hospital preparedness program. But, first, I would like to request that this Statement that was prepared by the Trust for America's Health, a nonprofit——

Chairman ISSA. Without objection, that will be placed in the record.

Mrs. MALONEY. It talks about the need for enhanced funding, that our funding is not up to the threat that our country faces.

I would like to ask you, how does the program help to ensure that our hospitals that are so designated across America are prepared to respond in a health emergency? And I would like to thank

your program for the help that you gave to the great city of New York. Thank you.

Chairman ISSA. The gentleman gentlelady's time has expired, but you, of course, can answer.

Dr. LURIE. Well, thank you so much. And we were very gratified last night to see the kudos to the program and kudos to New York City for their tremendous job in responding. Our program gives money to States—and, in the case of New York City, directly to New York City—to help the health care system become prepared. It is defined as a set of eight basic things that every health care facility needs to do and provides the funding for training, for exercising, for planning, for the purchase of personal protective equipment, and other things necessary for hospitals and other health care facilities to be prepared. It is, in fact, one of the reasons that Bellevue and I believe other hospitals in New York City have been able to do such a tremendous job getting ready for this. And we will continue to support them through this program and others as they move forward.

Chairman ISSA. Thank you.

The gentleman from Florida, Mr. Mica.

Mr. MICA. Well, first off, I have to take sort of a point of personal privilege. The chairman missed a word in his opening Statement and apologized for being on a plane.

The committee should know, you know, the country faces two incredible threats right now. One is ISIS, or this threat we face from terrorism we have seen this week. It threatens not only the United States, but the world and our allies. But Mr. Issa, and I accompanied him, and we had a Democrat Member from the Foreign Relations Committee, was in Iraq. We were in Iraq last night. We left there at 6 o'clock in the evening and flew all night. And this is how dedicated he is, to make sure that we are prepared over there. You would be so proud of our troops that we saw. Incredible.

And General, too, you get called on to do some tough stuff. But I saw our men and women. They are just awesome. And we had a chance to meet with some of our allies to get them to step up to the plate. But we face that threat nationally, domestically, and internationally.

We face Ebola, a very serious threat. Dr. Torbay, this ain't going away any time soon, is it?

Mr. TORBAY. We are hoping that we could contain it. If all steps that are being put in place are followed, it will be contained.

Mr. MICA. Here is a report I read on the plane last night. It says, "Experts warn the infection rate could reach 10,000 a week by early December." Ten thousand a week. Is that semi accurate?

Mr. TORBAY. That is what the——

Mr. MICA. The way things are going now. This is a report I got on probably the people that are most at risk are health care workers, whether they are there or here. Would that be correct? This isn't up to date, but you had 404 cases of Ebola in health care workers; 232 died. Pretty high fatality rate, right, Doctor?

Mr. TORBAY. That is correct.

Mr. MICA. OK.

Thank you, Ms. Burger, for representing the nurses. Do we know how those nurses were infected or exposed, how they caught Ebola, for sure?

Ms. BURGER. Thanks to the whistleblowing efforts of Briana Aguirre, we know that the nurses did not have optimal standards for personal protection.

Mr. MICA. OK. So we know that they weren't properly protected.

Ms. BURGER. Or trained on protocol.

Mr. MICA. Or trained. OK. All right.

Dr. Lurie, you said that we are putting additional protocols in place, guidance. Right? When was the most recent?

Dr. LURIE. The most recent——

Mr. MICA. A week ago? A month ago?

Dr. LURIE. The most recent guidance on personal protective equipment has been in the last couple days.

Mr. MICA. And what about—OK.

Dr. LURIE. It was changed in response—it was changed in response to the situation at Dallas Presbyterian.

Mr. MICA. OK. So in the last couple of days. You said airport screening. When was that instituted, the new guidelines?

Dr. LURIE. I can't recall exactly the date that it started.

Mr. MICA. A week ago.

Dr. LURIE. The funneling into the five airports was in response in the last week.

Mr. MICA. Last week. I can tell you, it is not working. OK? All we got to do is look at Craig Spencer. He was tested there. It is not working.

Now, he is a medical professional. He reported himself.

And then you see cases where, again, we are not prepared still. The whole part of this hearing is all about Mr. Roth's report. This is the inspector general's report, right, Mr. Roth?

Mr. ROTH. Yes.

Mr. MICA. We spent millions of dollars getting prepared, right?

Mr. ROTH. Correct.

Mr. MICA. OK. Didn't you just testify that in fact—and it is in this, I think page 7 here—200,000 of our pandemic respirators have gone beyond their 5-year manufacturer warranty?

Mr. ROTH. The ones that TSA——

Mr. MICA. On page six, don't you testify that—this is a bottle of hand sanitizer. You tested it. Eighty-four percent of the hand sanitizer is expired that you tested. Is that right?

Mr. ROTH. That is correct.

Mr. MICA. So how do I tell the American people that we are prepared, that we spent millions of dollars for a pandemic—and here it happens to be Ebola. And you just heard testimony how important it is to have the right protections. The equipment, almost all the equipment you cited in this report in fact is either out of date, it was—the purchasing made no sense. We don't know the inventory. We don't know who has got it. We don't know who is going to get it. Is that right, Dr. Roth?

Mr. ROTH. Mr. Roth, but thank you for the promotion.

Mr. MICA. OK. I upgraded you.

Mr. ROTH. Yes. You are correct.

Chairman ISSA. The gentleman's time has expired, but if you call everyone "doctor," you will do very well.

Mr. MICA. Your report is correct. And I thank you. I have additional questions. Thank you.

Chairman ISSA. Thank you.

The gentleman from Massachusetts, Mr. Tierney.

Mr. TIERNEY. Thank you very much, Mr. Chairman.

Thank the members of the panel for their testimony here today and for the work that they do on a regular basis. I think folks here that don't already know may be pleased to know that the news was just released that the Presbyterian Hospital Nita Pham is Ebola-free, according to the National Institute of Health. And she will be released today. I think that is good news on one front on that.

I think also a little bit of good news, and Mr. Torbay was mentioning it, is that the United States has taken the lead in the international response to this. And I think we don't often give credit where it is due on that. I think we should all be proud that this country at least recognizes that not only do we have issues within our own country here that we have to deal with in terms of people that may be exposed or come down with the disease and come to this country, or be here when they are treating somebody, but that you do have to go to the source with a shock-and-awe type of approach as if you were in some sort of battle. We are losing lives. And we are losing situations that could then endanger the entire international community. So we need a shock and awe, all the things that Mr. Torbay talked about. Do we have a large enough response? Is it coordinated accurately? Are the people that go there supplied and trained and equipped sufficiently to get the job done?

So my first question might be to Mr. Lumpkin and Dr. Lurie and Mr. Torbay, is the international effort now, in fact, large enough? Is it being well enough coordinated? Is there sufficient training and equipment for those that are involved in it? And if not, what remains to be done and by whom? So Mr. Lumpkin.

Mr. LUMPKIN. In West Africa, U.S. leadership is galvanizing support on the international front. So what we have seen is that since the—we have gone in with speed and scale that the international community is coalescing to come together in order to fight the Ebola epidemic.

Mr. TIERNEY. Dr. Lurie, is that coordinated enough? Are the people well trained and equipped enough? Is the response sufficient enough? Who should be responsible for what remains to be done, if anything?

Dr. LURIE. So I would agree with Mr. Lumpkin's assessment of the situation in West Africa. It has taken time to get the resources in place there. U.S. leadership has been incredibly welcomed and incredibly important. As a result of that, we are finally seeing many other countries of the world step up to put resources in place in West Africa.

Mr. TIERNEY. So, Mr. Torbay, maybe you can help me. Is the response adequate enough? Are people that are now involved trained enough and equipped enough? Is it well enough coordinated to be able to start containing the situation and then hopefully wrestling it to the ground?

Mr. TORBAY. The U.S. and the UK have stepped up. Now it is time for the rest of the world to follow suit. The training is picking up. The DOD started their training. We started our training. The minister of defense in the UK is starting their training in Sierra Leone. I think, within the next 3 to 4 weeks, the training would be up to speed, which is critical. Supplies, PPEs are coming in. The different levels of PPEs, they are coming in. We hope that the pipeline will continue to come in. I think the other countries need to step up. We cannot forget about Guinea and containment of the Ebola in Guinea. This is where it started. Businesses need to get involved more. The economical toll of this outbreak is just phenomenal. We need to think about that. We need to think about technology as well. The development of vaccine is critical, but also technology companies need to start thinking about creative ways to monitor people when they are coming back, monitoring the temperature instead of having to rely on patients checking their temperature twice a day. And I think if the interventions, the international interventions continue at the same pace that it is now, I think it will be contained within the next 4 to 6 months.

I would also like to thank the Department of Defense, the U.S. Navy, for putting a lab actually in Bong County, right next to our ETU. This has cut down the testing time from 3 to 5 days to 5 to 7 hours of Ebola patients. So we are accepting patients, testing them, releasing them if they are negative, and avoiding infections by them staying in the isolation ward.

Mr. TIERNEY. Thank you. This isn't the hearing for it, but Mr. Roth, thank you for your work. I am also amazed that agencies like DHS don't go to the Government Accountability Office or somebody in advance to learn how to set up a protocol as opposed to waiting until they get audited later and find out that they didn't do it correctly.

But Mr. Chairman, I suspect we will hear that later.

Dr. Lurie, last question. This is not new. Ebola has been around a while. Obviously, people think that we could have been a lot further along in terms of vaccination or some other type of treatment or medicine on that. But there has been no profit motive sufficiently involved on that. What are we doing—not just with Ebola, but anything along the situation line with the chairman's question earlier—what are we going to do to make sure that we have the kind of forward thinking that if the free market and the profit motive isn't going to resolve these things and get them done, what are we going to be able to do as a public policy?

Dr. LURIE. I this is a great question, and I thank you for it. Were it not for the investments in biodefense and getting going with Ebola vaccines and therapeutics, we would be nowhere near where we are now with the safety testing of two promising vaccine candidates going on and soon to be testing some therapeutics. So we do need to think about emerging diseases. We do need to think about developing products, countermeasures for them now. And we have appreciated the support from Congress for BARDA, the Biomedical Advanced Research and Development Authority, both through its direct funding and through the Project Bioshield Special Reserve Fund that have helped us ensure that there is a mar-

ket, ensure that product developers and manufacturers will step up to the plate and work on these important threats.

Mr. TIERNEY. So you are talking about public financing being used to establish those markets on that as opposed to just the private industry on its own going out and trying to work with the free market aspect?

Dr. LURIE. We have been talking about some very positive public-private partnerships and some tremendous models that we have developed over the past several years, whether it's been about biothreats or whether it's been about pandemic flu, and now with Ebola, that are really making that possible, yes.

Mr. TIERNEY. Thank you.

Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

The gentleman from North Carolina.

Mr. MCHENRY. Thank you, Mr. Chairman.

My questions are for the Assistant Secretary and—the Assistant Secretary and for the General. We have our men and women in uniform that are now in regions that are severely affected by Ebola. To their parents, their mothers and fathers of these men and women, do you have every confidence that they have every bit of the equipment and training that they need to be protected, to be safe, and to return home healthy?

Mr. Lumpkin?

Mr. LUMPKIN. The safety of our servicemembers——

Mr. MCHENRY. The right answer is yes.

Mr. LUMPKIN [continuing]. Is absolutely paramount. And while you can never mitigate risk to zero, I think we have taken all the steps to mitigate the risk. So my answer is yes.

Mr. MCHENRY. General?

General LARIVIERE. Sir, the combatant commander and the services are making every effort to ensure that the troops have the proper training and proper equipment they need for this mission so that they can return home safely.

Mr. MCHENRY. Mr. Lumpkin, you said in your opening Statement that if infected, if someone contracts Ebola in country, they will be returned back to the United States and cared for in a CDC facility. Is that correct?

Mr. LUMPKIN. I did not say that in my opening Statement.

Mr. MCHENRY. But you mentioned a CDC facility where treatment would be given. Then let me ask you a question: If somebody comes down ill in country, how would they be cared for? Will they be cared for in country, or will they be returned to the United States?

Mr. LUMPKIN. They will be returned to the United States. But I would defer to my Joint Staff counterpart on the specifics.

General LARIVIERE. Thank you for the question. So to take care of the troops in country, there will be two Role 2 hospitals; one established in Monrovia, one established in Sierra Leone. The medical personnel there will be trained in how to treat Ebola victims if a U.S. uniformed military person does, in fact, contract it. To answer your question whether they will be treated in country or sent home, the answer is obviously both. If they are identified for some reason of having high risk of exposure, or if they actually do start

to exhibit symptoms, they will be cared for initially in country, and then they will be moved home. If they are asymptomatic, they will do what we call a controlled movement, which will be an individual movement on a DOD aircraft.

Mr. MCHENRY. How many aircraft are outfitted to move these individuals out of country in the event that this happens?

General LARIVIERE. So, for controlled movement, any aircraft can do, because as has been pointed out, they are asymptomatic and not contagious at that point. So any aircraft could do. At the present time, the only aircraft that can move the symptomatic patients is the State Department's Phoenix Air Contract, which you have seen moving the other Ebola patients.

Mr. MCHENRY. How many patients can that aircraft hold?

General LARIVIERE. The aircraft can hold one at a time, and can do four movements a week at this point.

Mr. MCHENRY. Four movements a week?

General LARIVIERE. Yes, sir.

Mr. MCHENRY. Is that sufficient?

General LARIVIERE. Given the number of Ebola patients that the United States has had in total at the present time, it is sufficient. However——

Mr. MCHENRY. But that is not how these epidemics work.

General LARIVIERE. Right. So, at this time, the Department of Defense has an urgent U.N. Statement that is being worked through the system with TRANSCOM to put together an isolation pod that can carry multiple persons for C–17 aircraft. Testing will begin in October—or I am sorry, development will begin in October, testing in December. Procurement will begin in January.

Mr. MCHENRY. In January?

General LARIVIERE. In January.

Mr. MCHENRY. In January. And how many individuals will be able to be transported?

General LARIVIERE. Fifteen at a time.

Mr. MCHENRY. Fifteen at a time. What is the turnaround time for the plane? How many movements a week?

General LARIVIERE. We hope to procure a number of these systems so that they can be put on any C–17, so if we had—so we could move multiple C–17s to——

Mr. MCHENRY. So, at current State, we can take less than 10 people out of country in a week's time.

General LARIVIERE. If they are symptomatic.

Mr. MCHENRY. So this is not at all sufficient.

General LARIVIERE. We don't know—at the current time, we expect we will not be doing direct patient care. And so we anticipate——

Mr. MCHENRY. I understand. But how many American troops will we have in the region by the end of the year? What is our maximum?

General LARIVIERE. In the vicinity of 3,000.

Mr. MCHENRY. Of 3,000.

General LARIVIERE. Yes, sir.

Mr. MCHENRY. This is very disconcerting. Is it a question of—Mr. Lumpkin, is it a question of resources? Does Congress need to appropriate funds so that we can actually get more planes, more

logistical support here so that we can have the capacity if something absolutely horrible happens to our fighting men and women in country?

Mr. LUMPKIN. Well, we clearly have an identified requirement. And as we develop the capacity, I would like to take that one for the record just to make sure I get you—because I am not familiar with the acquisition and the process or the actual requirements that would——

Mr. MCHENRY. I think you should get familiar with the acquisition process if we currently have one plane that is controlled by the State Department. I am asking the Department of Defense, with the mass number of airplanes, equipment, and training capacity that we have, nearly—spending nearly half a trillion dollars annually on the Department of Defense. If you need it, you will get it. We will demand it. Because if we are putting these men and women in harm's way, potentially where they can contract Ebola, the idea that we have one airplane as the United States to get these men and women out of country in a safe manner if they contract what is absolutely horrible, which we want to control, which we absolutely want to control, the idea that you are coming before us and giving this type of testimony raises great concerns.

I know you have been asked to do a lot. And I absolutely respect that. But we are asking you in the legislative branch to tell us what you need, and we will get it. Because we don't want to put our men and women in harm's way without any capacity to care for them. Our veterans, our fighting men and women deserve the best health care in the world, the best training in the world. And they have it. But it means the proper protocols at the top level are there to make sure they are protected. And if something bad happens, they are immediately taken out of harm's way, cared for, and returned back to their normal State.

And, with that, Mr. Chairman, I yield back.

Chairman ISSA. I thank the gentleman.

We now go to the second gentleman from Massachusetts, Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman.

And I thank the ranking member, Mr. Cummings, for holding this hearing.

And I thank the panel. You have been very helpful.

As a matter of fact, there have been some marked contrasts between the testimony here this morning. And I want to drill down on that a little bit, because sometimes that is helpful when people on the panel disagree.

Dr. Lurie, you testified, and it is in the written testimony, that we are better prepared than ever and that you have a comprehensive response on the ground.

On the other hand, Mr. Roth, our inspector general, you were commenting how the analysis done by—I think you were talking about DHS in your testimony, how the equipment purchases are not adequate, in some cases the wrong equipment; in other cases the usefulness of the equipment or drugs are beyond the expiration date. Dr. Lurie, you testified that you have a very aggressive system in place.

And, on the other hand, President Burger from National Nurses United said that they have done a survey. They have done a survey of 3,000 nurses from every State in the Union and the District of Columbia. And 85 percent of those nurses say that they have not been trained to deal with Ebola, and that preparedness is, and this "woefully insufficient and dangerously inadequate."

So those are two different stories of what is going on here. Now I understand we don't want to panic people. But we also don't need happy talk in terms of what we are dealing with. And maybe it is just me, but lately, when a government agency comes before this committee especially and tells me there is nothing to worry about and we have got this, that is when I start to worry.

Now, as to who to believe, I think the nurses—and I know I have got some nurses here from the Massachusetts nurses association as well, I know how hard they work. They are on the ground. They are our front lines in this battle against Ebola. They are our ground troops. They are the people who are doing this work every day. They are exposing themselves, and perhaps their families, perhaps their families, if things go wrong, if they don't have the adequate equipment. So when they tell me that they are not prepared, I tend to believe them. I think those are facts. Those are facts. And we need to make sure that we get them the equipment and the training they need to protect themselves and to protect our communities and to protect their own families.

There are a couple of facts that we have gotten in the briefings from the various panelists. One fact is that the CDC estimates that by this January, there will be up to 1.2 million people in West Africa afflicted with Ebola—1.2 million. The estimate by DOD is 1.2 million, 1.2 million in January. Now, they were done at different times, so the difference might be just the period of time that they were taken, if things go as they are right now, 1.4 million. So we have got a real and present danger to the people of West Africa and to the people in the United States, who I am pledged to protect.

