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WORKING THROUGH AN OUTBREAK: PANDEMIC FLU PLANNING AND CONTINUITY OF OPERATIONS

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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WORKING THROUGH AN OUTBREAK: PANDEMIC FLU PLANNING AND CONTINUITY OF OPERATIONS

THURSDAY, MAY 11, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10:10 a.m., in room 2154, Rayburn House Office Building, Hon. Tom Davis (chairman of the committee) presiding.

Present: Representatives Tom Davis, Shays, Platts, Duncan, Issa, Foxx, Schmidt, Waxman, Cummings, Kucinich, Davis of Illinois, Watson, Lynch, Van Hollen, Ruppersberger, and Norton.

Staff present: David Marin, staff director; Lawrence Halloran, deputy staff director; Ellen Brown, legislative director and senior policy counsel; Jennifer Safavian, chief counsel for oversight and investigations; Patrick Lyden, parliamentarian; John Hunter, counsel; Chas Phillips, policy counsel, Rob White, communications director; Andrea LeBlanc, deputy director of communications; Susie Schulte, professional staff member; Teresa Austin, chief clerk; Sarah D'Orsie, deputy clerk; Allyson Blandford, office manager; Leneal Scott, computer systems manager; Karen Lightfoot, minority communications director/senior policy advisor; Robin Appleberry and Sarah Despres, minority counsels; Richard Butcher and Tania Shand, minority professional staff members; Earley Green, minority chief clerk; and Jean Gosa, minority assistant clerk.

Chairman TOM DAVIS. Good morning. The committee will come to order.

We are going to have two very distinguished panels of witnesses here today to discuss what health experts describe as one of the largest dangers facing our Nation—the threat of pandemic flu.

We don't know when or where the next pandemic will strike. We don't know what strain of influenza will be the culprit, although much evidence points to the avian flu. The virulent H5N1 strain has already caused 115 deaths in Southeast Asia, China, and the Middle East. Nor do we know if avian flu will turn out to be more like swine flu, a pandemic that never materialized.

But regardless, we need to improve our readiness because we can be sure that the next flu pandemic is a matter of when, not if. And when that time does come, the stakes will be enormous.

Experts have projected that more than half a million Americans could die. Over 2 million could be hospitalized. Forty percent of the

work force would be unable to report to work in the event of a U.S. pandemic flu outbreak.

It is our responsibility to make sure America is prepared, not just prepared to address the massive health implications of a pandemic, but prepared for the enormous economic and societal disruptions as well. Beyond efforts to protect human health, Government agencies and private sector businesses must have the ability to maintain essential functions through an outbreak. Recent natural disasters and terrorist attacks raise questions about how the Federal Government will continue to operate during emergencies.

Last week, President Bush released the administration's Implementation Plan for its National Strategy for Pandemic Influenza. The plan designates the National Response Plan [NRP], as the primary mechanism to coordinate the Federal Government's response. Under the NRP, the Department of Homeland Security is the lead agency to coordinate all Federal activities.

As seen during Hurricane Katrina, the NRP can be ambiguous, and individual authorities among agencies are not clearly identified. It is the committee's hope that lessons learned from Katrina are being applied to any deficiencies in the NRP so the country is more readily prepared for future disasters.

A key part of the Government's implementation plan is its emphasis on telework to ensure essential Government operations can continue during a pandemic, when it may not be possible or advisable for employees to report to work and be in close quarters. Much to my frustration, the Federal Government has long lagged behind the private sector in promoting telework, despite the traffic, energy, cost, productivity, and employee morale benefits it can provide.

I was pleased to see the pandemic implementation plan requires the Office of Personnel Management to develop guidance for Federal departments on continuity of operations planning criteria and telework to provide instructions for alternative workplace options during a pandemic.

This is an important step forward, and I am hopeful the pandemic implementation plan will spur the Government to take serious strides in getting more employees to become teleworkers. I am also hopeful that this will help the Federal Government address several inadequacies in the COOP planning including—we call it the COOP planning—including deficient guidance to identify essential functions and ensure continued delivery of services during a crisis.

The Government's implementation plan also acknowledges the limits of the Federal Government while highlighting the importance of preparedness by individuals, communities, and the private sector. I think all of us here today agree that our State and local health officials will be on the front lines of pandemic response. It is our job to provide them with the adequate support and essential guidance they need to effectively prepare for and respond to a pandemic.

Our experience with last year's hurricane season is a sad reminder of the need for State and local authorities to be prepared for anything. Disasters or pandemics don't happen according to

plan. Response requires agility, flexibility, and a willingness by leaders to take action when needed.

We have many important issues today to discuss within the context of pandemic flu. I look forward to a constructive dialog with our witnesses on these life-and-death issues.

[The prepared statement of Chairman Tom Davis follows:]

Chairman Tom Davis
Opening Statement
"Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations"
May 11, 2006

Good morning. Today, we have two very distinguished panels of witnesses here to discuss what health experts describe as one of the largest dangers facing our nation: the threat of pandemic flu.

We do not know when, or where, the next pandemic will strike. We do not know what strain of influenza will be the culprit – although much evidence points to avian flu. The virulent H5N1 strain has already caused 115 deaths in Southeast Asia, China, and the Middle East. Nor do we know if avian flu will turn out to be more like the swine flu – a pandemic that never materialized.

Regardless, we need to improve our readiness – because we can be sure that the next flu pandemic is a matter of when, not if. And when that time does come, the stakes will be enormous. Experts have projected that more than half a million Americans could die, over two million could be hospitalized, and 40 percent of the workforce would be unable to report to work in the event of a U.S. pandemic flu outbreak.

It is our responsibility to make sure America is prepared – not just prepared to address the massive public health implications of a pandemic, but prepared for the enormous economic and societal disruptions as well. Beyond efforts to protect human health, government agencies and private sector businesses must have the ability to maintain essential functions through an outbreak. Recent natural disasters and terrorist attacks raise questions about how the federal government will continue to operate during emergencies.

Last week, President Bush released the Administration's Implementation Plan for its National Strategy for Pandemic Influenza. The plan designates the National Response Plan (NRP) as the primary mechanism to coordinate the federal government's response. Under the NRP, the Department of Homeland Security is the lead agency to coordinate all federal activities. As seen during Hurricane Katrina, the NRP can be ambiguous, and individual authorities among agencies are not clearly defined. It is the Committee's hope that lessons learned from Katrina are being applied to any deficiencies in the NRP so the country is more readily prepared for future disasters.

A key part of the government's implementation plan is its emphasis on telework to ensure essential government operations can continue during a pandemic, when it may not be possible or advisable for employees to report to work and be in close quarters. Much to my frustration, the federal government has long lagged behind the private sector in promoting telework—despite the traffic, energy, cost, productivity, and employee morale benefits it can provide. I was pleased to see the pandemic implementation plan

require the Office of Personnel Management to develop guidance for federal departments on continuity of operations (COOP) planning criteria and telework to provide instructions for alternative workplace options during a pandemic.

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Our experience with last year's hurricane season is a sad reminder of the need for state and local authorities to be prepared for anything. Disasters, or pandemics, don't happen according to plan. Response requires agility, flexibility, and a willingness by leaders to take action when needed.

We have many important issues today to discuss within the context of pandemic flu. I look forward to a constructive dialogue with our witnesses on this life-and-death issue.

Chairman TOM DAVIS. And I would now recognize the distinguished ranking member, Mr. Waxman, for his opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman, for holding this hearing, and thank you for your leadership on this important issue.

Experts tell us there will be another influenza pandemic. We don't know if it is going to be the avian flu or not, but pandemics happen every so often. They also tell us that the Nation is not prepared to confront this threat. There are multiple holes in our capacity to respond.

We need to increase our vaccine production capacity, strengthen our public health infrastructure, create adequate hospital surge capacity, and draft contingency plans that will ensure the continued operation of important Government functions.

Because we do not know when or how severe the next pandemic that will strike us will be, we don't have the luxury of time. We need to act quickly and move beyond the planning stage to the implementation stage.

The administration has taken some important steps. In particular, they have produced several planning documents. But this is not enough, and some of their actions have actually been counterproductive.

According to the President's pandemic preparedness plan, the burden of responding to a flu pandemic will largely fall on State and local governments. Yet the President's fiscal year 2000 (sic) budget cuts more than $200 million from the public health programs at the Centers for Disease Control and Prevention that fund State and local training and preparedness efforts.

Pandemic preparedness also requires a clear and coherent leadership structure that is capable of responding in an emergency. Unfortunately, the President's implementation plan, which was released last week, creates divided authority. It would establish the same type of structure that led to the tragic confusion and delay in the response to Hurricane Katrina.

Under the President's plan, HHS is in charge of the medical response, but DHS is in charge of the overall response. There is no clear delineation of how that will work or who will have final authority over medical operations. This approach ignores the adage that when everyone is in charge, no one is in charge.

A related weakness is that the core Federal medical asset, the National Disaster Medical System, is currently a part of DHS. To lead a medical response, therefore, HHS has to rely on personnel, supplies, equipment, and communications systems that are actually controlled by the Department of Homeland Security. Well, this is the same arrangement—medical assets separated from those charged with leading the medical response—that was a major factor in the chaos after Hurricane Katrina.

According to the administration officials, there is a plan to move the National Disaster Medical System out of DHS to HHS. But these plans are not imminent. We cannot afford to wait until next year to be ready with a medical response.

Preparing for a flu pandemic will not be easy, and the Federal plans will change as we learn more about the threat and the best means of response. But the Nation has a right to expect that the

Federal Government will not repeat its mistakes, which is what it seems intent on doing.

One important part of the Federal response is ensuring continuity of operations, and I would like to thank Representative Danny Davis for his leadership in this area. Today, he will introduce legislation that would require the Federal Government to establish a demonstration project to test and evaluate telework from alternate work sites, including from employees' homes.

This demonstration project will be important for our understanding of the effectiveness of telework and will give us an opportunity to identify and fix problems that arise.

I want to thank the witnesses for coming today, and I look forward to your testimony.

[The prepared statement of Hon. Henry A. Waxman follows:]

Statement of Rep. Henry A. Waxman, Ranking Minority Member
Committee on Government Reform
Hearing on
"Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations"

May 11, 2006

Mr. Chairman, thank you for holding this hearing today and thank you for your leadership on this important issue.

Experts tell us that there will be another influenza pandemic. And they also tell us that the nation is not prepared to confront this threat.

There are multiple holes in our capacity to respond. We need to increase our vaccine production capacity … strengthen our public health infrastructure … create adequate hospital surge capacity … and draft contingency plans that will ensure the continued operations of important government functions.

Because we do not know when the next pandemic will strike, we do not have the luxury of time. We need to act quickly and move beyond the planning stage to the implementation stage.

The Administration has taken some important steps. In particular, they have produced several planning documents. But this is not enough. And some of their actions have actually been counterproductive.

According to the President's pandemic preparedness plan, the burden of responding to a flu pandemic will fall largely on state and local governments. Yet the President's FY 2007 budget cuts more than $200 million from the public health programs at the Centers for Disease Control and Prevention that fund state and local training and preparedness efforts.

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A related weakness is that the core federal medical asset – the National Disaster Medical System – is currently a part of DHS. To lead a medical response, therefore, HHS has to rely on personnel, supplies, equipment, and communications systems that are actually controlled by DHS.

This same arrangement – medical assets separated from those charged with leading the medical response – was a major factor in the chaos after Hurricane Katrina. Officials at HHS had no idea where disaster medical teams had been deployed; teams on the ground could not obtain critical medical supplies; and victims of the hurricane waited hours or days for treatment while trained medical personnel waited for an assignment.