Now, I understand that the current approach is to use what they call a post-arrival approach so that we are going to have these hospitals, and that as people arrive from West Africa, we are going to begin an analysis and a quarantine and checking them and making sure that they are not carrying Ebola.

But it seems to me—and I listened, and Mr. Torbay, you have given some very powerful testimony, a lot of it written, quite frankly, and you haven't had a chance to talk about it, but you were saying that the focus should be on West Africa. And what we are setting up here right now with this post-arrival in the U.S. approach is we are going to set up these hospitals, all this equipment, everything here in the United States, and wait for those folks to arrive.

And I believe that we should be doing just the opposite. Well, we should be doing that, but we should also be doing something else, and that is pre-departure. Pre-departure. We know that we are about to have 1.2 million, 1.4 million people in West Africa afflicted with Ebola. We ought to be on the ground there. We ought to have—instead of the restriction here in the United States after they come in of 21 days, there should be a 21-day pre-approval. When they say they want to travel to the United States, they need to present themselves and report in person 21 days before they get

on that plane. And we can take their temperature and a blood sample, if necessary, so that 21 days later, when they appear to travel, we can test them again. Now we have got two contact points on that person before they fly to the U.S., and we can also do that post-arrival check as well.

But we are not taking this seriously enough. We are not. And, you know, we need to help, you know, our brothers and sisters in West Africa, absolutely. But we have got to use—we have got to have a fact-based approach to this. This can't be just about ideology and happy talk. You know, we have to look at this very seriously and have a scientific-based approach to what we are going to do about this problem. And I don't think it helps to say we have got an aggressive thing on the ground, everything is good. Because I have got a feeling, in a couple of months, you are going to come back here and give us a whole different story. We have heard that before. So we have got to approach this in a very deliberate manner, and take it much more seriously than what I am hearing here today. And, you know, we owe that—we owe that to the citizens that we represent here in the United States as well as to those individuals in West Africa, who we obviously want to support as well.

But Mr. Torbay, let me just ask a question, wrapping up here. Your focus, you were saying that you want to make that containment effort in West Africa. Wouldn't it be—think about this. If we were putting our folks from all over the world, you know, medical personnel on the ground, you know, in Monrovia or at Freetown, wouldn't it be better, wouldn't it strengthen the infrastructure there on the ground in West Africa, as opposed to just having a post-arrival process here in the United States?

Mr. TORBAY. Thank you for your question, Mr. Lynch. You know, as I mentioned, it needs to be contained at the source in West Africa. This is where the majority of the investment needs to take place. This is where training needs to take place. This is where equipment and supplies need to take place. And this is where most of the investment needs to take place.

Now, that said, we cannot just focus on one without the other. What we are doing here in the U.S., we are treating the symptoms of the outbreak in West Africa. We need to deal with the root cause of the outbreak, of the problem, and that is actually at the community level in West Africa. I believe pre-departure there are some tests, temperatures being taken for anybody actually departing any of those countries before they board the flight.

Mr. LYNCH. At the time of the flight, yes, they get tested before they get on the plane. What I am talking about is doing something 21 days before, so that you have got two contact points that you can have measurements on. It is not foolproof. But having two contact points there in West Africa before you arrive in the United States——

Mr. JORDAN [presiding]. The gentleman can respond.

Mr. LYNCH. OK, Mr. Chairman. Thank you for your indulgence. I know I am way over.

Mr. JORDAN. Do you have a quick response, Mr. Torbay?

Mr. TORBAY. One thing that we worry about in terms of 21 days, we are having difficulties recruiting health personnel from the U.S. to go and work there because there is a minimum requirement of

6 weeks. If we impose an additional 21 days, that is 9 weeks. And it is extremely difficult for any hospital or university to allow doctors and nurses to take off for 9 weeks before they come back. Again, we cannot completely wrap ourselves in a bubble here. People will go from Guinea or Sierra Leone to Senegal, will wait a week, take a flight to Europe, wait a couple of days, then come here, and there is not much we can stop it from doing that. So the preparedness needs to take place at both ends.

Mr. LYNCH. With all due respect, though, there is only a few flights, there is only a couple of flights out of there. You can actually do this.

Mr. JORDAN. We have to move on. I thank the gentleman for his good points.

Dr. Lurie, when you were in front of Congress in 2011 back during the debate on the reauthorization of the Pandemic Act, the act that created your agency and your position, you had an exchange with Mr. Rogers, a colleague of ours, from Michigan. He said this: "There is a point person, somebody that makes the decision, somebody that is absolutely in charge. It's not CDC. It's not NIH. It's not FDA or anyone else. It's you." Your response was, "That's right." So you are the key person. Right?

Dr. LURIE. My role is to be the principal adviser to the Secretary on these matters, yes.

Mr. JORDAN. You are the key person in the government for medical preparedness, public health emergencies; you are the key person in the U.S. Government.

Dr. LURIE. In HHS.

Mr. JORDAN. Got it. Let's go to the first slide, if we could. I just want to put up a couple slides. This is straight from your Website, just to be clear. It says you are the person, your agency, the Assistant Secretary for Preparedness and Response to lead the Nation in preventing, preparing for, and responding to the adverse health effects of public health emergencies and disasters.

Further down, the Secretary of HHS delegates to you the leadership role of all health medical services, support, function in health emergency and public health events. You are the key person. Correct?

Dr. LURIE. That's what the legislation says, yes.

Mr. JORDAN. No, that is not the legislation. That is your Website.

Dr. LURIE. That is my role.

Mr. JORDAN. Yes, that's the Website. The legislation definitely says that. Your Website confirms that.

Dr. LURIE. That is my role.

Mr. JORDAN. You are the key person. Have you met with Ron Klain, the new Ebola response coordinator?

Dr. LURIE. Yes, I met with him his first day, and I had several conversations and an in-person meeting with him yesterday.

Mr. JORDAN. Have you met with Tom Frieden, Dr. Frieden at the CDC?

Dr. LURIE. I meet with and talk to Dr. Frieden almost every day.

Mr. JORDAN. Good. We would expect that to be taking place. Are you familiar with the story that Ms. Harrington did in the Washington Beacon I think, the story that says $39 million worth of NIH

funding that could have gone to an Ebola vaccine. Are you familiar with that story?

Dr. LURIE. I am not familiar with the story. But if you familiarize me on the specifics, I would be happy to respond.

Mr. JORDAN. I am going to do that. Are you familiar with the fact that $275,000 on a restaurant intervention to develop new children's menu was spent of NIH dollars? Are you familiar with that? Are you familiar with the fact that $2 million were spent to encourage the elderly to join choirs? Money from the NIH. Are you familiar with that?

Dr. LURIE. I am not familiar with the details of grant programs at NIH——

Mr. JORDAN. $53,000 on a project studying sighs. Are you familiar with that? Are you familiar with the fact that $39 million of NIH funding was spent for all kinds of things that—I mean that I guess cut to the chase. One of the things you learn in your first economics class. Not that I was a great student, but I did study a little economics. One of the things they tell you is the term opportunity costs. Right? When you spend and allocate resources for one thing, you by definition can't use those resources for something else. And so here is what I think a lot of American people want to know: Why, in fact, did we spend so much money on, for example, $374,000 to host fruit and vegetable puppet shows for preschoolers when, in fact, some of this money, as catalogued by the press account and by staff, totaling $39 million, could have been used to help with treatment for something like Ebola and potentially a vaccine? Are you involved in the decisions that NIH makes when they are deciding how to allocate some of that money?

Dr. LURIE. I am involved in the decisions related to our biodefense and our preparedness programs for emerging infectious diseases, yes. The NIH, the CDC, the FDA, my office, DOD, DHS, the VA, and the Department of Agriculture all work together on those issues.

Mr. JORDAN. But aren't you the point person in coordinating all of that?

Dr. LURIE. Yes.

Mr. JORDAN. So, at some point, you have to sign off and say it's OK that $374,000 is used for puppet shows instead of potentially being used—losing the opportunity to use that money to develop a vaccine to deal with something like Ebola.

Dr. LURIE. So, with respect, sir, I think you have—I would like do a little bit of clarification here. I think there is a little misunderstanding about how the NIH budget is allocated. But that is not my responsibility and my purview. So I suspect we should——

Mr. JORDAN. Let me go back to that same exchange you had with Congressman Rogers just a couple years ago, when we were reauthorizing the act that created your position and made you the key person. Mr. Rogers says this—you said this when you responded to Mr. Rogers—how can we improve functions at HHS to ensure that you are, in fact, in charge—that you are the person in charge? NIH is in HHS, right?

Dr. LURIE. Yes.

Mr. JORDAN. Yes. So you are the key person at HHS. How can we improve, Mr. Rogers asked you. You said, "I have found through

experience that indeed I have the authority that I need to be in charge." You followup by saying, "And I find that the collaboration with sister agencies and HHS, I don't think it has ever been better. We are working extremely close together. I think they recognize and respect the fact that we provide policy direction and are in charge. And I think all the efforts that we have undertaken to coordinate across HHS have done that." So you told Mr. Rogers, when we were discussing whether we were going to reauthorize this act to keep your position, that, in fact, everything was working great. You were the person in charge. You were working within HHS coordinating policy, direction, and you were in charge and working closely together.

Dr. LURIE. And I would stand by that Statement.

Mr. JORDAN. So back to the key question. Might we be a little closer to having a vaccine today if you weren't allowing all this millions of dollars—$39 million to be spent on what many Americans view as questionable uses for their tax dollars, particularly in light of the fact we have an Ebola outbreak in the United States?

Dr. LURIE. Thanks to the investments that we have had in biodefense and our focus and Department of Defense's focus on this critical issue over the past decade, we now have two vaccines in safety testing and at the NIH and Walter Reed.

Mr. JORDAN. Dr. Lurie, that's my point. Might they be further than safety testing if you hadn't wasted $39 million on a bunch of other things that most taxpayers think are ridiculous?

In fact, one of your specific charges is, in your—can we put up the second slide?

The second slide specifically mentions—this is again from your—Ebola. You are supposed to get ready for this. Might we be more ready if you hadn't spent $39 million of hard-earned taxpayer money on puppet shows for preschoolers instead of invested that in treatment and vaccines for Ebola?

It is a "yes" or "no." You can—might we be further along if that money had not been spent someplace and could have been applied to the question at hand?

Dr. LURIE. I don't believe that would be the case.

Mr. JORDAN. You don't think $39 million would have helped us get closer to a vaccine?

Dr. LURIE. You know, the development of a vaccine is a long and complicated process. It takes years——

Mr. JORDAN. Is it a costly process, too?

Dr. LURIE. It is. And it——

Mr. JORDAN. It's a costly process?

Dr. LURIE [continuing]. Takes years and years and years to do that.

Mr. JORDAN. $39 million could have been used for it. You are the person in charge who works closely to direct policy direction. Those are your words, not mine. Might we have been better off if, in fact, it had been used to develop a vaccine?

Dr. LURIE. I am not in a position to comment on the overall NIH budget.

Mr. JORDAN. The gentleman is recognized.

Mr. COOPER. I thank the chair.

I think the main public health message of this hearing is probably counterintuitive: that, at least for U.S. citizens, we face probably more risk from the flu. So hopefully everyone will be getting their flu shot after hearing this hearing. There are many other public health precautions we could be taking, such as handwashing, things like that, which are too often neglected.

Back to Ebola, the public is concerned that we are doing too little too late, so I would like to explore some of the gating factors that might limit an appropriate response.

Mr. Torbay was very specific in his testimony, mentioning that probably we are meeting—our manufacturers—there are only two, apparently—are going to be able to meet only 35 percent of the estimated demand for the appropriate type of coverall. Could you name those two manufacturers? And we could perhaps explore what could be done to augment the supply of those essential coveralls.

Mr. TORBAY. First of all, I would like to clarify that those manufactures manufacture the specific type that we use. It is different than types other organizations use.

And I do not remember the manufacturers, but I will be more than happy to provide it to the committee in writing after the testimony.

Mr. COOPER. For the record.

Mr. COOPER. There are some other gating factors. Of course, we all hope on the committee that we don't get to the point where we need augmented emergency flights by DOD to, you know, ship our soldiers back home, but Mr. McHenry asked an appropriate question. Because our men and women in uniform and their families want to know that there will be sufficient capacity to get them back home.

I think one of the concerns of the public is that three health workers have been infected in the U.S. and one actually overseas returning. And I think we are all looking for the right sort of response.

This doctor in New York—and we all hope and pray for his safe recovery, but when he felt sluggish on Tuesday, perhaps it would have been more appropriate to limit his contact with others, you know, since he had been exposed to some of the worst of the infections in Africa. But that gap from Tuesday to Thursday, that will take an extraordinary taxpayer effort—contact tracing, all sorts of things—to try to limit the risk of exposure.

What is the appropriate protocol for people who are known to be at risk during this crucial 10-day period, 11-day period, 21-day period to try to limit contacts? Like, everyone would have to feel sorry for his fiance or his girlfriend or the other folks, you know, he was close to, when he is a skilled medical professional who presumably should have known, well, it is getting a little dicey here, and to call in when he has a 103-degree temperature. Is there a better response than that?

For any of the panelists.

Ms. Burger?

Ms. BURGER. I think it is unrealistic to expect that any healthcare professional that is working under extremely stressful situations, including Tina and Amber and several doctors—you

have to remember that they are humans. You can't expect them to use their common sense at that point because they are patients. They need a team that they report to, that checks on them, as Mr. Torbay has indicated, that follows them and makes the decisions for them so that they are no longer healthcare workers, they are patients that need our protection and care.

And so, to that end, it would make sense to have a professional team monitoring them and making the recommendations so they can actually relax and not have to worry that they are contaminating or exposing anyone unduly to the infectious disease.

And I think that that would really help in making sure that everybody that volunteers to take care of these patients and puts their own families' lives at risk actually is well taken care of after their service.

Mr. COOPER. So you are suggesting that Dr. Spencer should have been viewed as a patient earlier than on Thursday and should have had a team of counselors to advise him because his judgment could not really be trusted at that point?

Ms. BURGER. Exactly. Exactly.

Mr. COOPER. Well, that is a pretty bold recommendation.

As far as international response is concerned, Mr. Torbay mentioned that U.S. and U.K. have stepped up. We have had some individuals in America—Paul Allen, Mark Zuckerberg—who have given more money individually than many nations have given. So that is an astonishing response.

But what can we do to get more nations involved? I am thinking, for example, of France that has had involvement in that area traditionally. What are these other nations—what should we expect of them?

Mr. TORBAY. I think an all-hands-on-deck approach is really necessary. I think a realization that this is, again, not a West African problem, it is a global problem that could hit any country anywhere around the world, especially with travel being the way it is. People need to realize the threat, and they need to realize that any contribution that they can make actually will make a difference.

As you mentioned, private foundations and corporations here contributed more than some countries did. And I think the U.S. Government should continue to put pressure on those countries to actually contribute to the cause.

Mr. COOPER. Thank you, Mr. Chairman. I see that my time has expired.

Mr. CHAFFETZ [presiding]. I thank the gentleman.

I now recognize the gentleman from Michigan, Mr. Walberg, for 5 minutes.

Mr. WALBERG. Thank you, Mr. Chairman.

General, thank you for your service.

Probably the number-one question or concerned phone call I have been getting on this issue in the past several weeks comes from family members of our military, whether it be Active, National Guard, Reserve troops—a concern that what they have seen go on in places where they expect their family members to potentially have a death sentence as a result of being proud members of the military and signing on for that and committed to their efforts. Yet there are concerns that the way it is carried out at times, their

loved ones haven't been given the necessary tools, armaments, rules of engagement, and all the rest to handle what they have been trained for, trained to do. That is a concern for them.

But the biggest concern that they are conveying to me on those phone calls or meetings in public is that this is a potential—a death sentence, being sent in to combat a virus, and with great uncertainty because of the multitude of changes in protocol, at least perceived by them, coming from what they hear in the news, hearing from leaders in this administration, with responsibilities, and also the lack of information coming from the military on what they are doing.

Let me ask if you would just briefly walk us through a daily routine of one of the soldiers that has been sent over to West Africa.

General LARIVIERE. Congressman, thank you for the question. I have spoken to the commander on the ground, and I have talked to the folks at AFRICOM, and this question comes up quite a bit, actually.

The protocols for an individual on the ground for your average soldier—and, again, I would like to emphasize first: None of the military personnel will be providing direct patient care. We have four lines of effort: command and control, logistics, engineering, and training. So we are not—the protocols for treating patients is not something that individual soldiers will be doing.

Mr. WALBERG. But they do come in contact with contractors, with aid——

General LARIVIERE. Absolutely. And so the protocols in place over there, as Mr. Lumpkin can testify to since he has recently returned, there is a no-touch policy over there. There is a 3-feet separation when you are talking to local nationals over there. And that is being enforced both on the Liberian and U.S. military side quite strictly.

In your average day for a soldier over there, it would be, obviously, getting up, eating chow, doing the usual morning routine, get your temperature taken first thing in the morning, and then go out to whatever task you are going to do. Again, if you are in the command center, that involves going from your building directly over to the command center and sitting at a computer terminal or working on the generators or whatever it is that you are doing inside the command center.

If it would involve—it involves eating only food from approved sources, drinking mostly bottled water, or exclusively bottled water, and washing your hands in chlorine solution virtually everywhere you go.

You go through your day. At the end of the day, every time you come back in the compound, at the end of the day, wherever you are living, you get your temperature taken again—again, more chlorine wash—in order to ensure that you stay Ebola-free.

Mr. WALBERG. Will the U.S. military personnel have ZMapp or any other experimental drugs available to them on the ground?

General LARIVIERE. There will not—there will not be any—I will have to take that for the record.

General LARIVIERE. I am not aware that there will be any ZMapp available on the ground.

The personal protective equipment will be issued to them, depending on their level of expected exposure. For the vast majority of people, that will include surgical gloves, overgloves, boots, and a Tyvek suit. Obviously, for the medical personnel, it will be more along the lines we talked about here for the healthcare providers.

Mr. WALBERG. OK.

Dr. Lurie, in 2005 the Bush Administration proposed a rule change that would allow the CDC broad powers to confine individuals that are believed to be infected with deadly pathogen-like—the pandemic flu. President Obama withdrew this rule in 2010.

Do you believe the CDC needs or should have this authority to ensure an infectious disease outbreak like Ebola is contained and controlled?

Dr. LURIE. Thank you for that question.

You know, I think, with every situation, we are always reviewing and taking a look at whether we have all the authorities we need to do the job. In our system of government, right now that authority rests with the States, and they have authority to do that when they think it is necessary.

Mr. WALBERG. But CDC shouldn't have that authority that they did have? And it could be flexible. There was certainly authorization. They didn't have to. Don't you think that would be a valuable authority to have?

Dr. LURIE. So what I would say is I think that we are always learning and adjusting based on our experience, and that is one of the things I think we will probably be looking at as we move forward.

Mr. WALBERG. Well, I hope so. We are sure learning right now. I am not sure we are adjusting as rapidly as possible.

And I am not—I am certain we are not giving any type of security to our medical workers, nurses, including our citizens out there, that we have a solid policy in place that is first and foremost protecting our citizens against these type of problems. And I think it is evident by the hearing today and hearings that will go on that you are not bringing us a sense of security.

And as a Member of Congress representing a district, I am expressing that point of view from my citizens, who believe that we are less secure than we ought to be if we had used the policies that had been put into place.

Mr. Chairman, I yield back.

Mr. CHAFFETZ. I thank the gentleman and will now recognize the gentleman from Virginia, Mr. Connolly, for 6 minutes in the spirit of equal time.

Mr. CONNOLLY. I thank the chair.

It seems to me that, based on what we know and what we are hearing today on the panel, the United States' objectives have to be twofold. Domestically, it is to protect and prevent. And that goal cannot be successful if we don't address the second goal, which is to deal with the disease at the source in West Africa. The two go hand-in-glove.

And especially given the fact that we are potentially looking at an explosion of infection that is exponential in a very short period of time, the next 2 months, it seems to me there is enormous ur-

gency in the latter, not to diminish at all the need to address the former.

Now, we had some good news today. A nurse, Ms. Pham, has been declared Ebola-free. Thank God. But as Ms. Burger points out, dealing with the first part, protect and prevent, it wasn't thanks to the protective gear and the protocols and the guidelines that were in place at her hospital. While CDC was giving us assurances how hard it was to contract the disease, "We're pretty confident we've got things in place," and so forth, two healthcare workers, including Ms. Pham, came down with it.

Dr. Lurie, in retrospect, do you think perhaps, not intentionally of course, but in a zeal to reassure the public, CDC misstepped?

Dr. LURIE. You know, I think that CDC has said that some missteps have been made. But they have taken a quick, hard look——

Mr. CONNOLLY. But isn't it——

Dr. LURIE [continuing]. At the experience. They have pivoted, as you see——

Mr. CONNOLLY. Dr. Lurie, I am asking—I am asking a public information, public health question. I have had to deal with that in my county, when I was the head of my county, during anthrax attacks. And one rule I had was: Never reassure the public when you don't know. Never do that. Because when you do that, you damage your credibility.

And you heard it here today from some of the questioning on the other side of the aisle. It gave them an opening to attack the credibility of the administration by extension because the CDC was not capable of saying, "Not yet. We don't know. We're still—it's a work in progress."

What is so horrible about doing that?

Dr. LURIE. I think right now, if we look at the situation, we see that it is a work in progress. And what you see is that we are taking constant steps to adjust as we learn more.

Mr. CONNOLLY. Ms. Burger, you indicated that you would welcome a law establishing—if not an Executive order, but preferably a law because that codifies it—establishing uniform guidelines, uniform protocols, so we don't have this up-and-down myriad of procedures at hospitals depending on where you live. Is that correct?

Ms. BURGER. You left out one critical word, which is mandatory optimal standards——

Mr. CONNOLLY. Yes.

Ms. BURGER [continuing]. For personal protection.

Mr. CONNOLLY. Yes. I——

Ms. BURGER. The CDC guidelines are merely guidelines, and all 5,000 hospitals in the USA get to pick and choose what part of the guidelines they implement and——

Mr. CONNOLLY. I take——

Ms. BURGER [continuing]. The personal protection.

Mr. CONNOLLY. I take your point.

Dr. Lurie, would the administration welcome such legislation? And/or is the President contemplating such Executive action?

Dr. LURIE. So one of the things I think to keep in mind is that the Federal Government does not license or regulate hospitals in this way. Hospitals are licensed and regulated primarily by the

States. But I think it is fair to say at this point that no hospital wants to see its healthcare workers infected.

The CDC guidelines now provide a couple of options for safe personal protective equipment in large part because there is probably not a one-size-fits-all solution. It is important for people to be able to practice in the equipment that they are using and comfortably using day-to-day, provided that it meets the safety standards that CDC has articulated.

Mr. CONNOLLY. OK. I am not sure what that means in terms of whether the administration is contemplating an Executive order or whether you would welcome some legislation that would make it mandatory, as Ms. Burger suggests. But we will be in touch, I am sure.

Final set of questions.

Mr. Torbay, in the United States, there are 245 doctors per 100,000 population; in Liberia, 1.4; in Guinea, 1—10; Sierra Leone, 2.2. Health spending per capita, $8,895 here in the United States; $65 in Liberia; $32 in Guinea.

CDC says if we don't achieve 70 percent of isolation of existing Ebola victims in the affected countries, the number of victims or people with Ebola in these areas could reach—could reach—1.4 million by January 20th, the day roughly around when the President gives his State of the Union address. That is astounding. And whatever problems we have with the relatively limited number of Ebola patients in the affected regions, obviously it becomes enormously magnified when you are looking at that kind of number.

How in the world do we contain this before it becomes explosive? It is already the largest Ebola epidemic ever recorded, but to go from roughly 10,000 or so to 1.4 million in the next 2 1/2 months is very—I mean, it is jaw-dropping.

Mr. TORBAY. Thank you for your question.

There are steps that could be taken and that are being taken to contain this and to hopefully never achieve that 1.4 million number. And that includes isolation of patients, quick isolation of patients the minute we know that they develop symptoms, treatment, referral to the Ebola treatment units, such as the one that International Medical Corps is running in Bong County——

Mr. CONNOLLY. And if I could interrupt you—and, Mr. Chairman, I promise I am done after Mr. Torbay.

CDC says if you isolate 70 percent now, you achieve complete abatement of Ebola in the affected regions. I mean, in other words, then we are on a path to the complete reversal of the progress of the disease. But if we don't do that, we are headed in the opposite direction.

Sorry.

Mr. TORBAY. In addition to treatment, community awareness and education is critical.

But, also, we cannot forget the need for regional preparedness outside of those three countries. We know of one patient in Mali already. Yesterday, a 2-year-old girl was taken into a hospital in Mali.

Regional preparedness is critical. And that includes training of teams that could actually treat Ebola, detect, burial teams, contact tracing. It includes consistent community messaging so there are

no two conflicting messages that go out, as well as stocking of supplies that are needed in case of an outbreak. This is critical, as well, and this is an area that is being ignored in terms of preparedness.

Mr. CONNOLLY. Thank you.

And, Mr. Chairman, thank you for generousness.

Mr. CHAFFETZ. I thank the gentleman.

I now recognize the gentleman from South Carolina, Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

I want to start, Mr. Chairman, by thanking nurses and doctors, hospital workers, soldiers, and others for their courage and their service and their sacrifice. Most of us, Mr. Chairman, in life run away from danger and disease and risk, and very few people are willing to run toward it. So I want to start by thanking that group of people.

Dr. Lurie, I want to read you a quote, and you tell me if you can tell me who the author of this quote is.

"Beginning with the development of a strategy, my role can be defined as helping our country to be ready for any kind of adverse public health event, including a response to any challenges the future may bring."

Do you know who said that?

Dr. LURIE. Yes, I do.

Mr. GOWDY. Who?

Dr. LURIE. I did.

Mr. GOWDY. You did. That is exactly right, in a Penn Medicine article.

And your bio page says that you are the Secretary for Preparedness and Response, and your work has included evaluating public health preparedness, conducting 32 tabletop exercises on hypothetical crises, such as smallpox, anthrax, botulism, plague, pandemic influenza.

Another story on you and your career, which is an incredibly commendable career, said your job is to plan for the unthinkable. "A global flu pandemic? She has a plan. A bioterror attack? She's on it. Massive earthquake? Yep." She's got a plan. It's a mission that includes both science and a communication strategy.

So I was sitting there, Dr. Lurie, thinking, here we have a doctor with an incredible background in medicine, who also happens to have planned for crises like Ebola, whose job description also includes communication strategy. So why in the hell did the President pick a lawyer to be the Ebola czar and not you?

Dr. LURIE. So I appreciate your questions. Before I answer your question, can I take just one moment to clarify my answer about the quarantine question? Because I think I didn't understand it fully.

CDC has ample quarantine authority to do what it needs to do. I think the—and it has used those authorities many, many times. The proposed regulation would have refined the process we have used, but the underlying statute already gives CDC the authority that is needed.

Mr. GOWDY. OK. You——

Dr. LURIE. So with that clarification, I just wanted to——

Mr. GOWDY. So the record is now complete with respect to——

Dr. LURIE. Thank you.

Mr. GOWDY [continuing]. Your position on——

Dr. LURIE. Right.

Mr. GOWDY [continuing]. On quarantine.

Now I want the record to be complete on why in the world the President picked a dadgum lawyer to head the Ebola crisis instead of somebody with your vast and varied background.

Dr. LURIE. And I appreciate the vote of confidence.

The role of the Ebola coordinator in the White House is a whole-of-government coordination role.

Mr. GOWDY. Well, I appreciate that, Dr. Lurie. But Mr. Klain is not a doctor. He is not an osteopath. He is not a nurse. He is not an epidemiologist. He doesn't have a background in communicable disease. He doesn't have a background in infectious disease. He doesn't have a background in West Africa.

So how in the world is he the best person to be the Ebola czar and not you or—and I don't want to hurt her career, I do not want to hurt Secretary Burwell's career, and I fear that I will by complimenting her. But she is an incredibly bright person. One of the more capable people I have met in the last 10 years is your boss, the Secretary of HHS. Now, we disagree, in fairness to her, on lots of policy, but she actually has a background, through her work, The Gates Foundation, in global health.

You are a doctor. I mean, if this were an outbreak of people who don't have wills in West Africa or if this were an outbreak on contested elections in West Africa, then I would say, yes, go hire Mr. Klain, but it is not. It is a medical crisis. So why not you?

Dr. LURIE. So right now I have a full-time job doing my job in the Department of Health and Human Services. I really appreciate the vote of confidence. And I have a lot of confidence in Mr. Klain.

Mr. GOWDY. Well, how about another doctor? How about somebody who is an expert in infectious disease or an expert in West Africa or the delivery of health care? I mean, God forbid we pick somebody with a background in medicine instead of a dadgum lawyer. And in the interest of full disclosure, I am one. But——

Dr. LURIE. So, with respect, I think that the role of the coordinator at the White House doesn't require a doctor. It requires somebody who is really expert at coordination and bringing the parts of government together to enhance the coordination.

Mr. GOWDY. Well, I am going to make you this promise, OK? And I want you to hold me to it, OK? The next time there is an opening on the Supreme Court, I want you to see whether or not the President considers a doctor or a dentist for that job.

And we actually are about to have a vacancy for our Attorney General, and I want you to consider or be mindful of whether or not he considers maybe, like, a tattoo artist to be our next Attorney General. I promise he will not. He will pick a lawyer for the Supreme Court, and he will pick a lawyer to be the head of the Attorney General—Department of Justice.

I am just lost as to why he wouldn't pick somebody with a medical or healthcare background to be the Ebola czar. I mean, can you understand why people might possibly think this could perhaps be a political pick instead of a medical/science/health pick? Can you understand how people might be just a little bit suspicious?

Dr. LURIE. I can understand the public's concerns about a whole variety of issues. I believe that Mr. Klain has tremendous experience in doing the job that he was chosen to do.

Mr. GOWDY. Well, cite me all his medical background then. I was going to let you go, but you said he has tremendous experience. Cite me all of his medical, infectious disease, communicable disease, healthcare delivery background.

Dr. LURIE. You know, one of the terrific things about the way the government works together is that experts come together all the time. There is tremendous knowledge——

Mr. GOWDY. I am going to take that answer as that he has none.

Dr. LURIE. There are a tremendous number of doctors that he has at his disposal. He has me, he has Dr. Frieden, he has Dr. Fauci, he has Dr. Collins. You could go on and on and on.

Mr. GOWDY. Yes, and it would just make—but you know what? We had access to all those people before we had Mr. Klain. All those people worked for the government before the President hired Mr. Klain, didn't they?

Dr. LURIE. And——

Mr. GOWDY. So why pick a lawyer to head our response to Ebola? It just—you know, color me cynical, it just appears to be political.

But, with that, Mr. Chairman, I would yield back——

Mr. CONNOLLY. Would my friend yield?

Mr. GOWDY. Of course I will yield to the gentleman from Virginia.

Mr. CONNOLLY. Well, I just wanted to join my friend in calling for a nonlawyer appointment to the Supreme Court. It would be the healthiest damn thing we have had in the last 50 years. Thank you.

Mr. GOWDY. Are you applying? Are you interested?

Mr. CONNOLLY. No.

Mr. CHAFFETZ. I thank the gentleman.

I will now recognize the gentlewoman from Illinois, Ms. Kelly, for 5 minutes.

Ms. KELLY. Thank you, Mr. Chair.

Dr. Lurie, are you trying to say that we need someone good at coordinating and managing and really cutting through a lot of the BS?

Dr. LURIE. That is exactly right.

Ms. KELLY. Thank you.

I want to thank the panel for meeting with our committee to discuss this important health crisis issue.

And I want to let you know that my thoughts and deep appreciation are with all the healthcare professionals dealing with this crisis and those in the audience. And because I represent Illinois, a special shout-out to those from Chicago, the Chicagoland area.

My questions are about the DOD's role in West Africa.

Secretary Lumpkin, I know there are some that have commented that there is no reason to involve the U.S. military in this type of humanitarian crisis. Why is the U.S. military so critical to getting the epidemic under control in West Africa?

Mr. LUMPKIN. Thank you for the question.

Again, we are in direct support of USAID and their whole-of-government efforts. USAID came to us because of our speed and their

scale with response. We can mobilize quickly. We can instill command and control, provide the infrastructure. We have the ability to do logistics. We do it very well, both strategically and tactically, to move supplies.

The one thing you have to keep in mind, within Liberia, they get about 200 inches of rain a year. When we were there, it was raining, you know, 6 to 8 hours a day some days. In that time, many of the roads are impassable except by foot. And what goes by foot is the Ebola virus, as well. So there was inaccessibility to the various areas. We have the ability to reach and get those areas and to support USAID.

We have the ability to do construction and to build these Ebola treatment units. When I was there, I had a chance to get on the ground and talk to some U.S. Navy Seabees who were building the Monrovia medical unit. And working through the rain with the equipment there to get what looks to be impossible, they make possible.

Then the final piece is we can do scaled training. We can bring a boot-camp-like training to train up to 500 healthcare workers per week to man and to staff these Ebola treatment units. And so we bring the capacity in order to do that.

So, again, we are an interim solution as we roll in there to support USAID until the international community can mobilize in order to take over our efforts.

Ms. KELLY. So you feel you have extensive experience in conducting humanitarian efforts like this.

Mr. LUMPKIN. Well, we have supported USAID on numerous occasions. We did it in Haiti. We have done it in places—Japan just several years ago, the Philippines most recently. The team on the ground we have worked with before. The team lead from the Disaster Assistance Response Team has extensive experience working with the Department of Defense. And we are very tightly lashed up, and I would say it is seamless.

Ms. KELLY. OK. Thank you.

General, can you provide us with a status update on the operations in the region and let us know what your biggest challenges are?

General LARIVIERE. Yes, ma'am. Thank you for the question.

As Mr. Lumpkin said, we were asked to do this mission because of our unique capabilities. As we are here today, we have 698 personnel on the deck, split between Liberia and Senegal. We are expecting here, in the next 24 hours, the 101st Airborne Division will complete its movement into country and we will begin a rotation for them to take over the command and control piece of this. Equipment continues to flow through our immediate staging base in Dakar, Senegal.

As Mr. Lumpkin said, we were asked to do engineering. USAID asked us to be prepared to buildup to 17 Ebola treatment units. We have actually been asked to build 12, and 3 are currently under construction.

And as for the training effort, we have identified the Paynesville National Training Center in Monrovia as the site where we will bring in military trainers to begin training healthcare workers here in the next couple of weeks.

Ms. KELLY. For both of you, if this epidemic is not contained and it spreads further over the continent, do you agree that this really affects international security?

Mr. LUMPKIN. Again, to reiterate my opening comments, this is a national security priority for the United States that truly has global impacts.

So we have an opportunity right now to flood the zone, to make sure we have the capabilities in country, working as a whole of government, and mobilize the international community to respond while it still is at a point, while dire—if it gets worse, it is going to be harder to manage. So we need to take this opportunity we have right now.

Ms. KELLY. General, did you have anything?

General LARIVIERE. Nothing additional.

Ms. KELLY. Well, I want to thank you both for your testimony and for your service to the country.

And, again, a deep appreciation to all the healthcare professionals.

Thank you. I yield back.

Mr. CHAFFETZ. I thank the gentlewoman.

I will now recognize myself for 5 minutes.

And I want to thank the six of you for your dedication and commitment to fighting this and for the efforts here in the United States of America.

And to the men and women who serve on the front lines, those healthcare workers and first responders, I join with Mr. Gowdy in thanking those that will actually run to the sounds of the guns in the crisis that happens. They are amazing individuals, and they have our thoughts and our prayers and our hearts behind them.

I have a few questions, particularly on the military side of things. I don't know whether to start with Mr. Lumpkin or the General. But help me understand their proximity to the challenge here. How many USAID personnel are they supporting?

Mr. LUMPKIN. I don't have that number off the top of my head, and I want to be accurate. So I would like to take that back——

Mr. CHAFFETZ. Do you have a range? I mean, is it hundreds? Is it——

Mr. LUMPKIN. It is so integrated—the disaster——

Mr. CHAFFETZ. OK. If you will get back to me.

Mr. LUMPKIN. I will be able to do that.

Mr. CHAFFETZ. My understanding, Doctor—we've got one doctor here on the panel—is that there is a 21-day window in which a person who may have been exposed to Ebola will actually potentially come down with Ebola and start to show signs of having this virus. Is that correct, 21 days?

Dr. LURIE. That is correct.

Mr. CHAFFETZ. So, General, why do we only hold our troops for 10 days before we release them to bring them back to the United States?

General LARIVIERE. Yes, sir. Thanks for the question. And I can understand the confusion on this, but let me—let me see if I can make it clear.