According to Administration officials, there is a plan to move the National Disaster Medical System out of DHS to HHS. But these plans are not imminent. We cannot afford to wait until next year to be ready with a medical response.

Preparing for a flu pandemic will not be easy, and the federal plans will change as we learn more about the threat and the best means of response. But the nation has a right to expect that the federal

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I thank the witnesses for coming today and I look forward to your testimony.

Chairman TOM DAVIS. Thank you, Mr. Waxman.

Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

Mr. Chairman, one, thank you for having this hearing. In this same room—and it is very eerie because I look around, and I don't see any TV media here. We are talking about one of the biggest issues, in my judgment, facing our country. Not unlike a hearing, I had a few years ago where a doctor of a major medical magazine said his biggest fear was that a small group of scientists would create an altered biological agent that would wipe out humanity as we know it.

If we know that influenza killed approximately 30,000 to 50,000 persons a year in the United States and 1 million to 3 million Nation (sic) wide when you don't have a pandemic, and when we realize that we have had 10 pandemics in the last 300 years—the one most severe in 1919, when our population was one third the size worldwide, and we lost 50 million to 100 million people—it should get our attention. And it is getting the attention of this committee, and it is getting the attention of some in Government.

But I think what we are going to find is that we need a much more unified effort to make sure that we minimize the deaths we know will occur. And I just salute you and others who are working on this. This is a very, very important hearing we are having today, and the work of the people that are appearing before us can't be measured lightly.

Chairman TOM DAVIS. Thank you very much.

Any other Members wish to make opening statements?

Ms. WATSON. Mr. Chairman.

Chairman TOM DAVIS. Yes, ma'am? The gentlelady from California.

Ms. WATSON. I, too, want to thank you for this hearing.

Biological preparedness is considered crucial in the current world climate. Our Government has no control over a natural phenomena that will threaten citizens every year. But the Government Reform Committee has an important public service to perform in regard to preparedness for a flu pandemic.

Flu pandemic has the ability to cause death in catastrophic proportions. On one hand, Government should not place the public into a state of fear. But on the other hand, Government should educate the public and have a clear plan for action in case of an outbreak.

Do we have a plan in place? Has this administration and Congress fully funded the resulting solution? Do we have the domestic manufacturing capability to cover the needs of the United States during a crisis?

Only one of the two FDA-approved flu vaccine manufacturers in America, and Chevron Corp. does not have a production facility located on the U.S.-controlled soil.

Mr. Chairman, the administration's May 3, 2006, Implementation for the National Strategy for Pandemic Influenza leaves too many concerns. The complete breakdown of DHS leadership, responsiveness, and accountability during the Hurricane Katrina places congressional oversight into question if we allowed a similar structure to be approved. "Fool me once, shame on you. But fool me

twice"—we are approaching a hurricane season again. Is the DHS structure equipped to handle the elemental fury of mother nature again—are we prepared—much less at the same time as her biological scorn?

So, Mr. Chairman, I am looking forward to today's testimony and the positive solutions that our witnesses can provide. The President has requested $7.1 billion, and the Congress appropriated $3.8 billion in the DOD appropriations act. Is the funding sufficient?

I am interested to hear the panel's assessment of the Danny Davis legislation, the Continuity of Operations Demonstration Project Act. We need a much better system in place to accommodate a flu pandemic or a large natural disaster situation.

So let us put a plan in place that answers the questions and not creates them. I yield back the balance of my time.

Chairman TOM DAVIS. Thank you very much.

Members will have 7 days to submit opening statements for the record.

Mr. Davis, do you want to say anything?

Mr. DAVIS OF ILLINOIS. Yes. Thank you very much. Thank you, Mr. Chairman.

I want to thank you and Ranking Member Waxman for calling this hearing and for your leadership of the Government Reform Committee.

In the late 1990's, the Government Reform and Education and the Workforce Committees held oversight hearings to examine the barriers to telecommuting and the development and promotion of telework programs by Federal agencies.

It was then thought that the primary benefits of telecommuting were a reduction in traffic congestion and pollution, improvements to the recruitment and retention of employees, a reduction in the need for office space, increased worker productivity, and improvements to the quality of life and morale of Federal employees.

These benefits continue to be compelling and valid reasons for implementing agency-wide telework programs. Representative Frank Wolf is to be commended for continuously pushing agencies to increase the number of Federal employees who telecommute.

However, with the Oklahoma City bombing, September 11th, Hurricane Katrina, and now the possibility of a pandemic, we have other very compelling reasons to push Federal agencies and ourselves to develop and to implement the infrastructure and work processes necessary to support telecommuting.

Federal agencies must be able to continue operations during an emergency. The question we must ask ourselves is this. In the event of an emergency, are we—this committee, our staffs, and all of the Federal agencies—prepared to serve the American people if our primary places of work are no longer available to us?

In conjunction with this hearing, the Government Accountability Office [GAO], will issue a report entitled "Continuity of Operations." Selected agencies could improve planning for use of alternate facilities and telework descriptions. From the population of alternate facilities, GAO selected six to evaluate for compliance with Federal Preparedness Circular [FPC] 65 guidance.

The report, which was requested by Chairman Tom Davis, found that most of the agencies' documented plans and procedures related

to alternate facilities included site preparation and activation plans. However, none of the agencies had conducted all of the applicable tests and exercises required by FPC 65, including annual exercises that incorporate deliberate and pre-planned movement of COOP personnel to an alternate facility.

Further, agencies did not fully identify the levels of resources necessary to support essential functions, thereby creating the lack of assurance that facilities are adequately prepared.

Today, I will introduce legislation that will push agencies to address the contingency planning failures detailed in GAO's reports. The legislation, a modified version of H.R. 4797, which I introduced in the 108th Congress, would require the chief human capital officer to conduct and to evaluate a 10-day demonstration project that broadly uses employees' contributions to an agency's operations from alternate work locations, including home.

The outcome of the demonstration project would provide agencies and Congress with approaches to gaining flexibility and to identifying work processes that should be addressed during an extended emergency. The number and types of potential emergency interruptions are unknown, and we must be prepared in advance of an incident with the work processes and infrastructures needed to establish agency operations.

In a world where anything is possible, we must be prepared for all of the possibilities, and I trust that Chairman Davis will join with Ranking Member Waxman and others to co-sponsor this bill.

And I thank you, Mr. Chairman, and yield back the balance of my time.

Chairman TOM DAVIS. Thank you. Well, I probably will.

We have a vote on. I have sent Mr. Shays over to vote so he can come back. And when he comes back, hopefully, we can keep this moving because I know we have some time constraints on some of our witnesses.

Anybody else need to make an opening statement? Mr. Kucinich.

Mr. KUCINICH. I thank the gentleman.

"You are on your own." That has been the credo for the administration's approach to health care, and it summarizes their approach to avian flu. The implementation plan gives a little guidance to State and local governments and businesses and then wishes them luck.

First, there is the leadership vacuum. The plan calls for HHS to coordinate the medical response, but calls for Homeland Security to coordinate Federal operations and resources.

A bipartisan report out of the Senate released in April found that the department has lagged in fixing the problems that plagued its atrocious response to Hurricane Katrina. It found that major structural reforms were necessary and that little has changed in the department so far.

So how can we expect Homeland Security to adopt a similar motto to the one they adopted last summer? The point is we can expect them to adopt that motto. "You are on your own."

What is more is that the plan has been called "the mother of all unfunded mandates." While $7.1 billion for avian flu preparedness is a step in the right direction, it is simply not enough. Dr. Irwin Redlener, director of the National Center for Disaster Preparedness

at Columbia University's Mailman School of Public Health, called the budget "completely unrealistic."

A big part of the reason it is insufficient is that it has to make up for years of steady erosion of the public health infrastructure due to lack of funding. In fact, Dr. Redlener points out the need for $5 billion just for staff, equipment and supplies, and general resiliency. Yet the vast majority of the administration's funding is going toward the antiviral and vaccine stockpile.

This plan, therefore, gives us inadequate leadership and inadequate funding, which leaves the clear impression that we truly will be on our own in a pandemic. And a crisis is precisely the time we need to look out for each other the most.

However, we can be assured that everyone is not left to his or her own devices. On November 4, 2005, in front of this committee, HHS Secretary Michael Leavitt stated during the Q&A that he would not be issuing a compulsory license for the antiviral drug Tamiflu. He also declared that he was in negotiation with Roche, manufacturer of Tamiflu, over the cost of the drug being purchased for the national stockpile.

On one hand, Secretary Leavitt has a congressional mandate to stockpile enough Tamiflu for 25 percent of the Nation. On the other hand, he withdrew the threat of compulsory licensing even if Roche tries to price gouge. In doing so, Mr. Leavitt undercut his own negotiating power and effectively surrendered control of the price to Roche.

On November 10th, 6 days after the hearing, the New York Times reported that Roche announced they would be charging developed countries for Tamiflu 15 euros or about $19 for a course of treatment. Wondering how the price negotiations between HHS and Roche went, my office recently asked HHS what they were paying for Tamiflu for the stockpile—the asking price of 15 euros or $19?

Even with the bulk purchasing power of 810 million pills, HHS did not bother to get a better deal than the asking price. Lest you get the impression that this price is fair, allow me to point out that Roche did not sink a dime into research on their drug. They simply licensed it from its inventor, Gilead Sciences. That means there is no need to recoup research costs.

Furthermore, we know it can be sold for a profit for much less. Cipla, a generics manufacturer in India, for example, is selling Tamiflu for only $12. That is 36 percent less than what the Federal Government here is paying. If we paid Cipla's price instead of Roche's, we would save over a half billion dollars.

Now I bet local health agencies and hospitals could save a lot of lives with that kind of money. Think of what we could do with a half billion dollars. We could reduce the deficit, put teachers in classrooms, invest in renewable energy, provide health care to some of the uninsured.

Those that stand to gain from the inflated prices for pandemic pharmaceuticals are doing well. Roche's sales for the first quarter of 2006 are up 22 percent to $7.7 billion. Gilead Sciences, the company that originally developed Tamiflu and continues to receive royalties on its sales, outperformed RBC Capital Markets estimate of $350 million in Tamiflu sales by $163 million.

In essence, we are telling State and local governments there is not enough money to fund things like medical personnel and equipment while we are giving away bags of money to the already incredibly profitable pharmaceutical industry. In other words, you are on your own unless you are a big pharma.

Thank you. I yield back.

[The prepared statement of Hon. Dennis J. Kucinich follows:]

Statement of Dennis Kucinich
U.S. House of Representatives
Committee on Government Reform

Hearing: "Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations"
May 11, 2006

You're on your own.

This has been the credo for the Administration's approach to health care and it summarizes their approach to Avian Flu. The Implementation Plan gives a little guidance to state and local governments and businesses and then wishes them luck.

First, there is the leadership vacuum. The plan calls for HHS to coordinate the medical response but calls for Homeland Security to coordinate federal operations and resources. A bipartisan report out of the Senate, released in April, found that the Department has lagged in fixing the problems that plagued its atrocious response to Hurricane Katrina. It found that major structural reforms were necessary and that little has changed in the Department so far. So we can expect Homeland Security to adopt a similar motto to the one they adopted last Summer: you're on your own.

What's more is that the plan has been called the mother of all unfunded mandates. While 7.1 billion dollars for avian flu preparedness is a step in the right direction, it is simply not enough. Dr. Irwin Redlener, director of the National Center for Disaster Preparedness at Columbia University's Mailman School of Public Health, called the budget "completely unrealistic." A big part of the reason it is insufficient is that it has to make up for years of steady erosion of the public health infrastructure due to lack of funding. In fact, Dr. Redlener points out the need for 5 billion dollars just for "staffs, equipment and supplies, and general resiliency."[1] Yet the vast majority of the Administration's funding is going toward the anti-viral and vaccine stockpile.