To start, the 21-day period for monitoring has to take place outside the infection zone. For us, that will be in the United States.

Out of an abundance of caution, prior to departure—in order to reduce their risk, commanders will be allowed to remove their personnel from whatever jobs they were doing for up to 10 days prior to departure from Liberia just to limit their exposure and provide an extra layer of protection. However——

Mr. CHAFFETZ. I am going to need further explanation on this——

General LARIVIERE. Right.

Mr. CHAFFETZ [continuing]. Because I don't understand the 10 days when the science says the 21 days, but——

General LARIVIERE. Well, the 21 day takes place—well, the 21-day monitoring for U.S. Military personnel will take place Stateside after they have left in order to ensure that they are Ebola-free, just as was described previously for other healthcare workers.

Mr. CHAFFETZ. Let me understand, Doctor. The written materials that I do see out there talk about fever, which is monitored twice a day in the case of the military, and other symptoms. What are the other symptoms?

Dr. LURIE. Other symptoms might include nausea, diarrhea, red eyes, muscle aches, fatigue.

Mr. CHAFFETZ. So any one of those symptoms could be happening and not have a fever and you could have the Ebola virus, correct? You could have fatigue, for instance, before you have a fever.

Dr. LURIE. That is correct, but you really only transmit the disease when you are febrile.

Mr. CHAFFETZ. So if you have one of these symptoms and you are coming through Customs and Border Patrol, for instance, is one of my deep concerns. We've got about a million people a day that come through the United States border. We've got these Customs and Border Patrol agents and officers that—they are wonderful people. I mean, they are dedicated and committed at a tough and difficult job. And we are asking them to make an assessment of somebody in about a minute or so as to whether or not this person potentially has Ebola.

How in the world are we going to train them so that they can have these assessments?

Dr. LURIE. So let's be clear about what's happening now. First, all travelers are funneled—from West Africa are funneled to five major airports, where people are specially trained to do tightened screening. If, in fact, they have symptoms of Ebola or they have a fever, then they get referred to secondary screening. And then, additionally, they are——

Mr. CHAFFETZ. But that didn't work.

Dr. LURIE [continuing]. Interviewed by staff——

Mr. CHAFFETZ. It didn't work. Are you telling me that it worked? Did it work in the case of Dr. Spencer? Did it work?

Dr. LURIE. So the reason that we now have moved to active monitoring of all people that come back from these countries to the United States is exactly for this reason, so that if people don't have a fever when they come——

Mr. CHAFFETZ. You see where we lack some confidence, right?

Dr. LURIE. If people don't have a fever when they come through—when they come through the CBP, Customs and Border

Patrol, stations, we still believe they need to be actively monitored for 21 days. That is exactly what happened.

Mr. CHAFFETZ. But active—this active——

Dr. LURIE. And Dr. Spencer took his temperature. At the earliest moment, as I understand it, he called authorities and was isolated very expeditiously.

Mr. CHAFFETZ. So you don't think he was contagious those 48 hours before?

Dr. LURIE. From what we understand, people are infectious when they have a fever, not beforehand.

Mr. CHAFFETZ. So why did you close the bowling alley? Why did they—why did they, you know, put other people in quarantine? If he is not contagious because he barely showed a fever and he is a doctor and he says he didn't have a fever until that morning, why did you have to shut down the bowling alley?

Dr. LURIE. You know, it is a good question, and I think it gets to your issue of confidence. We really want to move in an abundance of caution. The bowling alley is closed so that it be cleaned and decontaminated out of abundance of caution. And I expect it will be open and people will be bowling——

Mr. CHAFFETZ. So he could have gotten——

Dr. LURIE [continuing]. In the not-too-distant future.

Mr. CHAFFETZ. He could have gotten sweaty, right, and you can transfer this via sweat, right? That secretion could actually hold the Ebola virus for some time, correct?

Dr. LURIE. So the bowling alley is being cleaned out of an abundance of caution, yes.

Mr. CHAFFETZ. I just don't have the confidence that we are dealing with people who have a known—we are talking about people who have come in direct contact with Ebola patients. Why we wouldn't hold them for a 21-day period to make sure that their loved ones, themselves, the people of this country—I don't understand why we wouldn't put that travel restriction in place, why we don't get a little bit more strict in putting quarantines—the self-quarantine didn't work. It didn't work in the case of Dr. Spencer, and he is one of the great people of this earth. I mean, he went to go help save people's lives, and he is an emergency room physician, my understanding.

So that is the concern. That is——

Mrs. MALONEY. Will the gentleman yield?

Mr. CHAFFETZ. Sure.

Mrs. MALONEY. Thank you.

I would like a clarification from the Major on one of your responses to the chairman's questions. You said that the quarantine cannot happen in the country of origin or the country of infection and that you would quarantine him, as I understand from your answer, 10 days in, say, Liberia before you would allow them to come to the United States.

My first question is, why can't you quarantine——

Mr. CHAFFETZ. We don't have first questions. Ask the question.

Mrs. MALONEY. Clarification.

Mr. CHAFFETZ. We have to yield. People have flights——

Mrs. MALONEY. Clarification.

Mr. CHAFFETZ. Yes.

Mrs. MALONEY. Clarification. Why can't you quarantine in the country of infection, particularly if we are sending over military that could build a quarantine unit?

General LARIVIERE. Ma'am, I will defer to the doctors. But what our infectious disease personnel tell us, in order to be absolutely certain that everybody is Ebola-free, it has to be outside the infection zone. And for all intents and purposes, the entire country of Liberia is an infection zone. But I would defer to the doctor for clarification.

Mr. CHAFFETZ. Go ahead.

Dr. LURIE. So the CDC's guidelines right now indicate that if you have no risk, if you have been in—if you have not been exposed to other people, you haven't touched other people, you haven't cared——

Mr. CHAFFETZ. Her question was about military personnel who are in the infection zone who did have contact.

Dr. LURIE [continuing]. You haven't cared for sick Ebola patients, and if you are in personal protective equipment, you haven't had a breach of personal protective—you haven't had a breach of your personal protective equipment, that, depending on the category, you are at low or no risk.

Mr. CHAFFETZ. I am not buying it. I am just not buying it.

Dr. LURIE. Well——

Mr. CHAFFETZ. My time has expired.

Dr. LURIE. OK.

Mr. CHAFFETZ. We will go to the gentleman from Pennsylvania, Mr. Cartwright, for 5 minutes.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

I want to followup on that.

And thank you for joining us today, Secretary Lumpkin and Major General Lariviere.

But, you know, the expression "an abundance of caution" has been used here in this room here today. And what I am wondering specifically—and I will open that up to either of you gentlemen—is there any reason why this proposal—you know, Mr. Lynch brought it up, Mr. Connolly brought it up, Mrs. Maloney brought it up, I believe Mr. Chaffetz brought it up. Is there any reason why we wouldn't just want to use a 21-day waiting period in West Africa before we bring people back to the United States?

Mr. LUMPKIN. Our 21-day monitoring process is done at the unit. It is done twice a day, as far as where they have direct contact with a healthcare professional for everybody that comes home. And it is commensurate with guidelines that other organizations are following. So we are following the same guidelines as the—that CDC and others recommend.

Mr. CARTWRIGHT. When you say "in the unit," you mean in the unit whether it's in West Africa or in the United States.

Mr. LUMPKIN. No, no. Well, there is in-country monitoring, and there is monitoring once they return home.

Mr. CARTWRIGHT. OK.

Mr. LUMPKIN. So once they return back to the continental United States or their port of origin, so to speak, they will go through a 21-day process where twice a day, 12 hours apart, they will report to their unit and do positive discussion with the healthcare pro-

vider and have their temperature taken to see if—to make sure that they don't become febrile or show any symptoms.

But keep in mind, going back to the risk of the Department of Defense personnel in country, because we are not providing direct health care to Ebola patients, our risk is much, much lower than those that do to begin with.

Mr. CARTWRIGHT. All right. And you are telling—you are answering my question with what we are doing, and I am asking you, why couldn't you do it a little differently? Why couldn't you do the 21-day waiting period in country just to be extra careful that we are not bringing this virus back to the United States?

General LARIVIERE. Yes, sir. Again, everybody in country will be monitored twice a day for their temperature. So, for all intents and purposes, we are checking—we are basically doing what the CDC recommends every single day while we are in country by having their temperature taken twice a day.

Immediately prior to departure, we will have personnel—we will go through a questionnaire to find out if, in the last few days right before they left, if they have been in more—possibly could have come into contact and be anything other than a low-risk category before we transport them home to start the 21 days in CONUS.

The 10-day period, which is causing all the confusion, was merely an additional period in which case they would be at a—be removed from whatever jobs they were doing, if they were out and about the town, in order to further reduce their possible risk.

Mr. CARTWRIGHT. Well, General, I thank you for that answer, but, again, you are telling me what the plan is right now. And I am asking you, why couldn't you be a little more careful with the plan, go a little more overboard with the protection and extend the in-country waiting period to 21 days rather than the 10 days?

And it seems to me that you gentlemen are deferring to the CDC on this. Are you?

General LARIVIERE. Well, sir, it is the CDC; it is also the U.S. military infectious disease doctors who, in consultation with their interagency partners, are the ones that——

Mr. CARTWRIGHT. Well, let me cut it short, then. May I ask you gentlemen to please consult with those sources and ask them to consider a 21-day in-country waiting period just to be in a real abundance of caution?

Mr. LUMPKIN. We will do that.

Mr. CARTWRIGHT. I thank you for that.

I also wanted to ask: You know, we have heard about this terrible potential for the spread of this disease in West Africa. What did we say? By January, a million infections or more. The suffering, the horror there.

And one question I have is, No. 1, is 3,200 American service men and women enough to properly train to defeat this Ebola enemy?

Mr. LUMPKIN. Based on the requirements that have been asked of us from USAID, who we are supporting in country, the answer is yes.

Mr. CARTWRIGHT. And then the next question is, are there enough trainees, are there enough healthcare workers in West Africa that we can train enough people to take care of the problem?

Mr. LUMPKIN. That is a question I would have to defer to the USAID and their expertise on the ground to——

Mr. CARTWRIGHT. Would anyone on the panel like to take that question?

Mr. TORBAY. There are health workers, not necessarily from Sierra Leone and Liberia, from the U.S., from other African countries, from Asia, that we are bringing to the country, as well, to help with the treatment and the containment. And we are hoping, with the training that is being provided and the supplies and the momentum that is actually now ongoing, that actually that should be sufficient.

That being said, for the time being, it is still really difficult to encourage people to go and work in West Africa, given the conditions on the ground but also given the conditions that they might actually stay in West Africa for a longer period, as well. So this is why we are trying to balance it in terms of going there but, at the same time, make sure that they can actually leave and go back home when they can.

Mr. CARTWRIGHT. Well, my time has expired. I thank you.

Mr. CHAFFETZ. All right. I thank the gentleman.

Quickly, Mr. Lumpkin, are there any United States personnel, military or USAID, that have any symptoms of Ebola?

Mr. LUMPKIN. Not to my knowledge.

Mr. CHAFFETZ. Thank you.

I now recognize the gentleman from Texas, Mr. Farenthold.

Mr. FARENTHOLD. Thank you, Mr. Chairman.

I want to followup, before I go into my line of questioning, with Dr. Lurie.

You talked about an overabundance of caution as to why we closed the bowling alley, as to why the airline took out the seats and reupholstered and recarpeted. We are hearing a lot about an overabundance of caution.

From a purely health standpoint, wouldn't an overabundance of caution include an air travel ban, complete, to the affected countries, like we have seen in some European countries?

Dr. LURIE. No, I don't believe it would.

Mr. FARENTHOLD. All right. I am going to respectfully disagree.

Now, I am glad we are having this hearing today. This is my second hearing on Ebola, and I was actually really disturbed during the first hearing that the Homeland Security Committee had in Dallas to see the CDC pointing fingers at CBP, CBP pointing fingers at the National Institutes of Health.

It is one of the reasons I said we needed to appoint somebody to be the point person, someone where the buck stops. And the President chose Mr. Klain. I am going to join with Mr. Gowdy in being a little skeptical of putting a lawyer instead of a doctor in.

But Josh Earnest told reporters ultimately it will be his responsibility to make sure that all the government agencies who are responsible for aspects of this response, that their efforts are carefully integrated. He will also be playing a role in making sure decisions get made.

I think one of the key things in that role is working with Congress, and I think he should be here today or at a hearing to be called very soon. We are the ones that sign the checks. We've al-

ready signed a $750 million check to fight this Ebola. I think he needs to be here.

I also—part of the finger-pointing we saw was the CDC saying the nurses in Texas broke protocol, when I think they were following, to the best of their ability, what they were able to do. I think it was entirely inappropriate they threw the nurses under the bus. My wife is a nurse, and she and I were both—were individually hurt and offended by that. I think these nurses were doing the best they could.

And, listen, an Ebola patient isn't always going to present at an Ebola center. They are going to show up at their local hospital when they show symptoms. Every hospital needs to be trained.

And, Ms. Burger, am I correct in saying your testimony is—what was the percentage that weren't prepared?

Ms. BURGER. I believe it's 85 to 86 percent. But you have to remember these are voluntary guidelines; they are not mandates. And until there is a mandate from Congress or the President, we will continue to have issues.

Mr. FARENTHOLD. I was thinking maybe—you know, I am not a big fan of big government regulation—maybe the joint commissions or the States.

Mr. Chairman, I would also like to enter for the record a Statement from Texas Health Resources. They were also thrown under the bus, and this is one of their responses to that. So I'd like to enter that for the record.

Mr. CHAFFETZ. Without objection, so ordered.

Mr. FARENTHOLD. Now, we have talked about who is not here. I want to talk—since we do have Mr. Lumpkin and the General here, I wanted to ask a couple of quick questions about our military involvement.

General, why did you join the military?

General LARIVIERE. To serve my country. And my dad was a Marine.

Mr. FARENTHOLD. And, traditionally, the military's job has been to serve and protect this country with guns and bombs. I understand the mission is expanding and you all are out now building health facilities in Ebola-plagued areas. Very laudable, but is this really what the military was designed for?

It seems like if you wanted to build healthcare facilities and help countries, you would have joined the Peace Corps and not the—or USAID and not the military.

General LARIVIERE. Sir, as Mr. Lumpkin Stated, this is a national security threat. And, as has been Stated previously, the idea has been to fight this overseas so it doesn't further come back here——

Mr. FARENTHOLD. But isn't——

General LARIVIERE [continuing]. On our—I'm sorry.

Mr. FARENTHOLD. All right. And is the military the only organization that can build hospitals, morgues, and treatment facilities? Aren't there thousands, if not hundreds of thousands, of contractors worldwide that can do that?

General LARIVIERE. Absolutely. But we were asked to use our unique capabilities, as was Stated earlier, to jumpstart this process, get it in place, so we could turn it over to those organizations.

Mr. FARENTHOLD. And so are these facilities going to be near existing facilities for Ebola patients? Are they going to be greenfield facilities or brownfield facilities? Are the locations nearby where patients are going to be congregating?

General LARIVIERE. We have been asked to build treatment units in locations that were coordinated between USAID and the Government of Liberia.

Mr. FARENTHOLD. So very possibly you could be working on an expansion to an existing hospital that is treating Ebola victims within those guidelines.

Mr. Lumpkin, you look like you want to jump in.

Mr. LUMPKIN. No, of the ones we've been asked to construct per USAID, none of those are expansions. They are all unique, new——

Mr. FARENTHOLD. OK. And——

Mr. LUMPKIN [continuing]. Ebola treatment units.

Mr. FARENTHOLD. So, then, you talked a little about PPE. What personnel would be wearing PPEs? I mean, you've got 80-degree-plus, highly humid conditions in these countries, and the natural inclination is going to be, why do I need to wear this Tyvek suit?

General LARIVIERE. That is a great question.

So the protocols that will be followed are that all U.S. military personnel will be issued a basic set of PPE that they will have with them in country, but because of the temperatures and because, quite frankly, of the jobs they will be doing, they will not be required to wear it all the time.

Mr. FARENTHOLD. OK.

And I've got one quick last question. There has been a lot of confusion about this 10 days and then 21 days. After the 10 days in Africa, they are going to come back to the United States and go to their unit and be monitored in the unit. Between the 12 hours that they are not being monitored by their unit, are they going to be able to ride the subway, see their girlfriend, go to a bowling alley, and take an Uber?

General LARIVIERE. They will be on the military facility. They will be allowed to go home, either to the barracks or to their families. But, obviously, every 12 hours will limit their ability—having to report to the unit every 12 hours will limit their ability to travel much further off base than you could go in order to get back for evening formation.

Mr. FARENTHOLD. But you will be—all right. Thank you very much. My time has expired.

Mr. CHAFFETZ. And I thank the gentleman.

I now recognize the distinguished gentleman from Illinois, Mr. Davis, for 5 minutes.

Mr. DAVIS. Thank you very much, Mr. Chairman.

And I want to thank Chairman Issa for calling this hearing. I think it has been very instructive, very helpful.

And I want to thank all of the witnesses for appearing and being with us.

With O'Hare Airport being one of the busiest in the world and with Chicago, where I live, being an absolute transportation hub, where millions of people come to and through our city each and every week, I first of all want to commend our public health officials, under the leadership of the Illinois Department of Public

Health, and our city officials and Homeland Security for what they have done in terms of preparation to screen individuals as they come, to have places they can go should anything be detected. Our hospitals have been fully cooperative, and I commend all of them.

I also want to commend all of our health workers who are the frontline individuals. Because while others can stand and cheer from the sidelines, you are in the arena. You are actually there; you are not the spectators.

I have heard a great deal of information—and I am delighted to live in a country that is willing to use some of its resources to be available in such a way that it does play and understands an international role. So I want to thank AID and our military for being in West Africa.

I agree with those who recognize that we don't have enough resources there to actually do all that we can and all that is needed to be done. But I commend us for the effort, and I commend us for what we are indeed doing.

I think I have a little more confidence and a little more faith in the CDC and our health professionals because every day, as I understand it, our protocols are under review, that whatever has been established, that's for right now, but with every incident, we are learning new approaches, new techniques, and we are putting those into play. And so I am not sure that I have as much gloom and doom, because we have had crises before and we've found a way, and we will find a way to stay ahead of this one.