This plan, therefore, gives us inadequate leadership and inadequate funding, which leaves the clear impression that we truly will be on our own in a pandemic. And a crisis is precisely the time we need to look out for each other the most.

However, we can be assured that everyone is not left to their own devices.

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[1] Barrett, Jennifer, A Dramatic Disconnect, Newsweek, May 3, 2006 http://www.msnbc.msn.com/id/12610942/site/newsweek/

On November 4, 2005 in front of this Committee, HHS Secretary Michael Leavitt stated during the Q&A that he would not be issuing a compulsory license for the anti-viral drug, Tamiflu. He also declared that he was in negotiations with Roche, manufacturer of Tamiflu, over the cost of the drug being purchased for the national stockpile. On one hand, Secretary Leavitt has a Congressional mandate to stockpile enough Tamiflu for 25% of the nation. On the other hand, he withdrew the threat of compulsory licensing, even if Roche tries to price gouge. In so doing, Leavitt undercut his own negotiating power and effectively surrendered control of price to Roche.

On November 10, six days after the hearing, the New York Times reported that Roche announced what they would be charging developed countries for Tamiflu: 15 Euros, or about 19 dollars for a course of treatment. Wondering how the price negotiations between HHS and Roche went, my office recently asked HHS what they were paying for Tamiflu for the stockpile. The asking price of 15 Euros, or 19 dollars. Even with the bulk purchasing power of 810 million pills, HHS did not bother to get a better deal than the asking price.

Lest you get the impression that this price is fair, allow me to point out that Roche did not sink a dime into research on the drug. They simply license it from its inventor, Gilead Sciences. That means there is no need to recoup research costs. Furthermore, we know it can be sold for a profit for much less. Cipla, a generics manufacturer in India, for example, is selling Tamiflu for only 12 dollars.[2] That is 36% less than what the Federal Government is paying. If we paid Cipla's price instead of Roche's, we would save over a half a billion dollars. I bet local health agencies and hospitals could save a lot of lives with that kind of money. Think of what we could do with a half billion dollars – we could reduce the deficit, put teachers in classrooms, invest in renewable energy, provide health care to some of the uninsured.

Those that stand to gain from inflated prices for pandemic pharmaceuticals are doing well. Roche's sales for the first quarter of 2006 are up 22% to 7.7 billion dollars.[3] Gilead Sciences, the company that originally developed Tamiflu and continues to receive royalties on its sales, outperformed RBC Capital Markets estimate of 350 million dollars in Tamiflu Sales by 163 million dollars.[4]

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[2] Enserink, Martin, A Cheaper Way to Fight the Flu, ScienceNOW Daily News, April 26, 2006
[3] Herper, Matthew, Roche Profits Spike on Flu Scare Sales, Forbes.com, April 27, 2006
[4] Kang, Peter, Gilead's Debt Sale Seen Fueling Potential Deals, Forbes.com, April 27, 2006

In essence, we are telling state and local governments that there's not enough money to fund things like medical personnel and equipment while we're giving away bags of money to the already incredibly profitable pharmaceutical industry. In other words, you're on your own .... unless you're big Pharma.

Chairman TOM DAVIS. Thank you.

The gentleman from Maryland?

Mr. CUMMINGS. Thank you very much, Mr. Chairman, for holding this critically important hearing.

Hurricane Katrina demonstrated with abundant clarity that Government incompetence and poor preparation during a time of national peril are not victimless crimes. Those failures, coupled with the Government's inability to secure sufficient quantities of vaccine courses in a recent flu season, compel us to rigorously question our Nation's pandemic flu and continuity of operations plans.

It should give us all pause that a pandemic could result in the deaths of over 500,000 Americans and infect 25 percent of the world's population. The Baltimore Sun on June 12, 2005, reported in an article entitled "Fears of Flu Pandemic Spurring Preparations" that, "The threat of an avian flu pandemic from Asia could cause 12,000 deaths in the State of Maryland early on, with the possibility of many, many more later."

Make no mistake. Such a loss of life would fundamentally undermine our economy and our society. With H5N1 considered likely to cause a global pandemic, the time is long overdue for our Nation to have a comprehensive plan to withstand the onslaught of a pandemic.

The White House recently released the Implementation Plan for the National Strategy for Pandemic Influenza in an effort to provide clarity to the public and to private entities about their respective roles and responsibilities. Unfortunately, this plan suffers from critical deficiencies that need to be immediately addressed.

To begin, I am concerned that the Department of Homeland Security is charged with coordinating all Federal operations and assets. In no uncertain terms, DHS failed to ably respond to Hurricane Katrina. Nearly a year later, calls for major structural reforms and a substantive change in leadership at DHS have fallen on deaf ears.

With a pandemic being described as "Hurricane Katrina hitting all of America at the same time," how can we be confident in DHS's ability to coordinate effectively, dispense resources rapidly, or provide the type of leadership needed to steer this Nation out of a flu pandemic?

Second, the plan fails to identify a specific individual at the White House who is charged with the Federal response coordination. As illustrated in Hurricane Katrina, the lack of an identified ultimate decisionmaker at the White House could result in, one, unnecessary delays in addressing the needs of State and locals and, two, an unnecessary delay in comprehending the scope of human suffering and a loss of life in devastated communities on the ground.

Furthermore, the plan disturbingly fails to specify how States ought to distribute limited supplies of vaccines and antivirals. Make no mistake, who and under what conditions citizens get vaccinated or medicated with antivirals in the midst of a flu pandemic will be one of the greatest challenges that confront all levels of government.

Indeed, those decisions will literally be a matter of life and death for many, and it is not enough to say the Federal Government is working with the State governments to establish distribution plans.

And finally, Mr. Chairman, I am also deeply concerned that this Congress could find $70 billion for tax cuts that will disproportionately benefit the wealthy, but could not find the resources or the will to fully fund $7.1 billion requested to expand our vaccine capacity, purchase antivirals, conduct research, and support State and local preparedness.

The American people are closely watching how its Government responds to this challenge. One that will no doubt test the wisdom of our priorities, our ability to effectively govern in a time of international crisis, and the firmness of our resolve to protect our citizens from threats both seen and unseen.

These threats demand that we improve our preparedness efforts on everything from ensuring our governmental entities are clear as to their roles and responsibilities, to strengthening our continuity of operation plans that are essential to keeping Government up and running in the wake of a disaster.

And with that, Mr. Chairman, I thank you, and I yield back.

[The prepared statement of Hon. Elijah E. Cummings follows:]

Opening Statement

Representative Elijah E. Cummings, D-Maryland

Full Committee Hearing: "Working Through An Outbreak: Pandemic Flu Planning and Continuity of Operations"

Committee on Government Reform
U.S. House of Representatives
109th Congress

May 11, 2006

Mr. Chairman,

Thank you for holding this critically important hearing to evaluate our nation's pandemic flu preparedness.

Hurricane Katrina demonstrated with abundant clarity that government incompetence and poor preparation during a time of national peril are not victimless crimes. Those failures, coupled with the government's inability to secure sufficient quantities of vaccine courses in a recent flu season, compel us to rigorously question our nation's pandemic flu and continuity of operations plans.

It should give us all pause that a pandemic could result in the deaths of over 500,000 Americans and infect 25% of the world's population. The *Baltimore Sun* on June 12, 2005 reported in an article entitled, *Fears of Flu Pandemic Spurring Preparations*, that

"the threat of an avian flu pandemic from Asia…[could cause] 12,000 deaths in the state [of Maryland] early on, with the possibility of many more later."

Make no mistake, such a loss of life would fundamentally undermine our economy and society. With H5N1 considered likely to cause a global pandemic, the time is long overdue for our nation to have a comprehensive plan to withstand the onslaught of a pandemic.

The White House recently released the Implementation Plan for the National Strategy for Pandemic Influenza in an effort to provide clarity to public and private entities about their respective roles and responsibilities. Unfortunately, this plan suffers from critical deficiencies that need to be immediately addressed.

To begin, I am concerned that the Department of Homeland Security (DHS) is charged with coordinating all federal operations and assets. In no uncertain terms, DHS failed to ably respond to Hurricane Katrina. Nearly a year later, calls for major structural reforms and a substantive change in leadership at DHS have fallen on deaf ears. With a pandemic being described as "Hurricane Katrina hitting all of America at the same time," how can we be

confident in DHS' ability to coordinate effectively, dispense resources rapidly, or provide the type of leadership needed to steer this nation out of a flu pandemic?

Secondly, the plan fails to identify a specific individual at the White House who is charged with federal response coordination. As illustrated in Hurricane Katrina, the lack of an identified "ultimate decision maker" at the White House could result in: (1) unnecessary delays in addressing the needs of state and locals; and (2) an unnecessary delay in comprehending the scope of human suffering and a loss of life in devastated communities on the ground.

Furthermore, the plan disturbingly fails to specify how states ought to distribute limited supplies of vaccines and anti-virals. Make no mistake, who and under what conditions citizens get vaccinated or medicated with anti-virals in the midst of a flu pandemic will be one of the greatest challenges that confront all levels of government. Indeed, those decisions will literally be a matter of life and death for many, and it is not enough to say the federal government is working with state governments to establish distribution plans.

I am also deeply concerned that this Congress could find $70 billion for tax cuts that will disproportionally benefit the wealthy, but could not find the resources or the will to fully fund the $7.1 billion requested to expand our vaccine capacity, purchase anti-virals, conduct research, and support state and local preparedness.

In closing, the American people are closely watching how it's government responds to this challenge, one that will no doubt test the wisdom of our priorities, our ability to effectively govern in a time of international crisis, and the firmness of our resolve to protect our citizens from threats both seen and unseen.

These threats demand that we improve our preparedness efforts on everything from ensuring our governmental entities are clear as to their roles and responsibilities, to strengthening our continuity of operation plans that are essential to keeping government up and running in the wake of a disaster.

I yield back the balance of my time and look forward to the testimony of today's witnesses.

Chairman TOM DAVIS. Thank you, gentlemen.

We now welcome our witnesses. We have before us the Honorable David M. Walker, who is the Comptroller General of the GAO. We have the Honorable John O. Agwunobi, Assistant Secretary for Health, Department of Health and Human Services. The Honorable Jeffrey W. Runge, Acting Under Secretary for Science and Technology, Chief Medical Officer, Department of Homeland Security. The Honorable Linda Springer, Director, Office of Personnel Management.

Thank you all for being here. As you know, we swear you all in. So if you would rise?

[Witnesses sworn.]

Chairman TOM DAVIS. I would note for the record that our witnesses have responded in the affirmative.

Comptroller Walker, you have the floor. Thank you for being here.

And it is my understanding that you have convened a GAO-sponsored conference on Inspector General Act, and that Linda Koontz, Director for Information Management Issues for GAO, will remain and answer our questions. Did she stand to be sworn in?

Mr. WALKER. She did, Mr. Chairman.

Chairman TOM DAVIS. OK. Well, that is great. Thank you for doing that.

So you have a statement and then will be replaced by someone who will ably be able to answer the questions as well.

Mr. WALKER. Thank you, Mr. Chairman.

Chairman TOM DAVIS. Thank you, Mr. Walker.

Mr. WALKER. I want to thank you, and I want to thank the staff for your understanding.

The Congress had asked me to convene a panel on the IG Act. I am chairing it. It is going on right now, and so I appreciate your indulgence.

Chairman TOM DAVIS. It is easy to understand, and we appreciate and the staff appreciates you even being here.

STATEMENTS OF DAVID M. WALKER, COMPTROLLER GENERAL, GOVERNMENT ACCOUNTABILITY OFFICE, ACCOMPANIED BY LINDA D. KOONTZ, DIRECTOR FOR INFORMATION MANAGEMENT ISSUES; LINDA SPRINGER, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT; JOHN O. AGWUNOBI, M.D., ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND JEFFREY W. RUNGE, M.D., ACTING UNDER SECRETARY FOR SCIENCE AND TECHNOLOGY, CHIEF MEDICAL OFFICER, DEPARTMENT OF HOMELAND SECURITY

STATEMENT OF DAVID M. WALKER

Mr. WALKER. Thank you very much.

I appreciate the opportunity to participate in the committee's hearing on pandemic influenza and continuity planning. As each of you are well aware, the Government plays many important roles in responding to emergency situations, such as natural disasters, terrorist events, and pandemic flu outbreaks should they occur.

But in order to provide both direct emergency response as well as other essential services, Government agencies must be positioned to continue functioning even when the agencies themselves are disrupted. Accordingly, agencies are required to develop plans to ensure continuity of operations, or so-called COOP plans.

In preparing such plans, the executive branch agencies are to follow guidance that is issued by the Federal Emergency Management Agency [FEMA]. In developing COOP plans, a potentially useful option is telework. That is employees performing work from remote sites, often their homes or another location that is not a traditional office.

As we pointed out in April 2004, telework offers potential benefits to employers, employees, and society as a whole in the normal course of operations. It is also important and a viable option for Federal continuity planning, especially as the duration of an emergency is extended, which would be the case if a flu pandemic were to come to the United States.

According to health experts, absentee rates in a pandemic could reach 40 percent during peak periods. The need for care for family members, the need to deal with the illness, and the fear of infection would have a broad-based effect within the country.

In such a situation, the use of telework or other means to avoid unnecessary contacts among people, which is referred to as social distancing measures, is clearly appropriate. This is recognized by recent executive branch guidance recommending social distancing measures, such as telework and public health interventions, to control and contain infection during a pandemic outbreak.

GAO recognizes the importance of telework in continuity planning and is striving to lead by example on these issues. For example, about 13.5 percent of GAO employees used telework last year, as compared to 5.2 percent for Federal civilian employees in 2004.

Furthermore, our current telework policy allows me, during certain emergencies, to approve telework for all employees in an affected area to promote continuity of operations. We are also completing a supplement to our COOP plan that addresses preparation specific to a pandemic and are coordinating our continuity planning efforts with those of other legislative branch agencies and of Congress as a whole.

As per your request, the balance of my remarks will focus on the report that we are issuing today, which was referred to by Mr. Davis. In 2005, we previously issued a report based upon a survey of Federal officials responsible for continuity planning at 23 major agencies. For the current report, we basically reissued the same survey in order to try to be able to get an update and find out what type of progress has been made.

This time, more agencies reported plans for essential team members to telework during the COOP event than in the previous survey. However, only a few of the agencies documented that they had made the necessary preparations to effectively use telework during an emergency.

For example, although 9 of 23 agencies reported that they expected some of their essential team members to telework during a COOP event, only 1 agency documented that it had notified its team members of this expectation. In addition, none of the 23 agen-

cies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during an emergency, and only 3 of 23 agencies documented that they had actually tested the ability of their staff to telework effectively during an emergency.

One reason why agencies reported these low levels of preparation for telework is that none of FEMA's COOP guidance addresses the steps that agencies should take to ensure that they are fully prepared to use telework during a COOP event. In 2005, when we reported on the previous survey, we recommended that FEMA develop such guidance in consultation with the Office of Personnel Management. Unfortunately, this guidance has yet to be created.

This guidance suggests the use of telework and recommends that agencies consider which essential functions should be performed from remote locations, such as employee homes. That's the most recent guidance that the agency—that the executive branch has issued.

However, the guidance still does not address the steps that agencies should take when preparing to use telework during an emergency. For example, it does not address certain necessary preparations, such as informing designated staff that they are expected to telework or providing them with adequate technical resources and support to make it effective.

If agencies do not make adequate preparations, they may not be able to use telework effectively to ensure the continuity of their essential functions in emergencies, including in the event of a pandemic influenza. Accordingly, we recommended in our report that FEMA establish a timeline for developing such guidance. DHS partially agreed with our recommendation and stated that FEMA will cooperate with OPM in developing this timeline.

Last week, the White House released an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls for OPM to work with DHS and other agencies to revise existing telework guidance and to issue new guidance on human capital planning and COOP planning. The plan establishes an expectation that these actions will be completed within the next 3 months. We'll see.

We are encouraged that DHS has now established a timeline for issuing revised telework guidance. However, unless the forthcoming guidance addresses the necessary preparations, agencies may not be able to use telework effectively to ensure the continuity of essential functions.

On the other hand, if they prepare telework effectively, agencies could enable both essential and nonessential employees to contribute to agency missions during the extended emergencies, including a pandemic influenza.

Mr. Chairman, thank you very much. And I obviously will make Ms. Koontz available for any questions that you may have or the other members of the committee.

[NOTE.—The May 2006 GAO report entitled, "Continuity of Operations, Selected Agencies Could Improve Planning for Use of Alternate Facilities and Telework during Disruptions," GAO–06–713, may be found in committee files.]

[The prepared statement of Mr. Walker follows:]

United States Government Accountability Office

GAO

Testimony
Before the Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
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CONTINUITY OF OPERATIONS

Agencies Could Improve Planning for Telework during Disruptions

Statement of David M. Walker
Comptroller General of the United States

GAO-06-740T

May 11, 2006

GAO
Accountability-Integrity-Reliability

Highlights

Highlights of GAO-06-740T, a testimony before the Committee on Government Reform, House of Representatives

CONTINUITY OF OPERATIONS

Agencies Could Improve Planning for Telework during Disruptions

Why GAO Did This Study

To ensure that essential government services are available in emergencies, federal agencies are required to develop continuity of operations (COOP) plans. The Federal Emergency Management Agency (FEMA), within the Department of Homeland Security (DHS), is responsible for providing guidance to agencies on developing such plans. Its guidance states that in their continuity planning, agencies should consider the use of telework—that is, work performed at an employee's home or at a work location other than a traditional office. The Office of Personnel Management (OPM) recently reported that 43 agencies have identified staff eligible to telework, and that more than 140,000 federal employees used telework in 2004.

OPM also reported that many government operations can be carried out in emergencies using telework. For example, telework appears to be an effective strategy for responding to a pandemic—a global outbreak of disease that spreads easily from person to person and causes serious illness and death worldwide. In previous work, GAO identified steps that agencies should take to effectively use telework during an emergency.

GAO was asked to testify on how agencies are addressing the use of telework in their continuity planning, which is among the topics discussed in a report being released today (GAO-06-713).

www.gao.gov/cgi-bin/getrpt?GAO-06-740T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Linda D. Koontz at (202) 512-6240 or koontzl@gao.gov.

What GAO Found

Although agencies are not required to use telework in continuity planning, 9 of the 23 agencies surveyed reported plans for essential team members to telework during a COOP event, compared to 3 in GAO's previous survey. However, few documented that they made the necessary preparations to effectively use telework during such an event. For example, only 1 agency documented that it had communicated this expectation to its emergency team members. One reason for the low levels of preparations reported is that FEMA has not provided specific guidance on preparations needed to use telework during emergencies.

Recently, FEMA disseminated guidance to agencies on incorporating pandemic influenza considerations into COOP planning. Although this guidance suggests the use of telework during such an event, it does not address the steps agencies should take when preparing to use telework during an emergency. Without specific guidance, agencies are unlikely to adequately prepare their telework capabilities for use during a COOP event. In addition, inadequate preparations could limit the ability of nonessential employees to contribute to agency missions during extended emergencies, including pandemic influenza.

In its report released today, GAO recommends, among other things, that FEMA establish a time line for developing, in consultation with the OPM, guidance on preparations needed for using telework during a COOP event. In commenting on a draft of the report, DHS partially agreed with GAO's recommendation and stated that FEMA will coordinate with OPM in developing a time line for further telework guidance. DHS also stated that both FEMA and OPM have provided telework guidance. However, as GAO's report stated, present guidance does not address the preparations federal agencies should make for using telework during emergencies.

On May 3 the White House announced the release of an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls on OPM to work with DHS and other agencies to revise existing telework guidance and issue new guidance on human capital planning and COOP. The plan establishes an expectation that these actions will be completed within 3 months. If the forthcoming guidance does not require agencies to make necessary preparations for telework, agencies are unlikely to take all the steps necessary to ensure that employees will be able to effectively use telework to perform essential functions in extended emergencies, such as a pandemic influenza.

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to participate in the Committee's hearing on pandemic influenza and continuity of operations (COOP) planning. As you know, essential government services can be interrupted by a range of events, including terrorist attacks, severe weather, building-level emergencies, and public health emergencies, such as pandemic influenza. The federal government requires agencies to develop plans for ensuring the continuity of essential services during such emergencies. To assist agencies, the Federal Emergency Management Agency (FEMA), within the Department of Homeland Security (DHS), which is responsible for managing federal response and recovery efforts following any national incident, has issued guidance that defines the elements of a viable COOP capability.

A potentially useful option for continuity planning is telework (in which work is performed at an employee's home or at a work location other than a traditional office); this alternative has gained widespread attention over the past decade in both the public and private sectors as a human capital flexibility that offers a variety of potential benefits to employers, employees, and society. In a December 2005 report to Congress, the Office of Personnel Management (OPM) indicated that 43 of the 82 federal agencies it surveyed had employees eligible to telework during 2004, and more than 140,000 federal employees used telework that year.[1]

OPM also reported that there is a symbiotic relationship between COOP and telework because many government functions that must be carried out in emergencies can be accomplished using telework. Similarly, we reported in April 2004 that telework is an important and viable option for federal agencies in continuity planning and implementation efforts, especially as the duration of an emergency event is extended.[2] This option appears particularly appropriate in

[1] OPM, *The Status of Telework in the Federal Government 2005* (Washington, D.C.: Dec. 2005)

[2] GAO, *Human Capital: Opportunities to Improve Federal Continuity Planning Guidance,* GAO-04-384 (Washington, D.C.: Apr. 20, 2004).

the case of pandemic influenza, which occurs when an influenza virus causes an outbreak of disease that spreads easily from person to person and results in serious illness worldwide. Experts believe that the effects of a pandemic could come in waves that last for weeks or even months, in which time absentee rates could reach 40 percent during peak periods due to illness, the need to care for family members, and fear of infection. Recent executive branch guidance states that social distancing measures, such as telework, may be appropriate public health interventions for infection control and containment during a pandemic outbreak.

GAO recognizes the importance of telework and continuity planning and is striving to lead by example on these issues. For example, during certain emergencies, our current telework policy allows me to approve telework for all employees in an affected area to promote continuity of operations. We are also completing a supplement to our COOP plan that addresses preparations specific to a pandemic, and are coordinating our continuity planning efforts with those of other legislative branch agencies.

As you requested, I will discuss how agencies are addressing the use of telework in their continuity planning, based on work described in a report that we are issuing today.[3] In earlier work, we identified steps agencies that should take to effectively use telework during an emergency, and we surveyed agency officials responsible for continuity planning at 23 major agencies.[4] For this report, we repeated this survey to obtain updated information on the extent to which key telework practices were used in making continuity preparations. We reviewed documentation submitted by agency officials to support their survey responses and compared these responses to those from our earlier work; we briefed your staff on the results of our work on April 13, 2006. This work was conducted

[3] GAO, *Continuity of Operations: Selected Agencies Could Improve Planning for Use of Alternate Facilities and Telework during Disruptions*, GAO-06-713 (Washington, D.C.: May 11, 2006).