Mr. DAVIS. Dr. Lurie, let me ask you, notwithstanding the advances that we have made in medical science, infectious disease continues to cause millions of deaths every year throughout the world. And we know that the primary strategy has been vaccination, developing vaccines. Let me ask, are there other strategies and other approaches that are being used relative to human behavior activity? I always remember my mother, who didn't have any medical training, but she always told us that an ounce of prevention was worth much more than a pound of cure. Are we able, and are we doing things that can help prevent and arrest the impact of these infectious diseases?

Dr. LURIE. I very much appreciate your question, Congressman. As a primary care doctor, I see—every time I see a patient—how important communication is, both with my patients and with my community. One of the challenges of dealing with this outbreak in West Africa has been that there are a lot of deeply held beliefs. There has not been sufficient information about how one contracts this disease or how to prevent oneself from getting it. And I believe that there has been a tremendous effort at public education. And I expect that that's going to continue in the days and weeks and months ahead.

Here at home as well, there have been efforts to educate the public, but many of those have centered on the populations whose heritage is in West Africa. And in the areas of the country where those populations exist, State and local health departments have shown tremendous leadership in reaching out to those populations, helping them understand how to recognize and protect themselves here, and importantly helping them provide information for their families in West Africa, whether it's on the Internet, whether it's by

Skype, whether it's by text, whatever. There is certainly much more public education and outreach to do, both in West Africa and likely here. But I really applaud your observation because it is centrally important to anything that we do in medicine or public health.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman. I know that my time has expired. But I would just like to say to my colleagues who are concerned about the czar, you know, it occurred to me that there are those of us who know things, but then there are those who know how to make things happen and how to get things done. And I think the President may have had that in mind as he made the appointment. I yield back.

Mr. CHAFFETZ [presiding]. I thank the gentleman.

I now recognize the gentleman from Kentucky, Mr. Massie.

Mr. MASSIE. Thank you, Mr. Chairman.

Mr. Lumpkin and Major General Lariviere, as you already know, there are members of Kentucky's Air National Guard in country. And so I hope you will understand that my first questions will be focused on their safety and training and well-being.

But I need to ask Dr. Lurie a question first. Are you familiar with the treatment of the three patients in the United States, the treatment regimen that they have received? We heard in the press that they received ZMapp and also perhaps blood transfusions. Is that true?

Dr. LURIE. So there have been more than three patients treated in the United States, but I have some familiarity with their treatment, yes.

Mr. MASSIE. Right. So does it include blood transfusions and ZMapp?

Dr. LURIE. So my understanding is that some patients certainly early on received ZMapp when it was available, and some of the patients have received blood transfusions.

Mr. MASSIE. So the best minds that we have, the best doctors that we have in this country, their consensus was that that would be the best treatment for them.

Major General, my question to you is can you assure us that the best treatment available in this country will be available to our soldiers in the unfortunate circumstance that any of them contracts Ebola?

General LARIVIERE. Yes, sir, absolutely. As I Stated earlier, both—there will be a Role 2 hospital both in Monrovia and in Senegal, where your Kentucky National Guardsmen will be stationed that is there to exclusively take care of U.S. military personnel.

Mr. MASSIE. And when they return Stateside, will they have access to ZMapp and blood transfusions if that's what the doctors prescribe?

General LARIVIERE. Whatever the doctors prescribe, they will be—it will be available for them.

Mr. MASSIE. OK. Thank you very much. Mr. Torbay, you seem to be sort of where the commonsense resides here, because you have been on the front fighting Ebola. And I really appreciate what you have done over there. And clearly, our futures are linked with West Africa. We want to see it solved. We want to see it cured over

there. In some of the things that you have mentioned today about gradiating people into no risk, low risk, and high risk, and then treating them differently instead of a one size fits all makes a lot of sense to me. My question to you is, is it possible—not likely, but is it possible to contract Ebola by sitting next to somebody who is exhibiting symptoms on a bus?

Mr. TORBAY. Thank you for your question. First of all, for the record, I am not a doctor, so I cannot be very specific when it comes to that. From what we learned, unless there is contact with bodily fluid——

Mr. MASSIE. Would that include perspiration?

Mr. TORBAY. That could include perspiration.

Mr. MASSIE. And do you have to contact the skin or could you touch somewhere where that an Ebola victim has touched?

Mr. TORBAY. I can't answer that. My understanding is it has to be through broken skin, but I am not really sure about that.

Mr. MASSIE. So do your protocols—but would you say it's possible even if it's not likely? Your protocols that you described before say that somebody who has a classification of low risk is prevented from taking public transportation. So surely you foresee that somebody—it is maybe not likely, but is it possible that somebody could catch Ebola on a bus?

Mr. TORBAY. We haven't experienced that. You know, with Ebola, it could be possible. There is no scientific evidence that proves it or proves against it.

Mr. MASSIE. There is no scientific evidence that it can be transmitted through saliva, vomit, perspiration?

Mr. TORBAY. Saliva, vomit, perspiration, yes.

Mr. MASSIE. OK. Does it live on surfaces? Can it live for more than 15 minutes on a surface?

Mr. TORBAY. I can't answer that.

Mr. MASSIE. You can't answer that?

Mr. TORBAY. I do not know the answer to that.

Mr. MASSIE. Maybe Dr. Lurie can. Can Ebola survive outside of a patient on an inert surface for any period of time?

Dr. LURIE. It can survive on an inert surface for variable periods of time depending on the——

Mr. MASSIE. OK. Then let me ask you is it possible—I am not asking you is it likely—is it possible that somebody could contract Ebola sitting on a bus next to somebody who has it? Can you imagine a way that could happen? Is it possible?

Dr. LURIE. One would have to have been in contact with the body fluids of the person.

Mr. MASSIE. Does that include perspiration?

Dr. LURIE. It does include perspiration.

Mr. MASSIE. OK. Major General, I want to get back to our soldiers here. You have assured us that they have been adequately trained in avoiding the contraction of Ebola. If a soldier came to you and said, Major General, is it possible, not likely, is it possible to contract Ebola sitting next to somebody on a bus who has it, what would your answer be to them? And I trust you are going to give us a straight answer.

General LARIVIERE. So I would defer to the medical professionals, as the doctor just said. It can be transmitted through sweat. Bodily

fluids has been noted. And I would say that, you know, that is why we have the 3 feet separation, that is why we don't shake hands.

Mr. MASSIE. So if I am a soldier and I ask you that, sir, what would your answer be?

General LARIVIERE. Well, I guess my answer would be it's a hypothetical.

Mr. MASSIE. It could certainly happen.

General LARIVIERE. It could possibly happen.

Mr. MASSIE. I am asking you to answer a hypothetical then.

General LARIVIERE. You are asking to ask me to answer a hypothetical.

Mr. MASSIE. OK.

General LARIVIERE. So it could possibly happen, but I would defer and say, low likelihood, and you need to follow the procedures that you were taught in your training session.

Mr. MASSIE. I am hoping they are getting the best training possible. And I am concerned if they are being told they can't catch it on a bus. Can you tell me what your answer to the soldier would be if he said, Sir, can I contract Ebola?

General LARIVIERE. So, for the record, they are not getting on buses with Liberian citizens. And your Kentucky Guardsmen are actually in Senegal, so——

Mr. MASSIE. Understood. We have other members from Kentucky serving in the military.

General LARIVIERE. Absolutely.

Mr. MASSIE. They are going to be, as I understand it, hot zones.

General LARIVIERE. And Fort Campbell folks will be there obviously. But they won't be betting on buses with Liberian personnel either. I would tell them to go ahead and follow their protocols.

Mr. MASSIE. So, just quickly, our confidence has been shaken in the CDC because we get conflicting answers. And when I first heard the military was going overseas to combat Ebola, I was skeptical. But then, on second thought, I said that's where our competency in the government resides, where the confidence resides of the American public is with our military and their ability to focus on a mission.

Today you have answered some questions where you deferred to CDC guidance, for instance whether they should be quarantined for 10 days in country or 21 days in country. What I am asking you, for the safety of the soldiers and for the safety of the public, is to use your own judgment. We trust the military actually more than the CDC on this. So please use that to guide you.

General LARIVIERE. Absolutely. And that's why I reiterate that once they return, we are having not the self-monitoring, but we are actually exceeding CDC standards because we are the military and having those individuals monitored by their units once they are back.

Mr. MASSIE. And the public, by the way, would like to see them stay on the base for the 21 days after they are back.

General LARIVIERE. And I understand their concern. But again, this is—we think that it's prudent to have them checked twice a day on base, but be able to return to their loved ones in the evening.

Mr. MASSIE. What we appreciate is your mission is and always has been to protect this country. And we appreciate your service.

General LARIVIERE. Thank you.

Chairman ISSA [presiding]. I thank the gentleman.

And we now go to the gentlelady from New Mexico.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman.

Clearly, with the arrival of Ebola in the United States we are all in this committee really concerned about whether or not our emergency preparedness systems are effective, and whether our public health system is an effective response mechanism. And I think I share with everyone on this committee that we are concerned that we have seen protocols have to be adjusted, that we wish we had better training, that we are concerned about hospital responses. I would just add, particularly after the last Statements, and I don't disagree that we want the highest standard of response, but a multitude of responses that are not based on scientific evidence and best practices. If they are not—if they aren't sound, then we create even more confusion and more panic by individuals, and we can't really manage a public health or an emergency system's response. Those are clear lessons that I learned as the secretary of health dealing with—I wasn't there to deal with hantavirus in New Mexico, but we had those experts certainly there. But I was there for SARS, for potential pandemics, for not having enough flu vaccine. And I am still there dealing with one of the worst hepatitis C issues in the United States. So, unfortunately, in New Mexico we know how important it is to have a good, solid, strong public health and emergency response system.

To that end, I know that we have been both critical and we have recognized that whether or not Congress invests sufficient resources in the CDC and the NIH and all of our other partners that have a response to emergency preparedness, we expect that there is still in place a robust response. But I want to be clear that has the fact that these policymakers have failed Congress to invest appropriately and have cut funding, has that had a negative—Dr. Lurie, has that had a negative impact on our ability to respond not only to Ebola, but all public health crises?

Dr. LURIE. No. I think that, you know, we have seen an erosion in support for public health at several times in our country's history. And each time that happens, we look back through the retrospectoscope and wish we had done something different.

Ms. LUJAN GRISHAM. So I am not sure I understand your answer. So you don't think that having reduced resources targeted at these issues has had any negative impact?

Dr. LURIE. So we actually just had the opportunity to survey——

Ms. LUJAN GRISHAM. Because I will tell you that my public health team will say it is. My hospital association says it is. That individual hospitals around the country say it is. And the fact that you have a decentralized public health system—so even if you had the authority to mandate, you don't have a system that you could do a mandate. And I don't know that I agree, although I really respect my colleague, Mr. Connolly, that you want a mandate here, but we have another issue in this country, which is we do not have a centralized public health system. Your ability to manage State by State by State by State, and I have a poor State with a centralized

system, fairly effective, but I can tell you even there, it was hard for us to manage all of our county emergency response partners in a crisis.

Dr. LURIE. No, you are absolutely correct. And certainly we are hearing a lot from States that they are very concerned about the reductions in support for public health and for public health preparedness. And many of them are really looking hard at how they are going to have to cope with the latest rounds of reductions.

Ms. LUJAN GRISHAM. And are you prepared now to really think about best practices and more centralized approaches, and requiring maybe a different protocol for our public health emergency response systems in this country? I think if we did that even when Congress doesn't do its job to adequately fund for these public health issues so that we only react when there is a crisis instead of—and I appreciate someone talking about precautionary principles, that we ought to be proactive in as many cases as we can where the evidence is sound about being proactive in that particular manner. But, in fact, I do expect that the Federal Government, even with limited resources, does everything it can to identify what those best practices are and to regularly identify what the risks are if you don't adequately fund, and what the impact is to States who also find themselves without adequate resources to prepare and be trained effectively.

Dr. LURIE. I so much appreciate your passion for public health and for the resourcing of public health. It's so important. The way public health is organized in this country by law is that the Federal Government by and large can provide guidance and tools and best practices, but the implementation of other aspects of public health is either at a State or local level. And as I think you know well, it's organized differently in different States.

Ms. LUJAN GRISHAM. That's my point. Is it may be time to think about whether or not that in and of itself is an effective strategy in this country.

Dr. LURIE. I think it's a very interesting idea.

Ms. LUJAN GRISHAM. Thank you.

I yield back.

Chairman ISSA. The gentlelady's time has expired. I thank the gentlelady. I now ask unanimous consent that page 172 of the CRS report entitled Funding of the HHS Assistant Secretary for Preparedness and Response in millions of dollars be placed in the record. Additionally ask—without objection.

Chairman ISSA. Additionally ask that the Wall Street Journal article in the opinion section, entitled "There is Plenty of Money to Fight Ebola," be placed in the record.

Without objection.

Chairman ISSA. Last, I would ask that the Fiscal Year 2014 HHS appropriations overview by CRS be placed in the record at this time.

Without objection, so ordered.

Chairman ISSA. We now go to the gentleman from Michigan, Mr. Bentivolio.

Mr. BENTIVOLIO. Thank you very much, Mr. Chairman.

And thank all of you for coming today and testifying before this committee on a very important subject. A great deal of importance to the people in my district.

And Mr. Roth, a quick question. What is the Federal Government's present readiness status to handle a pandemic or other emergency where there is a surge in medical needs in a specific region?

Mr. ROTH. I can only speak to the DHS component, which is what we studied.

Mr. BENTIVOLIO. OK. Are you familiar with—do you have any idea how many mobile hospitals are in the inventory to be deployed at a reasonable amount of time, meaning 1 day to 3 days, to a region that is experiencing a surge in medical needs? And that's for any reason whatsoever, another Katrina, HAZMAT emergency, pandemic, earthquake, tornado.

Mr. ROTH. We did not look at that in the audit that I testified about.

Mr. BENTIVOLIO. OK. In 14 months being in office, or since I have been in office for the last 14 months, my office has been investigating that need. So our first responsibility is to protect this country. And I haven't found any in the inventory. So there is no mobile hospitals available, no mobile isolation units deployable that could be deployed within hours or days of an emergency.

And Ms. Burger, I have a question. You are a nurse. How long have you been a nurse?

Ms. BURGER. Forty-three years.

Mr. BENTIVOLIO. Forty-three years. My wife has been a nurse for 37 years. So thank you very much for your service. Now, I have a question. When a person has any type of infectious disease, whether it is Ebola or the flu, I know they are transmitted differently, but for each step that an infected person makes, does it or does it not increase the risk of its spreading exponentially?

In other words, give you an example. If somebody came down with the flu, it's quite possible that, you know, well, if they stay in their home, the only people that are probably going to get sick or infected from that flu is those people that are in the home. But if any member of that household leaves that house, goes to the drug store, goes to the supermarket, whatever the case may be, does the potential to infect others increase?

Ms. BURGER. Well, if it's the flu, if you know you are——

Mr. BENTIVOLIO. Airborne.

Ms. BURGER. And they also have good hand washing, so if you are not in direct contact with the airborne virus going into your eyes by yourself putting your hands into your eyes or something, that is not likely.

But what we are talking about here today is the Ebola preparedness in this country.

Mr. BENTIVOLIO. I understand.

Ms. BURGER. And it's completely different in this country because there are about 5,000 hospitals in this country and 5,000 ways to manage this disease.

Mr. BENTIVOLIO. How many of those hospitals have an isolation unit that is capable of containing the Ebola virus?

Ms. BURGER. Well, according to what the hospitals report on a daily basis in the newspapers is that they are all ready and they can isolate patients at a moment's notice. But what we just got reported to us yesterday was a nurse that thought she—from Kansas City who has a, quote, negative pressure room which was nonoperable.

Mr. BENTIVOLIO. OK. That is one negative pressure room. It is very important, especially with Ebola, correct, to have that capability?

Ms. BURGER. Correct.

Mr. BENTIVOLIO. OK. Now, what I am trying to get at is if a patient walks in with flu-like symptoms, the first thing they will do when they go to a hospital is they will visit an administrative clerk that does some triage, asks some insurance questions. Is that not correct?

Ms. BURGER. Well, if they have got the flu, most of the time, they are at home in bed.

Mr. BENTIVOLIO. Well, OK. That's not always the case. They could be experiencing fever and they—you know, they do come to the emergency room.

Ms. BURGER. If they are seriously ill from——

Mr. BENTIVOLIO. If they are seriously ill with flu-like symptoms. So is it possible—what is the protection that an administrative clerk that meets you at the hospital, the receptionist that asks, you know, what are your symptoms, why are you here, what is your insurance? What is the chances of them being infected by an Ebola virus?

Chairman ISSA. The gentleman's time has expired. She can answer. But I just—you are not talking—you are saying flu-like symptoms, but you are assuming that the person has Ebola?

Mr. BENTIVOLIO. Correct. Correct.

Chairman ISSA. The gentlelady can certainly answer.

Ms. BURGER. OK. Again, as I say, several, 5,000 hospitals all have different protocols on how they handle Ebola. Some security officers are now asked to step in. They are given little Ebola kits that have a gown, some gloves, and a surgical mask. But I think that that's what we are talking about is that everybody, everybody needs to be trained and prepared and educated on how to handle a potential Ebola patient so that that clerk is also not exposed to unnecessary virus from Ebola.

Mr. BENTIVOLIO. Thank you very much.

Chairman ISSA. I thank the gentleman.

We now go to the other gentleman from Michigan, Mr. Amash.

Mr. AMASH. Thank you, Mr. Chairman, and thank you to this panel for being here today. Earlier this month several airlines, including Kenya Airways, British Airways, Air Cote D'Ivoire, and Nigeria's Arik Air, suspended flights to and from certain affected countries in West Africa. Our own State Department issued travel warnings to our citizens, urging them to delay nonessential travel to Liberia and Sierra Leone. And recent reports suggest that more than two dozen countries have restricted entrance to persons who have traveled to West Africa.

So my question is to Dr. Lurie and to Mr. Torbay. Under what circumstances, if any, do you think a travel ban or increased travel restrictions would be appropriate to safeguard Americans?

Dr. LURIE. So I thank you for that question. Over the past week, we have increased and tightened up our screening measures for individuals traveling from the three affected countries. You know they are all now being funneled through the five major airports. They get screened before they leave. They get screened when they come. Every passenger coming from an affected country now has their information given to the State and local health authorities. And they will be actively monitored for 21 days. So we have really tightened that up quite a bit, and I believe it should be sufficient.

Mr. AMASH. How about a travel ban? Is there any circumstances in which you would support a travel ban?

Dr. LURIE. We think a travel ban would be incredibly unproductive or counterproductive.

Mr. AMASH. In what ways?

Dr. LURIE. Well, first of all, right now, we have a really good mechanism to identify and track every single person coming now from affected countries. If you were to put a travel ban in effect, for example, you would have people coming into this country who we wouldn't know were here, we wouldn't even know how to find them or monitor them. And that would become a serious problem.

Mr. AMASH. But if someone is flying commercial, for example, and they don't exhibit symptoms, but they have been in a region that's infected, how are you going to know that they are infected? Or that they might have been infected?

Dr. LURIE. I think the whole point of doing the exit screening and then the screening when they come to the United States, and then following them for 21 days, taking their temperature twice a day, is exactly so that we can see them through the end of the incubation period and, if necessary, be on top of that within hours of them exhibiting a fever.

Mr. AMASH. Mr. Torbay, same question.

Would you support a travel ban under any circumstances?

Mr. TORBAY. No. We don't. A travel ban, first of all, we have to recognize there are no direct flights from those three West African countries to the U.S. The majority of people actually transit through Europe. So a travel ban will have to include flights coming from Europe, which I don't think would be feasible at this stage. But even with that, we can't, because if we are talking about fighting Ebola at its source, we need health professionals to be able to travel in and out of the country. We need supplies to be able to be flown into the country in order for us——

Mr. AMASH. Do they predominantly travel through commercial airlines?

Mr. TORBAY. Absolutely.

Mr. AMASH. Would it be prohibitive to require them to travel through charter jets?

Mr. TORBAY. It would be very expensive.

Mr. AMASH. The question, a followup question, you had said earlier and the doctor had said that if there is no symptoms, there is no risk to other people. What if someone were to get onto an airplane with no symptoms, but you have an 8-hour flight to the

United States from a European country, let's say, and they have been in West Africa and then Europe to the United States. Couldn't they exhibit symptoms on the flight? And isn't that a risk?

Dr. LURIE. I very much appreciate your question and concern. And I think that is exactly why now all of the planes are being routed through the five airports, and why by the time a plane lands on the ground, both Customs and Border Patrol and the CDC quarantine office are notified about whether there are any sick passengers on the plane. When they get off the plane, they are asked the same questions again, and they are given information about the symptoms of Ebola and what to do if they have any.

Mr. AMASH. Thanks.

I am going to yield my remaining time to the gentleman from Florida, Mr. Mica.

Mr. MICA. Thank you.

First of all, what you have got in place has failed. The doctor, the New York doctor just came through, and he got the temperature thing and all of that. But it failed. He self-reported. I think basically what you have is a 21-day period from where they have been subject to the infection, and people need to be quarantined coming out of those countries. You don't need a travel ban. You need to go to the people who pose a risk.

I understand it is only 80 to 150 coming out of those countries right now entering the United States a week. Is that right? Approximate? That's what I am told. But you quarantine them. My grandparents, when they came into Ellis Island, were subject to quarantine. We quarantine lots of people. I will take you up to where we did it. Or they self-quarantine themselves. They pose a risk. Every traveler doesn't. But people need to be identified.

We just came through the airport today at Dulles. And, again, we didn't come from one of those countries, but we didn't have to. You just said transited. They can transit.

Chairman ISSA. The gentleman's yielded time has expired. If you could wrap it up.

Mr. MICA. Well, again, just some common sense that doesn't prevail around here or anywheres. You have 21 days. Look at this guy again. Learn by his example. He flew out, the 12th was his last day there. You count 21 days forward. So he should have been subject to quarantine, not exposing himself on the subway or other places. Then your guidance finally on——

Chairman ISSA. I will do a second round. I will come back.

Mr. MICA. Let me just finish because others went over.

Chairman ISSA. I ask unanimous consent the gentleman have an additional minute.

Mr. MICA. OK. Just an additional minute. Here is a picture. I don't know if it's true. It's New York. Your workers and how you spread this stuff. The nurses, it was either taking this their things off or exposure to the skin. We don't know.

Do you know, Ms. Burger? No.

We don't know. OK. Here is a picture I saw. My wife told me about this. She saw it on TV. These are New York police first responders. Do you have a memo to first responders on how to deal with this stuff?

Dr. LURIE. We do. We put out guidance for first responders. We had a——

Mr. MICA. This is a press account. Just a video. I don't know if it is true. But it shows them putting their gloves and other stuff and tape from the area of New York into a public trash can. So, again, what you have got to do, you have got to make sure first responders, nurses, all the protective things in place where we have exposure. And we have exposure.

And the testing at the airport is not working. We need a quarantine in place period for those coming out there or you are not going to stop this. The doctor was a very responsible, educated individual. Thank you.

Chairman ISSA. I thank the gentleman.

I ask unanimous consent the ranking member have 1 minute. Without objection.

Mr. CUMMINGS. Thank you. Mr. Torbay, the quarantine. Can you talk about that? I know you are interested in what is happening in Africa, but I know you are also interested in what is happening here. Can you just comment on that?

Mr. TORBAY. You know, as I mentioned, one of the main pillars for actually fighting Ebola in West Africa is the ability to take staff and bring them back home. We cannot recruit staff from the U.S. or anywhere else in the world if there is a chance that they might not be able to come back home to their families and to their duties, to their other duties.

And putting people in quarantine actually goes against our ability to recruit and to retain. And therefore, it will go against our ability to fight the virus in West Africa.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Florida for 5 minutes.

Mr. DESANTIS. Thank you, Mr. Chairman.

Dr. Lurie, as I understand it, Congress in 2006 passed the Pandemic All Hazards Preparedness Act. We reviewed that and reauthorized it in this Congress. And one of the key points in that was establishing an Assistant Secretary for Preparedness and Response, which is of course you. And this was supposed to be the focal point for these responses. You were quoted previously as saying that you have responsibility for getting the Nation prepared for public health emergencies, whether naturally occurring disasters or manmade, as well as for helping it respond and recover. It is a pretty significant undertaking, end quote.

And it just occurs to me I am glad to see you here, but I have not seen you out front. I know communications is supposed to be part of what you do. So have you been appearing at public meetings over the last several weeks in conjunction with Ebola? Have you been participating in any briefings for the public?

Dr. LURIE. So let me start by saying and repeating something I said in my testimony, that back in the spring, when we first learned about Ebola in West Africa, our whole office activated to start taking action on behalf of the country and on behalf of West Africa——

Mr. DESANTIS. I appreciate that. But can you speak since this has become heightened with the American people in the last 3 or

4 weeks, it seems like your profile has been a lot lower than some of the other folks even though your office is a key one. So how would you respond to that?

Dr. LURIE. So I think one of the things we know about dealing with public health emergencies is the public does better if there are one or two consistent spokespeople. Dr. Frieden has played the major role in that because the CDC has the lead for the public health aspects of the response. What I can tell you is——

Mr. DESANTIS. What would you say about this? I appreciate that. Let me ask you this. The President had what were billed in the press as emergency Ebola meetings at the White House. One last Friday and then a week ago tomorrow on Saturday, after I guess he played a round of golf. Did you attend either of those meetings?

Dr. LURIE. Our Secretary attended those meetings. And I have met with her every single day since we got involved in this response.

Mr. DESANTIS. Did you attend?

Dr. LURIE. No, I did not.

Mr. DESANTIS. OK. And so has the White House or the Secretary of HHS instructed your office to stand down as being the point office in favor of this new Ebola czar?

Dr. LURIE. Not at all.

Mr. DESANTIS. OK. So here is an issue. Thomas Eric Duncan, he brought Ebola to the U.S. Your office is clearly what was envisioned in this legislation. And yet he was able to bring the disease here. So what would you—were you guys prepared in your office for Thomas Eric Duncan, or did you drop the ball, and could you have done some things better?

Dr. LURIE. So what happened with Mr. Duncan required a whole system to work, right? It required the Federal components to be in place. It required State and local health departments to be in place. It required hospitals to be in place. And it required individual health providers, doctors or nurses, all to be able to do their job.

Certainly there were some breakdowns in links in the chain. Do I think that we have done a good job preparing hospitals and the health care system in our country for disasters? Yes, I do. Do I think we are being very aggressive now about preparing health professionals and health care providers and institutions to be able to recognize, treat, and isolate cases of Ebola? I think we are being very, very aggressive about that.

Mr. DESANTIS. So how would you—explain to me then, so the Pandemic Act seemed to have your office being kind of a point person in HHS. Now we have this Ebola czar. So how does the chain of command work in terms of how we are confronting Ebola at this stage? Is the HHS assets, is everyone reporting to Ron Klain now and then Klain is directly reporting to the President? What is your understanding of this?

Dr. LURIE. So Mr. Klain's role and responsibility is to coordinate all the different aspects so that we are increasingly working in a whole of government response. It's to make sure that all the parties are working together on a day-to-day basis to make decisions.

Mr. DESANTIS. Isn't that in your job description anyways? I mean aren't you kind of a czar to deal with these pandemics?

Dr. LURIE. So I have responsibility for dealing with medical and public health emergencies, particularly domestically. And the other thing that I think is really important to recognize is that the bulk of this response is a global health response. It's not a domestic response. My office has been active, along with the CDC, the NIH, the FDA, in meeting with the Secretary since the beginning of this, as I said, almost every day.

Mr. DESANTIS. Well, I appreciate that. I know that the chairman invited Mr. Klain here. I wish he would have come so we can ask—some people, as Mr. Gowdy pointed out, may have some reason to question whether this is the right individual to actually execute the medical component of this, or whether this is more for political reasons. I would have liked to have been able to ask him some questions to try to probe that further.

Chairman ISSA. Would the gentleman yield?

Mr. DESANTIS. Yes.

Chairman ISSA. For the record, we did invite him. We had hoped he would be here.

We also invited the World Health Organization representative. And as you know, we fund about half of their entire budget.

And their answer to us was that basically they don't do congressional hearings. So I am sending a letter to the appropriators, letting them know they don't do congressional hearings about how they are spending our money and how they are going to fight something like this.

But it is an area of concern. As you say, you have got an attorney who has been hired to do this as a czar, you have the World Health Organization, and neither wanted to appear.

I yield back.

We now go to the gentleman from Georgia for 5 minutes, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I appreciate you each being here and the sense. And there is a lot that has concerned me from this hearing. Actually, I came into this hearing hoping—in some ways, we got some assurance, but in also other ways very concerned about some of the answers that were given. And I may get to that in a moment.

But I want to focus on—being from Georgia, I want to focus on a positive note. And I want to focus on something that was really—because back when Dr. Brantly and Ms. Writebol, which seems like an eternity ago now, were brought to the United States, they came to the—really, the constituents, my constituents started feeling fear. A lot of people were concerned this is something that we don't understand and how you get it. And then in the weeks and days after that, the conflicting and inaccurate public Statements that followed the arrival from CDC, others, and as it just went ahead have caused even more panic. In fact, today in one of my local press outlets there is a—basically just an opinion poll that people can click in—and said 75 percent believe that the CDC's information from the beginning of this was just inaccurate and not helpful. You have a level of trust that is gone with many people. But what happened here was really time to switch gears and say that, frankly, from my perspective Georgia got it right. Emory got it right. Nebraska has got it right. There are some places that have got it

right. And what I want to know is as we continue this process, as we look at the precautions, as we look at the things that are going on, is focus on the protocols for Ms. Burger and the nurses and the folks who come into the very front stages of this, they do it in a way that they follow protocol, they have the protocols in place and have the equipment in place. And I think this is what I want to commend Emory University in Atlanta for being able to be the first hospital to successfully treat an Ebola patient. And actually the fourth, Amber Vinson, is our understanding is still recovering at Emory and has been declared Ebola free. That is a good thing.

Emory did this because they were set up with the CDC on those levels that we heard about your, Dr. Lurie, on the table tops. They worked with CDC. They are one of those outlets in case something happened, which the CDC is in Georgia as well, most of which I am so proud of, except some of the public Statements by the director, who has really lost confidence of many on this Hill and many in the country by the Statements that were made and the actions that he took. For him to be the face is really a concern of this.

So the question I have is in looking at this, Emory has put out a lot of great stuff. And, with unanimous consent, Mr. Chairman, I would like to add the editorial from John Fox, who is the president and chief executive officer of Emory Health Care, Beating Ebola Through a National Plan.

Chairman ISSA. Without objection, the entire article will be placed in the record.

Mr. COLLINS. And I do appreciate that, because I think this is a national response. You said something just a moment ago, Dr. Lurie, that I am not going to focus on, but you said this was not a domestic, this was a global issue. Well, aren't we part of global? So what part would you be missing in understanding of how that would affect us? In fact, when your main concern was if it was something overseas, when we have places like Emory and Nebraska doing it right, we have those doing the protocols that were not forced upon them, they had it ready to go, was it not—shouldn't it not have been a part of your job?

Dr. LURIE. Maybe you misunderstood what I was trying to convey. What I was trying convey is——

Mr. COLLINS. Very quickly enlighten me.

Dr. LURIE. OK. So I have domestic responsibilities for preparedness. In fact, one of the things that I was reflecting on when I was listening to your comments is that, prior to taking this job, I had an opportunity to go around to every county in Georgia with your Georgia public health officials and do those table top exercises for biopreparedness. I spoke to the leadership at Emory yesterday. And we are very grateful for their incredible response and their leadership, not only in taking care of patients at Emory but now helping us and helping the rest of the country as we build out and develop a regional strategy for taking care of——

Mr. COLLINS. I appreciate that. Because I do want to be—at least let's accentuate the positive, health care workers that are getting it right. But I share Ms. Burger's concern, and there was some other discussions lately, is let's say they did switch planes. There is not a tracking. They don't fly into one of the five airports. They come in in different ways and then present at an emergency room,

which by the way in my area, a lot of times poor areas, they do go to the emergency room with flu-like symptoms all the time. All the time. It is part of the problem we have got. And it is going to get worse. So the people who do ask those questions, having them trained and having them adequately prepared. And I think this is the part that concerns me.

You made this Statement, and I just want to end here because there is the concern out there is for the people to understand what is done right. Emory University, Nebraska, and those kind of things that have done what it took to follow protocols and be prepared. That is the No. 1.

From the CDC level and the spokesman level, there has been a disastrous failure at that. There has been now with Mr. Klain a disastrous failure in at least perception that we are taking this health care seriously, not just an administrative assistant. We needed someone else that has the credentials that you have or others.

But here is my problem. After we discussed everything on when they actually got here, the doctor in New York, which I was in New York, just came back last night and came this morning, up there seeing what is going on. Here is your response. And it is the response that the American people cannot hear anymore. And that is after it happened, out of an abundance of caution, we cleaned the bowling alley. Out of an abundance of caution, we went back. The American people need to see the abundance of caution beforehand. That is your job. That is the job of the CDC and the job of preparedness. And they wanted to see the abundance of caution before our health care workers were put at risk, before our system was bun, and that is where the abundance of caution needed to come. And from that, from a very positive Statements from Emory University and Nebraska and others who did it right, and I want to congratulate them, I want to also highlight that an abundance of caution should have started a while back, not after the fact.

And with that, Mr. Chairman, I yield back.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Florida, Mr. Mica.

Mr. MICA. Well, a perfect lead in. Now, you sat here and told us you are responsible for both domestic preparedness and a global response.

Dr. LURIE. No.

Mr. MICA. What are you doing?

Dr. LURIE. No, my responsibility is a domestic responsibility primarily.

Mr. MICA. OK. So you have nothing to do with the global response? More from this article about WHO, who wouldn't come here today. First of all, this is the worst Ebola outbreak in history. Is that right? Is that not right?

Mr. TORBAY. Yes.

Mr. MICA. OK. And it says the World Health Organization said today it would probe complaints that it had been too slow to wake up the scale of Ebola. Then it says critics have questioned why WHO only declared an international health emergency in August, 8 months after the epidemic began. Did the administration or any-

one in a position of authority from the United States, where we spend millions of dollars into WHO, ask them to proceed?

Dr. LURIE. So let me——

Mr. MICA. Did they?

Dr. LURIE. Let me put a finer point on this.

Mr. MICA. Do you know if they did? You can say you don't know.

Dr. LURIE. So I don't know if they did what?

Mr. MICA. If we did anything. Is there a letter? Anything? Did we go after WHO? This is a global——

Dr. LURIE. We have been——

Mr. MICA [continuing]. Disaster. We spend lots of money on the World Health Organization. And this isn't my stuff. I am just reading you what I am telling you that people are coming after.

OK. This isn't a panic. It is to be prepared. Now, are you in charge of being prepared?

Dr. LURIE. I am in charge of being prepared.

Mr. MICA. OK. Then I think you need to turn your resignation in. Have you read this report? Have you read this report about preparedness that the IG? Do you have some authority over preparedness at DHS?

Dr. LURIE. I have no authority over preparedness at DHS.

Dr. LURIE. Then you don't have the authority to do the job. Who has the authority to do the job? He has just prepared for this committee; it is dated the 24th. He says the stuff they bought, nobody knows even the inventory where it's gone. You have got equipment to protect people that is out of date; it won't protect them. They even put up hand sanitizer, they looked at 84 percent of them are expired. Is that your job or somebody else?

Dr. LURIE. DHS——

Mr. MICA. And if it isn't your job, isn't it the new czar's job? Whose job is it to protect the American people?

Dr. LURIE. First, let me clarify that DHS has responsibility to buy personal protective equipment for its——

Mr. MICA. Have you been over there to see what they have? Have you been over there to see what they are doing and have? Have you seen this report? Folks, staff, make sure she gets a copy of this report. This is a scathing report. Page after page, the inventory outdated, stuff that we bought, we spent millions of dollars, and we aren't prepared.

Let me ask you another question. Having been here a while, I was through the bird flu. This is transmitted even by an individual. And if it takes inconvenience—first of all, you should quarantine the health care workers.

You are wrong, Mr. Torbay. They are the most exposed to this. So anyone who has been exposed, for 21 days coming into the United States, must be quarantined. I don't care if it's inconvenient. They should recognize their own risks, too. And we should watch those people. You had one guy come in yesterday. He got to his what, 18th day or something, came down with it. OK. So I think—and it may not be that many health care workers. But they are the most exposed, unless you are burying the people like you just saw with the photo from him. If you are burying people or you are in the medical, you quarantine those people for their own risk, even if we pay for it, to keep this thing from spreading.

Right now we are lucky. OK. We don't know what infected the nurses. We don't know, again, if there will be other cases. But you have to take steps in an emergency situation like this.

She claims she doesn't have the authority to see what DHS has to keep us prepared. Somebody needs to see that we are prepared. Again, this isn't panic.