[4] GAO, *Continuity of Operations: Agency Plans Have Improved, but Better Oversight Could Assist Agencies in Preparing for Emergencies*, GAO-05-577 (Washington, D.C.: Apr. 28, 2005).

in accordance with generally accepted government auditing standards.

Results in Brief

More agencies reported plans for essential team members to telework during a COOP event than in our previous survey, but few documented that they made the necessary preparations to effectively use telework during an emergency:

- Nine of the 23 agencies reported that some of their essential team members are expected to telework during a COOP event. However, only one agency documented that it had notified its team members of the expectation that they would telework during such an event.
- None of the 23 agencies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during an emergency.
- Only 3 of the 23 agencies documented testing the ability of staff to telework during an emergency.

FEMA's guidance on COOP planning does not include specific information on preparations to use telework during emergencies; the absence of such specific guidance contributed to the low levels of preparations that agencies reported. Recently, FEMA disseminated additional guidance to agencies regarding the incorporation of pandemic influenza considerations into COOP planning. Although this guidance suggests the use of telework during such an event, it does not address the steps agencies should take when preparing to use telework during an emergency. If agencies do not make adequate preparations, they may not be able to use telework effectively to ensure the continuity of their essential functions in emergencies, including pandemic influenza events.

In our report, we recommended, among other things, that FEMA establish a time line for developing, in consultation with OPM, guidance on preparations needed for using telework during a COOP event. In commenting on a draft of this report, DHS partially agreed

with our recommendation and stated that FEMA will coordinate with OPM in the development of a time line for telework guidance.

Background

Federal operations and facilities have been disrupted by a range of events, including the terrorist attacks on September 11, 2001; the Oklahoma City bombing; localized shutdowns due to severe weather conditions, such as hurricanes Katrina, Rita, and Wilma in 2005; and building-level events, such as asbestos contamination at the Department of the Interior's headquarters. In addition, federal operations could be significantly disrupted by people-only events, such as an outbreak of severe acute respiratory illness (SARS). Such disruptions, particularly if prolonged, can lead to interruptions in essential government services. Prudent management, therefore, requires that federal agencies develop plans for dealing with emergency situations, including maintaining services, ensuring proper authority for government actions, and protecting vital assets.

Until relatively recently, continuity planning was generally the responsibility of individual agencies. In October 1998, Presidential Decision Directive (PDD) 67 identified FEMA—which is responsible for leading the effort to prepare the nation for all hazards and managing federal response and recovery efforts following any national incident—as the lead agent for federal COOP planning across the federal executive branch. FEMA's responsibilities include

- formulating guidance for agencies to use in developing viable plans;
- coordinating interagency exercises and facilitating interagency coordination, as appropriate; and
- overseeing and assessing the status of COOP capabilities across the executive branch.

In July 1999, FEMA issued the first version of Federal Preparedness Circular (FPC) 65, its guidance to the federal executive branch on developing viable and executable contingency plans that facilitate the performance of essential functions during any emergency. FPC 65 applies to all federal executive branch departments and agencies

at all levels, including locations outside Washington, D.C. FEMA released an updated version of FPC 65 in June 2004, providing additional guidance to agencies on each of the topics covered in the original guidance.

In partial response to a recommendation we made in April 2004, the 2004 version of FPC 65 also included new guidance on human capital considerations for COOP events.[5] For example, the guidance instructed agencies to consider telework—also referred to as telecommuting or flexiplace—as an option in their continuity planning.

Telework has gained widespread attention over the past decade in both the public and private sectors as a human capital flexibility that offers a variety of potential benefits to employers, employees, and society. In a 2003 report to Congress on the status of telework in the federal government, the Director of OPM described telework as "an invaluable management tool which not only allows employees greater flexibility to balance their personal and professional duties, but also allows both management and employees to cope with the uncertainties of potential disruptions in the workplace, including terrorist threats."[6] A 2005 OPM report on telework notes the importance of telework in responding flexibly to emergency situations, as demonstrated in the wake of the devastation caused by Hurricane Katrina, when telework served as a tool to help alleviate the issues caused by steeply rising fuel prices nationwide.[7]

In 2004, we surveyed major federal agencies at your request to determine how they planned to use telework during COOP events.[8]

[5] GAO, *Human Capital: Opportunities to Improve Federal Continuity Planning Guidance,* GAO-04-384 (Washington, D.C.: Apr. 20, 2004).

[6] OPM, *Report to the Congress: The Status of Telework in the Federal Government* (Washington, D.C.: January 2003).

[7] OPM, *Report to the Congress: The Status of Telework in the Federal Government* (Washington, D.C.: Dec. 2005).

[8] The plans that we reviewed in 2004 were created before the issuance of FEMA's revised FPC 65, which instructs agencies to consider the use of telework in their continuity planning.

We reported that, although agencies were not required to use telework in their COOP plans, 1 of the 21 agency continuity plans in place on May 1, 2004, documented plans to address some essential functions through telework. In addition, 10 agencies reported that they intended to use telework following a COOP event, even though those intentions were not documented in their continuity plans.

The focus on using telework in continuity planning has been heightened in response to the threat of pandemic influenza. In November 2005, the White House issued a national strategy to address this threat, which states that social distancing measures, such as telework, may be appropriate public health interventions for infection control and containment during a pandemic outbreak. The strategy requires federal departments and agencies to develop and exercise preparedness and response plans that take into account the potential impact of a pandemic on the federal workforce. It also tasks DHS—the parent department of FEMA—with developing plans to implement the strategy in regard to domestic incident management and federal coordination. In May 2006, the White House issued an implementation plan in support of the pandemic strategy. This plan outlines the responsibilities of various agencies and establishes time lines for future actions.

Few Agencies Demonstrated That They Had Adequately Prepared to Use Telework in a COOP Event

Although more agencies reported plans for essential team members to telework during a COOP event than in our 2004 survey, few documented that they had made the necessary preparations to effectively use telework during an emergency. While FPC 65 does not require agencies to use telework during a COOP event, it does state that they should consider the use of telework in their continuity plans and procedures. All of the 23 agencies that we surveyed indicated that they considered telework as an option during COOP planning, and 15 addressed telework in their COOP plans (see table 1). For agencies that did not plan to use telework during a COOP event, reasons cited by agency officials for this decision included (1) the need to access classified information—

which is not permitted outside of secured areas—in order to perform agency essential functions and (2) a lack of funding for the necessary equipment acquisition and network modifications.

Table 1: Agency Responses to Selected Questions on Telework in COOP Plans

Question	Year	Yes	Yes (no doc[a])	No
Does the agency's COOP plan specifically address telework?	2005	12	3	8
	2004[b]	2	1	19
Are any of the agency's essential team members expected to telework in a COOP event?	2005	3	6	14
	2004	1	2	19
Were staff informed of their responsibility to telework during a COOP event?	2005	1	10	12
	2004	1	3	18
Has the agency ensured that it has adequate technological capacity for staff to telework during a COOP event?	2005	0	14	9
	2004	0	5	17
Will the agency provide technological assistance to staff during a COOP event?	2005	3	11	9
	2004	0	5	17
Has the agency tested the ability of staff to telework during a COOP event?	2005	3	7	13
	2004	0	2	20

Source: Analysis of agency responses to GAO questions.

[a]Agencies provided a positive response but did not provide adequate documentation to support their response.

[b]In 2004, one agency did not respond, resulting in a total of 22 responses.

The agencies that did plan to use telework in emergencies did not consistently demonstrate that they were prepared to do so. We previously identified steps agencies should take to effectively use telework during an emergency. These include preparations to ensure that staff has adequate technological capacity, assistance, and training.[9] Table 1 provides examples of gaps in agencies' preparations, such as the following:

- Nine of the 23 agencies reported that some of their COOP essential team members are expected to telework during a COOP event. However, only one agency documented that it had notified its team members that they were expected to telework during such an event.

[9] GAO, *Continuity of Operations: Agency Plans Have Improved, but Better Oversight Could Assist Agencies in Preparing for Emergencies*, GAO-05-577 (Washington, D.C.: Apr. 28, 2005).

- None of the 23 agencies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during a COOP event.

No guidance addresses the steps that agencies should take to ensure that they are fully prepared to use telework during a COOP event. When we reported the results of our 2004 survey, we recommended that the Secretary of Homeland Security direct the Under Secretary for Emergency Preparedness and Response to develop, in consultation with OPM, guidance on the steps that agencies should take to adequately prepare for the use of telework during a COOP event. However, to date, no such guidance has been created.

In March 2006, FEMA disseminated guidance to agencies regarding the incorporation of pandemic influenza considerations into COOP planning. The guidance states that the dynamic nature of a pandemic influenza requires that the federal government take a nontraditional approach to continuity planning and readiness. It suggests the use of telework during such an event. According to the guidance, agencies should consider which essential functions and services can be conducted from a remote location (e.g., home) using telework. However, the guidance does not address the steps agencies should take when preparing to use telework during an emergency. For example, although the guidance states that agencies should consider testing, training, and exercising of social distancing techniques, including telework, it does not address other necessary preparations, such as informing designated staff of the expectation to telework or providing them with adequate technical resources and support.

Earlier this month, after we briefed your staff, the White House released an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls on OPM to work with DHS and other agencies to revise existing telework guidance and issue new guidance on human capital planning and COOP. The plan establishes an expectation that these actions will be completed within 3 months.

If the forthcoming guidance from DHS and other responsible agencies does not require agencies to make the necessary

preparations for telework, agencies are unlikely to take all the steps necessary to ensure that employees will be able to effectively use telework to perform essential functions during any COOP event. In addition, inadequate preparations could limit the ability of nonessential employees to contribute to agency missions during extended emergencies, including a pandemic influenza scenario.

In summary, Mr. Chairman, although more agencies reported plans for essential team members to telework during a COOP event than in our previous survey, few documented that they had made the necessary preparations to effectively use telework during an emergency. In addition, agencies lack guidance on what these necessary preparations are. Although FEMA's recent telework guidance does not address the steps agencies should take to prepare to use telework during an emergency event, new guidance on telework and COOP is expected to be released later this year. If the new guidance does not specify the steps agencies need to take to adequately prepare their telework capabilities for use during an emergency situation, it will be difficult for agencies to make adequate preparations to ensure that their teleworking staff will be able to perform essential functions during a COOP event.

In our report, we made recommendations aimed at helping to ensure that agencies are adequately prepared to perform essential functions following an emergency. Among other things, we recommended that the Secretary of Homeland Security direct the FEMA Director to establish a time line for developing, in consultation with OPM, guidance on the steps that agencies should take to adequately prepare for the use of telework during a COOP event.

In commenting on a draft of the report, the Director of DHS's Liaison Office partially agreed with this recommendation and stated that FEMA will coordinate with OPM in the development of a time line for further telework guidance. In addition, he stated that both FEMA and OPM have provided guidance on the use of telework. However, as stated in our report, present guidance does not address the preparations agencies should make for using telework during emergencies.

With the release of the White House's Implementation Plan regarding pandemic influenza, a time line has now been established for the issuance of revised guidance on telework; however, unless the forthcoming guidance addresses the necessary preparations, agencies may not be able to use telework effectively to ensure the continuity of their essential functions.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Committee may have at this time.

Contacts and Acknowledgements

For information about this testimony, please contact Linda D. Koontz at (202) 512-6240 or at koontzl@gao.gov. Key contributions to this testimony were made by James R. Sweetman, Jr., Assistant Director; Barbara Collier; Sairah Ijaz; Nick Marinos; and Kim Zelonis.

Chairman TOM DAVIS. Thank you, Mr. Walker.

If you don't mind just coming up here a quick second, we will start with you, Ms. Springer. Thank you.

STATEMENT OF LINDA SPRINGER

Ms. SPRINGER. Thank you, Mr. Chairman and members of the committee.

OPM appreciates being invited to testify before this committee today about the steps we are taking to prepare the Federal Government as an employer for the possibility of a pandemic influenza.

The President's Implementation Plan for the National Strategy for Pandemic Influenza tasks OPM with developing appropriate guidance on human resources management policies relating to a possible flu epidemic. In addition, the implementation plan directs OPM to update three existing telework guides.

We've approached these tasks with a set of guiding principles in mind. First, that we should cause no harm. In other words, don't induce any panic or contribute to that type of atmosphere in the Federal work force while, at the same time, maintaining a sense of urgency.

Communication will be a key to carrying out our role. Our communications with Federal agencies and employees on these HR issues relating to a possible pandemic epidemic would be credible, clear, timely, frequent, visible, and sensitive.

In coordination with the White House, we will consult with other key departments and agencies, as well as the Chief Human Capital Officers Council and the Federal executive boards, to identify the issues to be addressed in our guidance materials and the audiences to which these materials should be directed.

Our policies will strike an appropriate balance between the institutional interests of the Federal Government as an employer and the needs and concerns of individual Federal employees and their families.

Finally, we will draw on OPM's considerable experience in providing advice and assistance to Federal agencies and employees in emergency situations. The internal pandemic working group we have already established at OPM has been at work identifying categories of human resource issues for which guidance already exists, needs revision, or should be developed.

We've been aided in this process by keeping an inventory of questions we've already received from Federal HR professionals and from individual employees. I'd like to share a couple of those with you and give you a sense——

Mr. SHAYS [presiding]. I am going to interrupt you and ask you, Mr. Walker, why don't you get on your way? Because you have things you have to do.

Mr. WALKER. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. You are making me nervous here. [Laughter.]

I am sorry to interrupt you.

Ms. SPRINGER. We've received so far dozens of questions from employees from HR professionals in the Federal Government. I will give you a couple of examples, and you'll get the flavor of this.

Question No. 1, what kinds of alternative work arrangements are available to assist agencies and employees in accomplishing a critical agency mission during a pandemic influenza?

Local health officials have confirmed that since the children in my son's daycare center have been exposed to the flu, their families have also been exposed to the virus. My child is not yet sick. What leave may I take to care for my child?

Another one. My elderly mother died due to complications from the flu. I have to make arrangements for and attend her funeral. May I use sick leave?

If I have been designated as an emergency employee, may I refuse to report for work if I don't think it is safe to do so?

And these go on and on and on. And that's been an ongoing indicator to us of the concern and the interest at all levels throughout the civilian work force.

So while we have not yet finalized answers to these questions and the others that we've received, or completed our consultation with other Federal departments and agencies, it is clear that our guidance materials must include information on alternative work arrangements.

We're also keenly aware of this committee's interest in ensuring that Federal agencies take appropriate steps to integrate telework policies into their continuity of operations plans. And let me assure you that we will include a discussion on teleworking options and policies in our guidance to Federal agencies, as we're required to do under the President's plan.

Our guidance will also describe relevant leave and work scheduling policies, as well as other benefits and flexibilities designed to assist Federal employees in the event of a pandemic influenza. In addition, our guidance will include information on hiring flexibilities and additional categories of guidance that we will identify as our review continues.

OPM is on track to meet the 3-month deadline specified in the President's implementation plan. In addition, we anticipate and plan to release some information interimly during that 90-day period.

It is important to note that OPM must prepare to carry out its own responsibilities in the event of a pandemic influenza. We will be practicing our plan for continuing to carry out the work that Congress and the President have entrusted to us. We expect that what we learn from these efforts will help inform the guidance we provide to other Federal agencies and employees.

Mr. Chairman, I appreciate again the opportunity to testify today and look forward to any questions you may have.

[The prepared statement of Ms. Springer follows:]

STATEMENT OF LINDA M. SPRINGER
DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

on

PANDEMIC INFLUENZA PREPAREDNESS EFFORTS

MAY 11, 2006

Mr. Chairman and Members of the Committee:

Thank you for inviting OPM to testify before this committee today about the steps we are taking to prepare the Federal Government, as an employer, for the possibility of a pandemic influenza. This responsibility is consistent with our mission to ensure the Federal Government has an effective civilian workforce. As the President's principal advisor on human resources management policies in the Federal Government, OPM has a Governmentwide role to play in preparing for a possible pandemic influenza.

The President's *Implementation Plan for the National Strategy for Pandemic Influenza* (*Implementation Plan*) tasks OPM with developing appropriate guidance on human resources (HR) management policies relating to a possible pandemic influenza. In addition, the President's *Implementation Plan* directs OPM to update three existing telework guides. But even before the *Implementation Plan* was released by the White House last week, I established an internal working group to identify issues facing Federal HR professionals and other officials responsible for ensuring that the business of

Government continues even in the face of potential disruptions to the Federal workforce caused by a pandemic influenza. The working group also is charged with addressing the concerns of Federal employees regarding the possibility that they, or members of their family, might be affected by a pandemic influenza.

We have approached these tasks with a set of guiding principles in mind. First, we should "cause no harm" and avoid contributing to an atmosphere of panic in the Federal workforce, while at the same time maintaining a sense of urgency. Communication will be key to carrying out our role. Our communications with Federal agencies and employees on HR issues relating to a possible pandemic influenza will be credible, clear, timely, frequent, visible, and sensitive. In coordination with the White House, we will consult with other key departments and agencies, as well as the Chief Human Capital Officers Council and Federal Executive Boards, to identify the issues to be addressed in our guidance materials and the audiences to which these materials should be directed. Our policies will strike an appropriate balance between the institutional interests of the Federal Government as an employer and the needs and concerns of individual Federal employees and their families. Finally, we will draw on OPM's considerable experience in providing advice and assistance to Federal agencies and employees in emergency situations.

OPM will reach out to any information source or other resource that can help us carry out the tasks assigned by the President's *Implementation Plan.*

The internal Pandemic Working Group we established at OPM has already been at work identifying the categories of HR issues for which guidance already exists, needs revision, or should be developed. We've been aided in this process by keeping an

inventory of questions we've already received from Federal HR professionals and individual employees. Here is a sampling of the questions we've received so far:

What kinds of alternative work arrangements are available to assist agencies and employees in accomplishing a critical agency mission during a pandemic influenza?

Local health officials have confirmed that since the children in my son's day care center have been exposed to the flu virus, their families have also been exposed to the virus. My child is not yet sick. What leave may I take to care for my child?

My elderly mother died due to complications from the flu. I have to make arrangements for and attend her funeral. May I use sick leave?

If I have been designated as an emergency employee, may I refuse to report for work if I don't think it is safe to do so?

While we have not yet finalized answers to the questions we've received so far or completed our consultation with other Federal departments and agencies, it is clear that our guidance materials must include information on alternative work arrangements and other HR policies—including telework policies—that can assist Federal agencies in continuing to perform their critical missions in the event of a pandemic influenza. We are keenly aware of this Committee's interest in ensuring that Federal agencies take appropriate steps to integrate telework policies into their continuity of operations plans. Let me assure you that we will include a discussion on teleworking options and policies in our guidance to Federal agencies.

Our guidance also will describe relevant leave and work scheduling policies, as well as other benefits and flexibilities designed to assist Federal employees and their families in the event of a pandemic influenza. In addition, our guidance will include

information on hiring flexibilities available to deal with the possibility that large numbers of Federal employees might be unable to carry out their duties and responsibilities for an extended period of time—at least on a local or regional basis, if not on a national or worldwide basis. We may identify additional categories of guidance that should be provided as our review continues.

OPM is on track to meet the 3-month deadline specified in the President's *Implementation Plan.* In addition, we anticipate that some information will be provided in the interim.

It is important to note that OPM also must prepare to carry out its own responsibilities in the event of a pandemic influenza. To this end, we have been updating OPM's critical responsibilities and tasks and making decisions about how those tasks will be accomplished in the adverse circumstances presented by a different kind of emergency situation. We will be practicing our plan for continuing to carry out the work Congress and the President have entrusted to us. We expect that what we learn from these efforts will help inform the guidance we provide other Federal agencies and employees. We will also encourage other Federal Departments and agencies to practice their continuity of operations plans in the context of a possible pandemic influenza.

The Federal Government must ensure that it can respond to the needs of our employees so that we will be able to respond to the needs of the Nation. OPM will fulfill its responsibility to prepare the Federal Government to do just that.

Thank you again for the opportunity to testify today. I look forward to responding to any questions you may have.

Mr. SHAYS. Thank you.

I want to make sure I am pronouncing your name correctly. It is Dr. Agwunobi?

Dr. AGWUNOBI. That is correct.

Mr. SHAYS. Thank you. Your mic needs to be on. So you have to hit that button there.

Dr. AGWUNOBI. That is correct.

Mr. SHAYS. Thank you. Lovely to have you here. Thank you. You have the floor.

STATEMENT OF JOHN O. AGWUNOBI, M.D.

Dr. AGWUNOBI. Thank you, Mr. Chairman and members of the committee, for this opportunity to testify before you on the critically important subject of pandemic influenza preparedness.

Pandemics are, indeed, a fact of life, a reality of living on this planet. They have occurred numerous times in the past, and they will likely, unfortunately, occur in the future.

Our ultimate goal must, therefore, be to achieve a constant, yet flexible state of national preparedness, an enduring national ethic of readiness for any and, indeed, for all hazards.

If the next pandemic is anything like the one that we experienced as a planet in 1918, I know currently of no nation that can credibly claim to be ready today. Therefore, much work remains to be done.

We hope and pray that the next pandemic is a mild one. But as my colleague Julie Gerberding often says at the CDC, hope is not a strategy, and prayer is not a plan. More, quite frankly, is expected of Government.

Fortunately, some recent modeling shows that with aggressive Nation-wide preparedness, exercised readiness—not just a paper plan, but an exercised plan—and an unhesitant leadership when the alarm bell rings, that we can actually manage our way through a pandemic, greatly reducing its negative impact on individuals and our community.

We learn more with each passing day. And as we learn, we will continue to strengthen our planning and our preparedness.

On November 1, 2005, the President announced the release of the National Strategy for Pandemic Influenza, including a request for $7.1 billion to fund that strategy. Already $3.8 billion has been appropriated, and our journey of preparedness is now well underway.

This month, the White House released a more detailed implementation plan that delineates 300 critical preparedness tasks for agencies of Government and the private sector. Of these, 199 are assigned to the department—the U.S. Department of Health and Human Services.

HHS is clearly identified as being in charge of all the public health and medical aspects of preparedness and our response in a pandemic, and we work very closely with our sister agency, the Department of Homeland Security.

We have international and domestic responsibilities. Our efforts abroad involve the strengthening of international public health and medical partnerships and cooperation, global surveillance, and

rapid response—the building of rapid response capabilities and enhanced capacity globally to respond.

Our efforts at home include improved intra- and interagency collaboration, coordination, at both the horizontal and vertical level across public health in medical communities, the continued strengthening of surge capacity across the Nation, enhanced domestic surveillance, and improved State and local planning and exercising of those plans, including a recent effort to reach out to every State in the form of pandemic summits in which the Secretary himself participated. We've now completed 49, and we continue to reach those that we haven't got to yet.

We focus and recognize the importance of preparedness of individuals and families in this movement to develop a nation prepared for a pandemic. The development of clear and open risk communication is an essential strategy and a part of our plan.

Our efforts include the stockpiling of pre-pandemic H5N1 vaccine and efforts to build our capacity to provide 300 million pandemic vaccine courses within 6 months of the declaration of a pandemic. Our strategy includes efforts to promote scientific research and to advance technology used in vaccine development and manufacturing. While we are working to stockpile antiviral drugs, we are also investing in the search for new and improved antiviral alternatives.