Last question. OK. Bird flu. I was involved in bird flu. These people are coming by planes. When some plane comes from Africa or transit through and it has passengers from there, what are we doing with it? The plane.

Dr. LURIE. With the plane itself?

Mr. MICA. Yes, the plane. They have been on the plane. They might have barfed in the plane. There might be excrement. There may be vomit. There may be a body fluid. They sat in a seat. We don't know. We don't know if those nurses got it from taking off equipment incorrectly or if it touched their skin.

Dr. LURIE. There are protocols for cleaning the plane.

Mr. MICA. You just testified earlier that perspiration would do it.

Dr. LURIE. There are protocols for cleaning the plane.

Mr. MICA. I want to know the protocols they have in place. I have seen the equipment that we have, and Centers for Disease Control actually got some then. And we could bring up—it is a heating device that heats the plane to 140 degrees to kill the germs. That is what we used in the bird flu. Are we doing anything like that to make sure those planes aren't little Ebola transporters?

Dr. LURIE. Mr. Mica, you sound upset. And I am sorry for that.

Mr. MICA. I am not upset. I am a happy boy.

Dr. LURIE. We will make sure that you get the protocols for cleaning the plane.

Mr. MICA. But I am not happy with, again, you told me you are responsible for preparedness. Now, if that is not your responsibility, is it the new guy's—does he have the ability to go in and make certain that we are prepared? It hasn't hit here yet. But what you want to do is be prepared. The Boy Scouts marching song. Be prepared. We spent millions of dollars, and this inspector general of the United States of America has gone in at our request and looked at what one agency is doing to be prepared, and it is a scathing report we are not prepared.

So you go back to the other guy who didn't show up today, the new czar. We want to work with you. We don't want the American people at risk. We have already been through this, as I said, with bird flu. Are those planes being properly sterilized? Because this can spread. OK? It hasn't spread. We aren't at risk right now. And then the protocols. You give to the committee and put in the record——

Chairman ISSA. The gentleman's time has expired.

Mr. MICA. I want to see the first responders' direction. Then I will put these pictures of the videos from New York disposing of the gloves and the masks.

Chairman ISSA. Without objection, they will be placed in the record.

Mr. MICA. Thank you.

Dr. LURIE. We would be happy to get you those protocols and the protocol for cleaning the plane. And I very much look forward to

working with you and other Members of Congress as we move forward with this.

Mr. MICA. Thank you.

Chairman ISSA. Thank you.

Mr. MICA. I have a plane to catch.

Chairman ISSA. I thank you. And have a safe flight. It will be about your 12th in 4 days.

I am not going to ask a second round of questioning. But I do want to ask just one question, and then we will go to Mr. Cummings for his close.

There was a Statement made just it seems like an eternity ago, but about maybe 15 minutes ago, about following people for 21 days after they land.

Dr. Lurie, currently there is no visa restriction or law that gives you specific authority. Do you believe you have the authority under existing public health laws to force followup daily temperature checks and the like? Let's just assume for a moment we take the gentleman from Florida's analysis that a plane comes in, a person tests—let's just say elevated temperature for a moment—they test positive later or not, for the other people on the plane, do you have the authority then to compel them to go to be tested, or is it just hope for the best that they will recognize a high temperature and report it?

Dr. LURIE. No, I believe that we have the authorities that we need. But you know, we are constantly looking at and updating our policies based on the situation at the time. And so we will continue to look and be sure we have the authorities that we need.

Chairman ISSA. OK. In addition to asking for those protocols, which you have already said you are willing to give us, I am going to direct the committee to, in fact, ask questions of you and other areas and, of course, our new czar as to specific authorities you may have that would support requiring people. There has been a lot of discussion about restrictions on people's travel.

And I agree, quite frankly, with many of the people here that it sounds like a great idea; it's a great sound bite, but then when you actually try to figure out how you would stop somebody from leaving Sierra Leone, going to Paris, spending a day there and then booking a flight here, the practical reality could well be that it would be circumvented.

However, the question of a planeload of people coming in—and I came in today into Washington, DC, I came in with a Marine major. I came in with a Marine major who has a cold and who has many of the symptoms. And he did not go through a check. They are not doing temperatures. If he later reports, the whole question from a public health standpoint of, are we prepared to locate and to mandate surveillance on people so that after the fact, we can accurately do a containment is one that I am directing the committee to ask a series of questions.

And Doctor, your organization obviously would be a part of it.

Dr. LURIE. We would be happy to. Would you give me a moment, since you talked about the guy with a cold, to do a quick educational sound bite?

Chairman ISSA. This will be your closing Statement, Doctor.

Dr. LURIE. Sure. Anybody who has a fever or flu-like symptoms during this season ought to be asked to provide a travel history, to look at whether they have been out of the United States in the past 21 days, and whether they have been in one of the affected countries.

Chairman ISSA. I couldn't agree with you more. And if I get a fever, having been in Iraq, Kuwait, Saudi Arabia, UAE, and, well, additional places, meeting with people, many of whom have traveled to Africa recently, I will be the first to rush to the hospital to report.

With that, we go to the gentleman from Maryland, Mr. Cummings.

Dr. LURIE. We will take care of you.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

First of all, I want to thank all of our witnesses for being here today. And I must tell you that I can understand the emotion of the American people. When there is an issue of life and death, and when you have people who put their lives on the line to take care of the sick, not knowing whether they will become sick themselves, that's serious business. When you have our military going across the sea to try to make a difference, as I always say, change the trajectory of somebody's destiny, and the idea that they may come back with a disease that could possibly kill them, that's serious business.

So, you know, as I listen to you, Mr. Lumpkin, you, Major General, I have absolutely no doubt that you will do everything in your power to protect our military. I have no doubt about that. And I think that if you find that as you go through the procedures that you have in place, if you feel those procedures need to be changed or even tweaked so as you might be more effective and efficient in that goal, you will do that. Is that correct?

Mr. LUMPKIN. That is correct.

Mr. CUMMINGS. And you, Dr. Lurie, I want to thank you for what you are doing.

And one of the things I guess that really concerned me, you know, when I looked at all, Dr. Lurie, and I saw all those health workers, nurses I guess it was, and then I see Ms. Burger sitting next to you, and then I hear about people not being not trained in the hospitals, I think it would be almost legislative malpractice for me not to ask the question—and it may have been asked before when I was out of the room—how do we make sure that those folks receive the training? They are not just running around saying—just complaining to be complaining. They want to be the best. They don't mind—they don't mind putting their lives in danger. But they want to know that everything possible to make sure that they are safe, they want to make sure those things are in place. And I am so glad that Ms. Pham, Nurse Pham, has been found to be Ebola free now. But how do we make sure that they know that?

And Ms. Burger talked about an Executive order, and then the chairman was asking you about, Dr. Lurie, whether you had all the things you need to be able do what you need to do. I just got to ask you when you listen to Ms. Burger—and Ms. Burger, I watched you on television. I know your passion. No, I am serious. I feel it.

It's contagious. And it is strong. And I know you care about the people that you represent. No doubt about it.

So how do we do that, Dr. Lurie? Help me.

Dr. LURIE. Sure. First, let me say, Ms. Burger and I, and probably every nurse in America share the same goal, to keep them safe, to be sure that they are trained, to be sure that if they are front line providers that they have the education, the knowledge, the adequate PPE, the training, and the exercises to stay safe. So I can tell you a little bit about what we have been doing. We have been reaching through the top—we have got a very comprehensive now national education program going on. We have reached through the top for all the hospital associations, through all the hospitals, through the nursing associations. I was on the phone with 10,000 nurses the other night. And there were more that wanted to get on the phone. And we have said to them all, Please, if you are a hospital, conduct a medical and a nursing grand rounds. Do first patient training—do first patient drills and exercises. Make sure that your nurses are trained and your front line nurses have to practice putting on PPE to proficiency. OK. Have policies, plans, and protocols in place, and drill and exercise them.

We have said to the nurses and other front line health professionals, Here is the guidance. Please be sure that the checklists and other things are posted in your places of front line care. Please ask your hospitals and your administrators to be sure there are plans, practices, and policies in place, and that you have the PPE required to do your job.

We have said to State and local health departments, We would like you to call every hospital in your jurisdiction, find out if they put those plans in place, find out if those exercises are in place, find out if that PPE is in place, and report back to us.

And we will continue to be reaching out with material, with training, with education opportunities until we have got this done.

Mr. CUMMINGS. Ms. Burger, this is your moment. This is your moment. Dr. Lurie just talked about—I hope you don't mind, Mr. Chairman, this is important.

Chairman ISSA. Not at all.

Mr. CUMMINGS. Dr. Lurie just talked about what they are going to do and what they are doing. Those ladies that were behind you today, they want to know—some of them left now—but they want to know that they are going to be protected. Now, you heard what she just said. Can you just react? Maybe you might want to give her some advice as to what you all—and I am not trying to be smart, I am serious. This is a critical moment. Go ahead.

Ms. BURGER. The nurses that were here have legislative visits. They are getting fully engaged in this hearing, and they appreciate the opportunity to be here. But—and what I would like to say is that until the CDC guidelines and training and education and personal protective gear at an optimal level are mandatory, no matter how good the guidelines are, no matter how good the intentions are, we need to ask Congress to step up and do what is right for the United States of America and its citizens by making sure the frontline caregivers have mandatory optimal standards for protective gear and training and education.

Mr. CUMMINGS. So there is a gap, Dr. Lurie. Am I right? Based upon what she just said—in other words, you may be saying all these things, but then it's a whole other thing for the hospitals to provide the things that you tell them they need to go and get. Am I right?

Dr. LURIE. I think Ms. Burger and I share the same goal, and I share the same goal, as I said, with most nurses and nursing organizations around the country, and look forward to working with them and moving forward so that we can be sure that nurses across this country, who put themselves on the line of fire every single day with other front line health care providers, are safe.

Mr. CUMMINGS. As I close, I just want to thank you, Mr. Torbay, for your testimony.

And I want to say to all of us, it goes back to we have to address the issue here in America. No doubt about it. But we also have to go back to the source. We have got to do that.

And I think, Mr. Torbay, your testimony about some basic things that are needed, such as food, vehicles, fuel, staff, supplies, resources, things that can be—that will allow us to try to stop this in Africa so that it does not continue to come to our shores is so very, very important. And I just hope that the Congress is listening to you. And I realize that there are—we need more international partners—I think that's what you just told us—people coming in and helping this. Because this does not just affect Africa or the United States, it affects the world. And so I don't know how we convince folks to—that is other countries to do more to get up to that $988 million figure, but we have got to figure out a way to do that. Would you agree? Then I will close. I will close.

Mr. TORBAY. Absolutely. I fully agree with you.

I think the whole world needs to realize that we are all in this fight together and the resources need to be available until we get this virus under control.

And, at the same time, I would like to thank the committee for its leadership on this issue as well as the U.S. Government and its agencies for taking the lead and responding to the Ebola crisis. They have been doing a tremendous job, and we are very proud to be part of it.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. Thank you. I want to thank all of our witnesses here today.

In closing, I am going to make a comparison. And I think it is an important comparison for the American people to put it in perspective.

As was alluded to earlier, I just came back from what has become a theater of operation in Iraq where ISIS now, like an ugly, resilient virus or infection, has shown up again and Islamic terrorism is murdering people far away.

While I was there, there was a murder in Canada. And around the globe, small, but significant, events occur in which we realize that terrorism does not stay in the country that we think it begins in or is predominantly in.

In the war on terror, we rely on the Department of Defense and our U.S. military as our primary way to eliminate that—those actors in faraway places, like Iraq, Afghanistan, and Syria.

We also rely on the Department of Homeland Security to deal with a comparatively small risk, small event, here in the United States, whether it is 9/11, which was horrific, or—and led to its founding, or the occasional lone actor or small group that try to conduct terrorism here in the United States.

It is that teaming of the large effort at the source and, in fact, an equally important effort at home for the relatively isolated cases that come through that seem to be so close to the problem we are facing with Ebola.

Ebola is, in fact, a disease that has periodically reared its ugly head for more than three decades. It will, in fact, until there is a cure, rear its head again. Like many diseases in which a virus, eventually we find a cure. That cure is only good if everyone takes it.

The idea that we are going to find a shot in a country—in a continent of a billion people living mostly in poverty means that, even when we find it, it may, in fact, be there for generations, and like smallpox, tuberculosis, and others, they never seem to be completely gone.

Our effort and the effort that all of you articulated very well today has to be, first of all, in Africa, at the source. There World Health Organizations, USAID and, once again, the United States military have and are taking up the fight against this dreaded disease.

Mr. Roth, your testimony and the testimony that I believe we will have following this that the Department of Homeland Security has an obligation, a unique obligation, one in which they were formed to deal with things which threaten the home front, Ebola and particularly the movement of people who may be infected fall squarely within their jurisdiction, and they seem to have not been prepared.

So, as we conclude here today, it is my view that we will be doing both public and nonpublic investigation in the weeks and months to follow, looking for transparency—and, Dr. Lurie, you said this very well—transparency to the American people. What we tell nurses and doctors and healthcare professionals we need to tell the public.

Because unlike some things where the first responder is, in fact, the greatest threat, the first responder with Ebola is not the first to come in contact with the infected individual.

Almost in every case there will be a cab driver, a bus driver, family, friends, and others who will already have had an unprotected contact by the time a first responder is aware that there may be a problem. By the time that person suits up, he or she already will, in fact, be exposed.

So as we begin looking at the protocols, I think we have to understand one thing: There is no perfect solution. There is no way that every American is going to place themselves in a HazMat suit from morning until night.

To deal with this disease, we will have to go to its source. We will have to work together with our partners around the world to eradicate it in Africa, because, ultimately, like terrorism has been to the American people for more than a decade, this disease will not, in fact, be eradicated if we wait until it comes to our shore.

So I thank you. I believe this was a worthwhile hearing.

I thank Mr. Cummings and the tremendous turnout of members who came back on the eve of their elections for this important hearing.

And, with that, we stand adjourned.

[Whereupon, at 1:34 p.m., the committee was adjourned.]

News Releases

Ebola Update - Statement from Texas Health Dallas

10/16/2014

Statement from Texas Health Presbyterian Hospital Dallas

Texas Health Presbyterian Hospital Dallas is committed to working together with its employees to provide a safe, healthy and satisfying workplace.

In the pursuit of open feedback, Texas Health Dallas has a strict nonretaliation policy. Employees are encouraged to raise issues and concerns via the chain of command. This process is a core tenet of our culture and values. It is documented in our Code of Business Ethics.

Ebola Virus

News and Updates

Get the latest news, answers and resource links.

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In addition, Texas Health Dallas employees have two mechanisms available to anonymously raise issues about safety concerns or related matters. It is important to note that no Texas Health Dallas employee did so concerning their care of Mr. Duncan or our two co-workers.

Third parties who don't know our hospital, our employees and who were not present when the events occurred are seeking to exploit a national crisis by inserting themselves into an already challenging situation. Based on our strong track record of having excellent relationships with our employees, we do not believe it is necessary or helpful for outside parties to intervene in this relationship. Everyone should be focused on supporting each other in our pursuit of learning and continuous improvement that can be applied to hospitals throughout the nation. We are dedicated to providing a wide range of opportunities for employees to give input and influence decision making. From Magnet® designation to multiple Employer of Choice awards, this has long been a recognized strength of our organization.

Many of the comments we have seen or heard in the media are only loosely based on fact, but are often out-of-context and sensationalized. Others are completely inaccurate. We would like to address some of those that have surfaced over the last 24 hours:

- We have conducted interviews with well over 100 caregivers involved in Mr. Duncan's care, some multiple times. The consistent and universal theme we have heard is that all caregivers reported being consistently compliant with utilizing the appropriate PPE in accordance with guidelines from the CDC. The CDC guidelines changed frequently, and those changes were frustrating to them and to management. Nonetheless, they endeavored to remain compliant with what was communicated as the most recent and appropriate guideline.
- When Mr. Duncan returned to the Emergency Department (ED), he arrived via EMS. He was moved directly to a private room with a negative air pressure and placed in isolation. There were no other patients in that room. Again, THD staff wore the appropriate PPE as recommended by CDC at the time.
- The Infection Prevention coordinator was properly notified in a timely manner of the initial diagnosis and followed Dallas County Health and Human Services process of notification, which includes notification of the CDC.
- Mr. Duncan's initial ED specimens were handled in accordance with normal protocol, bagged and sent in a sealed container through the tube delivery system. There was no spillage of Mr. Duncan's specimens.
- Mr. Duncan's later specimens in the ED were triple-bagged, placed in a transport container and hand-carried to the lab utilizing the buddy system.
- Mr. Duncan's specimens in the Medical ICU were hand-carried and sealed per protocol. Routine labs were done in his room via wireless equipment.
- Nurses who interacted with Mr. Duncan wore PPE consistent with CDC guidelines. Staff had shoe covers, face shields were required, and N-95 mask was optional – again, consistent with CDC guidelines at the time. When CDC issued updates, as they did with leg covers, we followed their guidelines.
- When CDC recommended that nurses wear isolation suits, the nurses raised questions and concerns about the fact that the skin on their neck was exposed. Two onsite CDC members approved and recommended that they pinch and tape the necks of the gown. Because our nurses continued to be concerned, particularly about removing the tape, we ordered medical shrouds.
- The CDC classified risk/exposure levels. Nurses who were classified as "no known exposure" or "no risk" were

allowed to treat other patients per CDC guidance.

- Patients who may have been exposed were always housed or isolated per CDC guidance.
- Waste was contained in accordance with CDC standards, and waste was located in safe and containable locations. It is a gross exaggeration to say that trash was stacked up to the ceiling.
- When we received Tyvek suits, some were too large. We have since received smaller sizes, but it is possible that nurses used tape to cinch the suits for a better fit.

It is incorrect and disturbing to many of our staff to hear media exaggerations about their commitment to the organization they love. They are understandably worried and concerned in the eye of this storm, but they are steadfastly supporting their patients, each other, and the hospital they love.

Texas Health Dallas was the first hospital in the United States to receive a patient with undiagnosed Ebola. We have acknowledged that we made mistakes and that we are deeply sorry. Our amazing caregiving team did not hesitate to rise to the challenge despite being in an unprecedented situation.

Texas Health Dallas remains a safe place for employees and patients. We support the tireless and selfless dedication of our nurses and physicians, and we hope these facts clarify inaccuracies recently reported in the media.