We are working to further the search for rapid, accurate, yet portable diagnostic tests for H5N1, and we continue to stockpile other drugs and resources, including ventilators and personal protective equipment.

In conclusion, Mr. Chairman, preparedness is a journey, not a destination. It's a journey that must be Nation wide, involve Federal, State, and local leaders in partnership, and include every sector of society. Every individual, every community must do their part.

In combination, our efforts to prepare for a pandemic can and will have a dramatic impact on even the worst type of pandemic. But it may also help us resolve the recurring problems that we have seen in recent years with seasonal flu vaccine distribution and perhaps even reduce the dramatic numbers of citizens lost each year to seasonal influenza. As you know, sir, on average about 36,000 lives are lost per year.

Preparedness for a pandemic makes us a nation better prepared for any and all hazards, man made or natural. We're better prepared today than we were yesterday, and Mr. Chairman, I have no doubt we will be better prepared as a nation tomorrow than we are today.

Thank you.

[The prepared statement of Dr. Agwunobi follows:]

Testimony
Before the Committee on Government Reform
U.S. House of Representatives

Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations

Statement of

John O. Agwunobi, M.D.

Assistant Secretary for Health
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, May 11, 2006

Mr. Chairman and members of the Committee, I am honored to be here today to describe for you how the Department of Health and Human Services (HHS) is working to improve the nation's preparedness for a potential human influenza pandemic. Thank you for the invitation to testify on this issue, which is one of our highest priorities at HHS.

Strategy and Threat Assessment

On November 1, 2005, President Bush released the *National Strategy for Pandemic Influenza*, which outlines the roles of the Federal government and sets expectations for State, local, and tribal governments, private and international partners, and individual citizens in preparing for and responding to an influenza pandemic. The following day, Secretary Leavitt announced the *HHS Pandemic Influenza Plan*-a blueprint for all HHS pandemic influenza preparedness and response planning. The HHS Plan provides guidance to national, State, and local policy makers and health departments with the goal of achieving national readiness and the ability to respond quickly and effectively to a pandemic. The HHS plan also includes an outline of key HHS roles and responsibilities during a pandemic. In the event of a pandemic, under the National Response Plan, HHS will lead the public health and medical response with the Department of Homeland Security carrying out its responsibility for overall domestic incident management and Federal coordination. However, ultimately, the center of gravity for such a response will be at the state and local level.

As you know, the President requested $7.1 billion in emergency funding for the *National Strategy for Pandemic Influenza*, of which $6.7 billion was requested for HHS. Congress appropriated $3.8 billion as the first installment of the President's request to begin these priority activities, and of this amount, $3.3 billion was provided to HHS. We appreciate the action of Congress on this appropriation as it takes us an essential step forward to becoming the first generation in history to be prepared for a possible pandemic.

We must also continue to prepare against a possible pandemic influenza outbreak. The President's Budget includes $2.3 billion in funding for the 2007 portion of the emergency funding request to fulfill the next phase of the Strategy. It is vital that this funding be allocated in the most effective manner possible to achieve our preparedness goals, including producing pandemic influenza vaccine for every American within six months of detection of sustained human-to-human transmission of bird flu virus; ensuring access to enough antiviral treatment courses sufficient for 25 percent of the U.S. population; and enhancing Federal, state and local as well as international public health infrastructure and preparedness.

The President's FY 2007 budget also requests more than $350 million for important ongoing pandemic influenza activities at HHS such as safeguarding the Nation's food supply (FDA), global disease surveillance (CDC), and accelerating the development of vaccines, drugs, and diagnostics (NIH).

Pandemics are not new. There were three in the 20th century, the worst of which was the Spanish flu epidemic in 1918-1919 that is estimated to have killed over one half million people in the U.S. and 50 million worldwide. While we are focusing today on the impact

of the H5N1 avian flu virus from a strain currently circulating in birds in many parts of Asia and Europe, many of the policy issues and preparedness measures that arise for this strain of influenza apply as well to pandemics of other types of influenza, other emerging infectious disease outbreaks and public health emergencies. For example, pandemic preparedness offers tangible benefits in the fight against seasonal influenza which causes an average of 36,000 deaths each year.

Scientists cannot accurately predict the severity and impact of an influenza pandemic, whether from the H5N1 virus or the emergence of another influenza virus of pandemic potential. However, it is still useful to model possible scenarios based on analysis of past pandemics. In a report released in December 2005, the Congressional Budget Office presented the results of modeling a severe pandemic scenario similar to the 1918 Spanish flu outbreak and a more moderate outbreak resembling the flu pandemics of 1957 and 1968. In the severe scenario, roughly 90 million people become ill and 2 million die in the United States and the impact on the real Gross Domestic Product [GDP] is about a 5 percent reduction in the year following the outbreak. While there is substantial uncertainty associated with these estimates, they illustrate the enormous public health threat of an influenza pandemic and the need for effective access to vaccines, treatments, and a robust public health infrastructure to meet the challenge.

There are several important points to note about an influenza pandemic:

- A pandemic could occur anytime during the year and is unlikely to behave like a typical seasonal influenza. Rather, past pandemics have occurred in multiple "waves" of infection and could persist in the world for over a year.

- In the absence of effective vaccines and antivirals, the capacity to prevent or control transmission of the virus once it gains the ability to be efficiently transmitted from person to person will be limited.

- Right now, the H5N1 avian influenza strain that is circulating in Asia and Europe among birds is a significant concern, but there is no way to know whether this virus will in fact lead to a human pandemic. Whether of not the H5N1 adapts itself to the human host, we know that influenza viruses are constantly evolving, and it is possible that this strain or another influenza virus, which could originate anywhere in the world, could cause the next pandemic. This uncertainty is one of the reasons why we need to maintain year-round surveillance of influenza viruses to be able to determine if there are genetic changes that may signal a potential pandemic, to develop reference viruses that can be used to develop pandemic vaccines, and to assess whether influenza viruses have developed resistance to antiviral drugs. As is the case with the H5N1 that is currently in birds around the world, pandemic influenza viruses often emerge in animals. Like other viruses, they tend to remain within a species. However, as we have seen already in the more than 200 documented cases of human infection of H5N1 confirmed by the World Health Organization, they do have the ability to infect humans who have been exposed to infected birds. Of greatest concern for human health is the question of whether the viruses will develop the ability to readily infect people and whether these viruses will be able to transmit efficiently from person to

person as is the case with seasonal flu. For all of these reasons, it is critical to maintain constant surveillance of viruses worldwide affecting animal populations and that can potentially be transmitted to humans.

- We often look to history in an effort to understand the impact that a new pandemic might have, and how to intervene most effectively. However, there have been many changes in society since the "great influenza" of 1918, including dramatic changes in population and social structures, medical and technological advances, and a significant increase in international travel. Some of these changes have increased our ability to plan for and respond to pandemics, but other changes may have made us more vulnerable.

HHS Preparations for Pandemic Influenza

As you know, the President announced the *Implementation Plan for the National Strategy for Pandemic Influenza* on May 3, 2006. The purpose of this plan is to ensure that the efforts and resources of the Federal government and State, local and tribal governments and the private sector will be brought to bear in a coordinated manner against the pandemic threat. The *Plan* describes more than 300 critical actions, many of which have already been initiated, to address the threat of pandemic influenza. The *Implementation Plan for the National Strategy for Pandemic Influenza* confirms HHS' role as the lead federal agency for the public health and medical preparation and planning for and response to a pandemic. The Secretary of HHS will lead the Federal health and medical

response efforts, serve as the primary Federal spokesperson for pandemic health issues, and coordinate the actions of other departments and agencies in the overall public health and medical emergency response efforts. The Secretary of the Department of Homeland Security (DHS) will provide broader overall incident management for the Federal response, will ensure necessary support to HHS to coordinate the public health response, and coordinate with HHS and other Federal, State, and tribal agencies in providing non-medical support.

The timing of the release of this Plan does not signal that a pandemic is imminent. The Plan is the result of much work in many Federal Departments and agencies to further prepare the government for a pandemic, whenever it might occur. It is important to note that the H5N1 avian influenza is a disease of birds, the virus has not yet appeared in the U.S., and there is no influenza pandemic in the world at this time.

HHS has been working with many Federal agencies, including the U.S. Department of Agriculture, the Departments of Homeland Security, State and others, in drafting the public health and medical aspects of the *Implementation Plan for the National Strategy*. The Plan spells out over 199 specific tasks that HHS will take the lead in or play a supporting role in to accomplish the human health aspects of the strategy. It is important to note that HHS has already started to make progress on many of the tasks delineated in the plan.

The Department's key tasks outlined in the plan include:

- Building stockpiles of pre-pandemic vaccine adequate to immunize 20 million persons against influenza strains that present a pandemic threat;

- Expanding domestic influenza vaccine manufacturing surge capacity for the production of pandemic vaccines for the entire U.S. population within 6 months of a pandemic declaration;

- Building stockpiles of antivirals adequate to treat 25% of the U.S. population, divided between Federal and State stockpiles;

- Building a Federal stockpile of 6 million treatment courses reserved for domestic containment efforts.

- Developing clear guidelines and decision criteria to assist State, local, and tribal governments and the private sector in defining groups that should receive priority access to existing limited supplies of vaccine and antiviral medications and other critical medical care.

- Working with State and tribal entities to develop and exercise influenza countermeasure distribution plans and to include the necessary logistical support of such plans, including security provisions.

- Establishing a strategy for deploying Federal medical providers from across the USG, including expanding and enhancing programs such as the Medical Reserve Corps and supporting the transformation of the Commissioned Corps of the Public Health Service.

- Creating plans to rapidly credential, organize, and incorporate volunteer health and medical providers as part of the medical response in areas that are facing workforce shortages.

- Supporting local and national efforts to:
    - establish "real-time" clinical surveillance in domestic acute care settings such as emergency departments, intensive care units, and laboratories;
    - link hospital and acute care health information systems with local public health departments; and
    - advance the development of the analytical tools necessary to interpret and act upon these data streams in real time.

- Establishing a single interagency hub for infectious disease modeling efforts, and ensuring that this effort integrates related modeling efforts for transportation decisions, border interventions, economic impact, etc. HHS will also work to ensure that this modeling can be used in real time as information about the characteristics of a pandemic virus and its impact become available.

- Providing guidance to all levels of government on a range of options for infection control and containment, including those circumstances where social distancing measures, limitations on gatherings, or quarantine authority may be an appropriate public health intervention.

Current HHS Progress

In December 2005, Congress appropriated $3.8 billion to help the Nation prepare for pandemic influenza preparedness activities. Of that total, Congress allocated $3.3 billion to HHS for the first year of funding of the HHS Pandemic Influenza Plan. HHS will use these emergency funds to help achieve five primary objectives:

1. Monitoring disease spread to support rapid response;
2. Developing vaccines and vaccine production capacity;
3. Stockpiling antivirals and other countermeasures;
4. Coordinating Federal, State and local preparation; and
5. Enhancing outreach and communications planning.