Contact:

Wendell Watson, Director
Public Relations
Media Hotline: 800-314-7722

Funding for the HHS Assistant Secretary for Preparedness and Response (ASPR) dollars in millions

FY2007	694
FY2008	633
FY2009	797
FY2010	891
FY2011	913
FY2012	926
FY2013	897
FY2014	1,054
FY2015 req.	1,206
FY2015 Senate	1,198

Sources: Annual HHS Budget in Brief documents, www.hhs.gov/budget; and Senate Labor/HHS/ED Appropriations Subcommittee, FY2015 draft report, page 172.

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http://online.wsj.com/articles/tommy-g-thompson-theres-plenty-of-money-to-fight-ebola-1414106735

OPINION

There's Plenty of Money to Fight Ebola

Thanks to spending since 9/11, public health resources and expertise have never been better.

By **TOMMY G. THOMPSON**
Oct. 23, 2014 7:25 p.m. ET

The emergence of Ebola cases in the U.S. has put America's public-health preparedness under a spotlight. Disturbingly, election-year politics are leading some to point fingers at Republicans in Congress about the level of funding to fight the disease, alleging that budget cuts have hamstrung the federal Centers for Disease Control and Prevention in its response. This displays a fundamental lack of understanding about the recent history of public-health funding.

While there are undoubtedly areas in need of improvement, the U.S. is better prepared to respond to a public-health emergency than at any time in its history, thanks to investments made in the aftermath of 9/11 and the anthrax attacks a month later.

Those investments, supported by both parties, placed us light years ahead of where we were 15 years ago, when state and federal governments, public-health officials and hospitals were genuinely ill-prepared to handle mass casualty events, bioterror attacks or naturally occurring infectious-disease outbreaks.

In 2001 the federal government spent $300 million on these public-health preparedness programs. In the four years after 9/11 it spent $14.8 billion to rebuild the nation's public-health infrastructure. This money included unprecedented investments in state public-health programs, infectious-disease research, food-safety, and the purchase of medicines and vaccines in bulk.

Recognizing the need for a strong local response, the Department of Health and Human

Services alone sent more than $4.3 billion over three years (2002-04) to hospitals, states and cities to strengthen their ability to respond to any public-health emergency, including infectious-disease outbreaks and natural disasters.

GETTY IMAGES

The federal government also ramped up biodefense medical research and badly needed laboratory construction at the National Institutes of Health. We funded research and construction at $1.5 billion a year in fiscal year 2003 and 2004, 30 times the level of fiscal year 2001. NIH researchers used this money to develop new and improved treatments and vaccines against smallpox, anthrax and—for the first time—research on Ebola, among other infectious diseases.

These significant investments have continued—albeit at relatively flat levels after the initial surge to build the infrastructure that gave the public-health officials the tools they needed on the front lines in emergencies. The investments paid off as the public-health system successfully managed SARS, avian flu, Middle East respiratory syndrome and emergencies following Hurricane Sandy, Rita and other natural disasters.

The CDC, as its leaders have acknowledged, made some early mistakes in its response to Ebola. These included the agency's failure to immediately send a team to Texas Health Presbyterian Hospital in Dallas to support the local response to the first Ebola patient there, and poorly managing the response when two nurses contracted the disease. This led to a sense of disorder and President Obama 's appointment last week of a so-called Ebola czar, longtime Democratic aide Ron Klain, to coordinate the response to this disease.

Yet the CDC and its partner agencies in the federal government have successfully managed at least five major public-health emergencies over the past 13 years. Why wasn't the administration prepared to manage this one?

Some Democrats believe the problem is a lack of funding—and are quick to blame Republicans for the alleged shortfall. This is absurd. The Obama administration has sought budget cuts of tens of millions of dollars for the CDC's state and local preparedness in each of its last four budget requests. Each time, Congress denied those requests and approved more funding.

Spending on research and public health—while below the peak years after 9/11—are far higher than at any time in U.S. history. Significant resources continue to be allocated to

state health departments, hospitals and research. U.S. public-health officials now have better facilities, better equipment and have more expertise available than ever.

With isolated Ebola cases in the U.S., our government and public-health officials must ensure that they are communicating calmly and clearly and using the resources they have as effectively and prudently as possible. Above all, they must make sure that federal, state and local governments and hospitals are prepared to respond immediately in the event of an outbreak.

Mr. Thompson, the former governor of Wisconsin, was U.S. Health and Human Services secretary from 2001-05.

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FY2014 HHS Appropriations Overview

The FY2014 omnibus provided roughly $621 billion in combined mandatory and discretionary funding for HHS. This is about $22 million (+3.6%) more than the FY2013 post-sequester funding level and $2 million (-0.3%) less than the FY2014 request. (See **Table 5**.) Of the total provided for HHS in the FY2014 omnibus, roughly $70 billion (11%) is discretionary. This is $4 million (+6.1%) more than the post-sequester FY2013 discretionary funding level and $2 million (-2.9%) less than the discretionary amount requested in the FY2014 President's Budget.

Table 5. HHS Appropriations Overview
(dollars in billions)

Funding	FY2013 Enacted (pre-sequester, post-0.2% ATB)	FY2013 Operating (post-sequester, post-0.2% ATB, post-transfers & reprogramming)	FY2014 Request	FY2014 Senate Cmte. (S. 1284)	FY2014 Enacted (P.L. 113-76)
Discretionary	69.90	66.41	72.50	74.66	70.44
Mandatory	533.06	532.95	550.64	551.15	550.64
Total BA in the Bill	**602.96**	**599.36**	**623.14**	**625.81**	**621.08**

Source: CRS amounts for FY2013 enacted and the FY2014 Senate committee-reported bill (S. 1284) were estimated based on data provided in S.Rept. 113-71, the committee report accompanying S. 1284. FY2013 operating levels were largely estimated based on FY2013 operating plans for HHS agencies, which are available at http://www.hhs.gov/budget/fy2013/index.html (scroll to bottom for FY2013 Agency Operating Plans). Operating estimates reflect reductions required as a result of the FY2013 sequester, as well as any transfers and reprogramming of funds reported by HHS in these operating plans. Amounts for the FY2014 President's request and the FY2014 omnibus (P.L. 113-76) were estimated based on the Joint Explanatory Statement accompanying the FY2014 omnibus. For consistency with source materials, the FY2014 enacted levels do not reflect sequestration for nonexempt mandatory spending programs, where applicable.

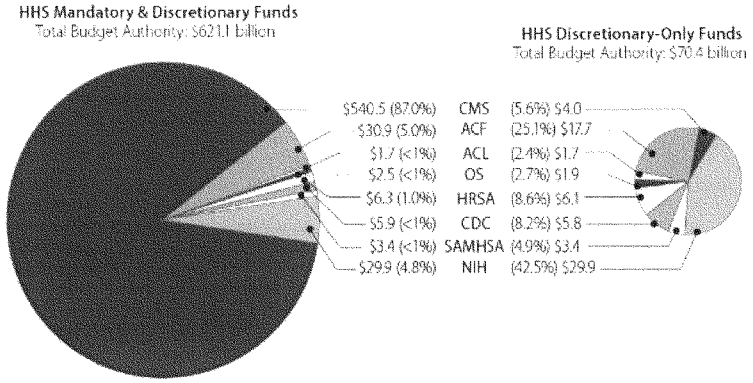
Notes: BA = Budget Authority. ATB = across-the-board rescission. Cmte = Committee. Details may not add due to rounding. Amounts in this table: (1) reflect all BA appropriated in the bill, regardless of the year in which funds become available (i.e., totals do not include advances from prior year appropriations, but do include advances for subsequent years provided in this bill); (2) have generally not been adjusted to reflect scorekeeping; (3) comprise only those funds provided (or requested) for agencies and accounts subject to the jurisdiction of the Labor, HHS, Education Subcommittee of the House and Senate Committees on Appropriations; and (4) do not include direct appropriations that occur outside of appropriations bills. FY2013 totals do not include supplemental funds provided by the Disaster Relief Appropriations Act, 2013 (P.L. 113-2).

Annual HHS appropriations are dominated by mandatory funding, the majority of which goes to CMS to provide Medicaid benefits and payments to health care trust funds. When taking into account both mandatory and discretionary funding, CMS accounted for roughly 87% of all HHS appropriations in FY2013 and FY2014. NIH and ACF account for the next largest shares of total HHS appropriations, receiving 5% apiece of total HHS appropriations in FY2013 and FY2014.

By contrast, when looking exclusively at discretionary appropriations, CMS constituted only 6% of discretionary HHS appropriations in FY2013 and FY2014. Instead, the bulk of discretionary appropriations go toward the PHS agencies, which combined to account for over 60% of discretionary HHS appropriations in FY2013 and FY2014. NIH typically receives the largest share of all discretionary funding among HHS agencies (over 40% in FY2013 and FY2014), with ACF accounting for the second-largest share of all discretionary appropriations (24% in FY2013 and 25% in FY2014).

See **Figure 3** for an agency-level breakdown of HHS appropriations (combined mandatory and discretionary) in the FY2014 omnibus.

Figure 3. FY2014 HHS Appropriations in P.L. 113-76 by Agency



Source: CRS amounts are estimated based on data provided in the Joint Explanatory Statement accompanying the FY2014 omnibus (P.L. 113-76). For consistency with source materials, the FY2014 enacted levels do not reflect sequestration for nonexempt mandatory spending programs, where applicable, or any transfers or reprogramming of funds that may have occurred pursuant to executive authorities.

Notes: BA = Budget Authority. Details may not add due to rounding. Amounts in this figure: (1) reflect all BA appropriated in the bill, regardless of the year in which funds become available (i.e., totals do not include advances from prior year appropriations, but do include advances for subsequent years provided in this bill); (2) have generally not been adjusted to reflect scorekeeping; (3) comprise only those funds proposed for agencies and accounts subject to the jurisdiction of the Labor, HHS, Education Subcommittee of the Senate Committees on Appropriations; and (4) do not include direct appropriations that occur outside of appropriations bills.

Selected HHS Highlights from FY2014 Appropriations Actions

This section discusses several important aspects of discretionary HHS appropriations. First, it provides an introduction to two special funding mechanisms included in the public health budget, the Public Health Service Evaluation Set-Aside and the Prevention and Public Health Fund. Next, it reviews a limited selection of FY2014 discretionary funding highlights across HHS. Finally, the section concludes with a brief overview of significant provisions from annual HHS appropriations laws that restrict spending in certain controversial areas, such as abortion and stem cell research.

Public Health Service Evaluation Tap

The Public Health Service (PHS) Evaluation Set-Aside, also known as the PHS Evaluation Tap, is a unique feature of HHS appropriations.[20] The Evaluation Tap, which is authorized by Section 241 of the PHS Act, allows the Secretary of HHS, with the approval of appropriators, to redistribute a portion of eligible PHS agency appropriations across HHS for program evaluation purposes. The PHS Act limits the set-aside to 1% of eligible program appropriations. However, in recent years, L-HHS-ED appropriations laws have established a higher maximum percentage for the set-aside and have distributed specific amounts of "tap" funding to selected HHS programs. The tap provides more than a dozen HHS programs with funding beyond their regular appropriations and, in some cases, the tap may be the sole source of funding for a program or activity. The FY2014 omnibus maintained the set-aside level at 2.5% of eligible appropriations, the same percentage as FY2013. The omnibus rejected the FY2014 President's Budget proposal to increase the set-aside to 3.0%.

Prevention and Public Health Fund[21]

The Patient Protection and Affordable Care Act (ACA) authorized and directly appropriated funding for three multi-billion dollar trust funds to support programs and activities within the PHS agencies.[22] One of

these, the Prevention and Public Health Fund (PPHF, ACA Section 4002, as amended), is intended to provide support each year to prevention, wellness, and related public health programs funded through HHS accounts. For FY2014, the ACA directly appropriated $1.5 billion in mandatory funds to the PPHF. However, Congress subsequently passed the Middle Class Tax Relief and Job Creation Act of 2012, which reduced ACA's annual appropriations to the PPHF over the period FY2013-FY2021 by a total of $6.25 billion.[23] This reduced the FY2014 PPHF appropriation to $1 billion.

PPHF funds are intended to supplement, sometimes quite substantially, the funding that selected programs receive through regular appropriations, as well as to fund new programs, particularly programs newly authorized in ACA. Congress may direct the Secretary to allocate PPHF funds to specific accounts. Otherwise, PPHF funds become available to the Secretary on October 1 of each year, for allocation as the Secretary decides. The FY2014 President's Budget included the Administration's proposed distribution of PPHF funds. The Joint Explanatory Statement accompanying the FY2014 omnibus recommended PPHF allocations that would, similar to prior years, distribute most of the funds to CDC, including $160 million for Immunization and Respiratory Diseases and $446 million for Chronic Disease Prevention and Health Promotion.

The Washington Post

Opinions

Beating Ebola through a national plan

By John T. Fox

John T. Fox is president and chief executive of Emory Healthcare in Atlanta.

The appointment of Ebola czar Ron Klain is an important initial step in mobilizing a coordinated national effort to confront this deadly virus.

As the first U.S. hospital to successfully treat Ebola patients, Emory University Hospital has a unique perspective on the scope of the effort and skill required to care for such patients while also protecting the staff and public. One key lesson learned has been that training and strictly following protocol are paramount. Although that may sound simple, it takes an enormous amount of dedication, resources and planning.

The staff at Emory Healthcare is committed to sharing our knowledge with the Centers for Disease Control and Prevention, as well as hospitals around the world, including through a new Web site listing our protocols. Sharing information in this way is critical, but it will not be enough. The new czar and other officials must create a long-term local, regional and national strategy to tackle not only Ebola, but also other life-threatening infectious diseases that we will face in the future.

This is not a time for finger-pointing. We need to grasp this opportunity to put a system in place that can serve as a model moving forward. The existence of four specially designed isolation units, including Emory's, has helped buy some time, but we are operating with a razor-thin margin. Even a modest surge of 10 to 20 patients would strain the capacity of these centers. The U.S. health-care system has the

resources and talent to deal with a larger challenge, but it must move immediately to build a truly scalable model.

The federal government should create a national medical infrastructure. We can start by establishing several National Ebola Support Centers, beginning with ones at Emory, Nebraska Medical Center and the National Institutes of Health, to serve as clinical training bases for other hospitals around the country.

At the same time, we need to:

• Require every major metropolitan area to help prepare its two or three largest health-care systems to care for Ebola-infected patients and give them the needed resources and training. These regional care centers must have significant sub-specialty support capabilities, including critical care expertise and capacity, particularly for nursing. Appropriate training must be provided to establish a culture of safety.

• Require all U.S. hospitals to undergo a prescribed level of preparedness based on their size, location and other factors. Establishing a common approach to classification of patients potentially at risk will help immensely in treating and controlling Ebola, as well as in preparing for future outbreaks of other infectious diseases.

• Establish regional and national standards and mechanisms for coordination of transportation services, supply distribution, specimen handling and waste management. The logistics involved in safely caring for patients with Ebola are extraordinary and must be a priority for any health-care system.

These measures sound daunting — and they are. But our national experience with Ebola has revealed vulnerabilities in our public health preparedness that must be addressed. Getting this right will serve us well into the future.

We cannot be a country ruled by fear. We must care for those in need. But a few hospitals cannot combat this public health threat alone. We need government leadership to provide the resources necessary to implement a coordinated, scalable national plan. It can be done.

Read more on this topic:

The Post's View: Missteps in handling Ebola in the U.S. can't be repeated

The Post's View: Ebola outbreak suggests a faster response is needed

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Association of American Physicians and Surgeons, Inc.
A Voice for Private Physicians Since 1943
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STATEMENT
of the
ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS

Submitted by Jane Orient, M.D.
October 24th, 2014

Mr. Chairman and Members of the Committee:

My name is Jane Orient, M.D. I am a practicing internist from Tucson, Arizona, and serve as the Executive Director of the Association of American Physicians & Surgeons ("AAPS").

AAPS is a nationwide organization of physicians devoted to defending the sanctity of the patient-physician relationship. AAPS revenue is derived almost exclusively from membership dues. We receive no government funding, foundation grants, or revenue from suppliers of pharmaceuticals, vaccines, medical devices, computer hardware or software, compliance materials, or other commercial products.

During the recent surge of illegal aliens across our Southern border citizens and local officials were not receiving adequate information from federal agencies, and Border Patrol officers and medical personnel were reportedly threatened with firing or even arrest if they spoke out.

Whistleblowers must be protected. But, more importantly government must be accountable for their decisions.

Now Ebola, already declared to be a Public Health Emergency of International Concern (PHEIC) on August, 8th by the World Health Organization (WHO), has spread to at least one patient on American soil.

What has the Administration done about the outbreak? Dismiss, defend, deter, and deflect.

The U.S. Centers for Disease Control and Prevention (CDC) has stated that a widespread outbreak in the U.S. is highly unlikely because of our sophisticated medical and public health infrastructure. And, multiple members of the Administration as well as other politicians have made public statements that there is 0% chance of contracting Ebola. However, the system is only as strong as its weakest link, and violation of basic precautions necessitated the monitoring of dozens of contacts of just one patient in Dallas who entered by air from Liberia.

Now, two of his caretakers have already been diagnosed with Ebola and they were wearing full protective garments and understood that they were in an infectious situation, and we are starting see even more additional cases.

Basic public health principles dictate that epidemics need to be contained at the source. Even a "small outbreak" of Ebola would be extremely costly in lives and treasure.

Hemorrhagic fever viruses such as Ebola have been widely discussed as a biological weapon. Deliberate introduction of such a weapon, whether in a warhead or a human vector, would be an act of war and a crime against humanity. Protection of our population is a matter of national security.

In addition to the Ebola threat, thousands of American children have been sickened, a few have died, and some have been paralyzed, probably permanently, because of enterovirus D-68. The CDC has been silent about the source of this epidemic. It is speculated that it could be from sending tens of thousands of children from an endemic region to American schools.

Since the primary role of the federal government is to protect the citizenry, AAPS calls for congressional hearings and consideration of legislation to:

- Require persons entering the U.S. from West Africa or other areas reporting Ebola to undergo a 25-day period of quarantine;
- Require that all illegal entrants undergo an adequate period of quarantine with screening to assure freedom from tuberculosis, infestation with scabies or lice or other ectoparasites, or other communicable diseases;
- Protect whistleblowers who report potential public health threats;
- Assure that timely and accurate information is reported to the public and medical facilities about the existence of threats and effective precautions.

I urge the Committee to consider the public health questions and pursue more answers and immediate action by the Administration. I also urge the Committee to pursue more answers and explanations about the Administration's continued efforts to distort the truth for their own self-interest which is also in opposition to what is best for the public's health. I look forward to working with the Committee as this urgent issue develops.

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