HHS is working both domestically and internationally to monitor the spread of H5N1 and other possible pandemic viruses. On the international front, HHS is spending $125 million of its FY 06 allowance to promote international pandemic preparedness and planning and augment existing capabilities in areas such as international surveillance,

epidemiological investigation, and diagnosis of illness. Through collaborations with the World Health Organization (WHO), the United Nations Food and Agriculture Organization, the World Organization for Animal Health, and numerous national governments, HHS is working to build capacity in other countries to detect outbreaks early and to contain the spread of the virus. HHS has signed Memoranda of Understanding (MOUs) on influenza and other emerging infectious diseases with Institute Pasteur (IP); the Gorgas Institute and the Ministry of Health of Panama; and most recently, the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B). HHS experts have participated in WHO-led investigations into human cases of avian influenza in Indonesia, China, and Turkey and are providing substantial technical assistance for influenza containment activities to many other countries on an as needed basis. Overall, HHS is supporting influenza activities in approximately 40 countries and has assigned influenza staff to the World Health Organization (WHO) Secretariat, Regional, and country offices in Europe and Southeast Asia.

On the domestic front, CDC is devoting $50 million to strengthen local laboratory capacity and capability and $35 million to accelerate the implementation of the national BioSense program to enhance our ability to detect an outbreak early. On January 1, 2006, BioSense RT (Real-Time) was launched in 10 select cities and 32 healthcare institutions across the country. Real-time transmission of existing clinical diagnostic and health information is being sent to CDC and analyzed. In April 2006, CDC launched a new data visualization and analysis tool for the use of all jurisdictional levels of public health (hospital, city, county, state, national). The BioSense implementation timeline is to link up to several hundred hospitals in over 30 cities by the end of 2006.

In the event of a pandemic, infection control practices and social distancing measures (such as school closures, cancellation of public gatherings, etc), and antiviral drugs will be the first line of defense before a vaccine is available and could limit and delay the spread of the pandemic. Currently, the Strategic National Stockpile (SNS) has over 5 million treatment courses of antiviral drugs on hand. On March 22, Secretary Leavitt announced the purchase of additional antiviral drugs that could be used in the event of a potential influenza pandemic. With these purchases, the SNS will have 26 million treatment courses of antiviral drugs that will be available to the States when an influenza pandemic is imminent. HHS' strategy is to federally procure an additional 24 million treatment courses of antiviral drugs through FY 07 and FY 08 funds and to offer a 25 percent federal subsidy for state purchase of another 31 million treatments courses. Thus, additional money will be needed to meet our goal to have enough antivirals for 25 percent of the population during a pandemic. Congressional support of $2.3 billion for the second year of the President's Pandemic Influenza plan will be critical to meet this goal.

The cornerstone of the HHS Pandemic Influenza Plan is to create domestic manufacturing capacity sufficient to produce 300 million vaccine courses within 6 months of the onset of a pandemic outbreak, and to maintain a stockpile of pre-pandemic vaccine. We currently have approximately 4 million courses of pre-pandemic vaccine against a clade 1 H5N1 avian influenza strain. Plans and procedures are also underway to manufacture pre-pandemic vaccine against a clade 2 H5N1 avian influenza strain that is currently circulating the globe.

On May 4, 2006 Secretary Leavitt announced the award of $1 billion for five contracts to support the development of advanced techniques using a new cell-based, rather than an egg-based, approach to producing influenza vaccines. Using a cell culture approach to producing influenza vaccine is a promising technology and offers a number of benefits. Vaccine manufacturers can bypass the step needed to adapt the virus strains to grow in eggs. In addition, cell culture-based influenza vaccines will help meet surge capacity needs in the event of a shortage or pandemic, since cells may be frozen in advance and large volumes grown quickly. U.S. licensure and manufacture of influenza vaccines produced in cell culture also will provide security against risks associated with egg-based production, such as the potential for egg supplies to be contaminated by various poultry-based diseases, including pandemic influenza strains. Finally, the new cell-based influenza vaccines will provide an option for people who are allergic to eggs and therefore unable to receive the currently licensed vaccines.

A total of $1.7 billion in FY 2006 funding is allocated for vaccine development to increase vaccine production capacity by accelerating cell-based manufacturing technology, increasing egg-based vaccine production capacity, and supporting the advanced development for antigen sparing technologies that could extend the vaccine supply by decreasing the amount of antigen needed to protect each individual.

Progress has also been made in the SNS purchase of medical supplies and equipment essential to pandemic readiness. HHS has purchased over 150 million N95 respirators and surgical masks with approximately $50 million of FY06 funds. Other planned

procurements include personal protective equipment (PPE), ventilators, IV antibiotics, and other medical supplies. Advanced development for rapid diagnostic tests also continues through the use of FY06 funds. A request for information (RFI) was issued for a point-of-care diagnostic on March 30, 2006 and a request for proposal (RFP) will be issued soon.

State and Local Preparedness

Pandemic influenza preparedness requires the active planning and participation of States and local communities. If a pandemic were to occur in the U.S., it would likely affect thousands of communities at the same time over the course of many weeks. The Federal Government is working to provide guidance regarding how state, local, and tribal governments can develop pandemic preparedness plans and respond in the event of a pandemic. As part of the Administration's effort to enhance State and local pandemic preparedness, HHS has held pandemic influenza summits in 47 States and the District of Columbia so far. These summits have brought together State and local officials, public health, schools, businesses, and other stakeholders to discuss pandemic preparedness. With the FY 2006 emergency funding, HHS has awarded $100 million of the $350 million allocated for State preparedness for pandemic influenza preparedness planning activities. The remaining portion of these funds will be awarded based on benchmarks that will measure States' progress.

It is important to note that HHS funding to enhance State and local preparedness for public health emergencies, including pandemic influenza, has existed since 2001. Principally through CDC and HRSA funds have been provided to States and localities to upgrade infectious disease surveillance and investigation, enhance the readiness of hospitals and the health care system to deal with large numbers of casualties, expand public health laboratory and communications capacities and improve connectivity between hospitals, and city, local and state health departments to enhance disease reporting.

First, CDC provides preparedness funding annually to public health departments of all the States, certain major metropolitan areas, and other eligible entities through cooperative agreements. Second, HRSA employs complementary cooperative agreements to provide preparedness funding annually within States for investment primarily in hospitals and other healthcare entities. HHS collaborates with DHS toward ensuring that the guidance associated with the CDC and HRSA awards is coordinated with the guidance associated with those DHS awards that address other aspects of State and local preparedness, such as emergency management and law enforcement. Including the funding we have requested for FY07, CDC and HRSA's total investments in State and local preparedness since 2001 will total almost $8 billion.

In addition, the ability to quickly increase the number of health care workers available is a critical component of State and local public health emergency response capacity. HRSA has supported efforts to improve personnel surge capacity. Funds are used to allow jurisdictions to develop or enhance Emergency Systems for Advance Registration of

Volunteer Health Professionals (ESAR-VHP), authorized under the Public Health Security and Bioterrorism Preparedness and Response Act. ESAR-VHP is designed to help States develop registries of volunteer health professionals whose credentials have been verified in advance of an emergency so that they can be quickly called on and utilized in an emergency. In addition to the FY07 budget request of $8 million to continue HRSA's registration system, the budget also proposes development of a web-based portal that would create the means for integrating the state ESAR-VHP systems into a National system, thereby promoting a more coordinated national deployment of personnel. The portal is intended to not only integrate existing state ESAR-VHP systems, but to also provide a credentialing service that could assist states with the development of their ESAR-VHP databases. The budget also proposes to fund a Mass Casualty Initiative, including the Medical Reserve Corps and Healthcare Provider Credentialing and the Commissioned Corps Transformation initiatives.

Lastly, effective communications and outreach are essential to pandemic preparedness at the Federal, State and local levels. President Bush called for the development of a single, comprehensive web site to be the official Federal source of pandemic and avian influenza information. This web site, www.PandemicFlu.gov, includes a wide range of information on pandemic influenza and preparedness activities. In addition, HHS has developed a series of checklists intended to aid preparation for a pandemic in a coordinated and consistent manner across all segments of society. Thus far, ten checklists have been released and are aimed at State and local governments, the business community, the

education sector, the health sector, community organizations, and individuals and families.

Conclusion

Thank you for the opportunity to share this information with you. Although much has been accomplished, continued vigilance and preparation are needed for us to be ready for a pandemic. I am happy to answer any questions at this time.

Mr. SHAYS. Thank you.

Before you jump in, Mr. Runge, I have heard three kind of memorable statements. Hope is not a strategy. Prayer is not a plan. Preparedness is a journey, not a destination.

So I want to add mine. When one of the witnesses says, "We are taking steps in the right direction," I want to remind you of what former senator Sam Nunn, his observation, said. It is often not enough to take steps in the right direction. A gazelle running from a hungry cougar is "taking steps in the right direction." But survival in that case, and in ours, is more a matter of speed than direction.

So the question isn't just are we doing the right things, but are we doing them in time? The sense of urgency is as critical against a pandemic flu as the plan to fight the outbreak.

So now I have added mine. And Mr. Runge, you can add one, too, if you care to. [Laughter.]

STATEMENT OF JEFFREY W. RUNGE

Dr. RUNGE. Thank you, Mr. Chairman.

I would like to add that my name is Jeff Runge, R-U-N-G-E. Yes, sir. Thank you very much for the chance to——

Mr. SHAYS. Mr. Runge, I apologize.

Dr. RUNGE. That's no problem.

Mr. SHAYS. It is nice to have you here, Mr. Runge.

Dr. RUNGE. I serve as the Chief Medical Officer for the Department of Homeland Security, as well as the Acting Under Secretary for Science and Technology. I am very pleased to be here with my colleague, Dr. Agwunobi, to discuss the role of DHS as the overall incident manager and the coordinator of the Federal response in the event of a flu pandemic.

DHS is working very closely with its Federal partners—the HHS, Department of Defense, USDA, and the Veterans Administration, and the Homeland Security Council—to prepare for the worst and to ensure that we are coordinated. Together with our Federal partners, we understand our roles in managing the outbreak of disease, whether it's an outbreak that's confined to the bird population or whether it is a full-scale human pandemic.

The USDA, with support from its State agriculture counterparts, will manage an outbreak in the bird population without help from DHS. HHS will manage the public health and medical aspects of an outbreak in the human population in prevention, response, and treatment. DHS will support HHS in fulfilling their responsibilities in any way we can.

Now even though we recognize the need to be ready at the Federal level, Secretary Leavitt and Secretary Chertoff, as well as Dr. Agwunobi and I, have made the point on numerous occasions that preparedness for an incident such as this must be defined at the local level. We have stood shoulder to shoulder with our colleagues in HHS and USDA at nearly 50 State pandemic summits, discussing the need to work together with State and local governments, nongovernmental organizations, faith-based organizations, and the private sector to ensure a condition of readiness.

Now the mechanism for coordination of a broad Federal response like this is the National Response Plan. The NRP supports the con-

cept that incidents are handled at the lowest jurisdictional level, even as it provides the mechanism for a concerted national effort.

Let me digress a moment into the likely scenario if a pandemic were to present serious and socioeconomic problems for the United States. The Secretary of Homeland Security, in consultation with other Cabinet members and the President, would likely declare an incident of national significance and implement the appropriate coordinating mechanisms. DHS is already ensuring that the appropriate multi-agency coordinating structures are in place well before an outbreak.

As a threat becomes more imminent and as a situation warrants, the Secretary may consider activating various elements of the national response, including designating a principal Federal official [PFO] standing up the joint information center and joint field offices.

Secretary Chertoff has already identified a candidate to become the national PFO for pandemic influenza. This individual will be intimately involved in the planning and exercising of all the contingency plans as we work toward the condition of readiness.

In the event we are faced with a pandemic, the Secretary would also activate a national planning element composed of senior officials of relevant Federal agencies, who have already been identified, to coordinate strategic level national planning and operations. He would also likely establish as many as five regional joint field offices that would be staffed and resourced with a deputy principal Federal official in charge of each of these regional joint field offices to work directly with their State and local counterparts.

Now this framework provides a coordinated response for all levels of Government, for non-Government agencies and volunteer organizations, and the private sector. This system also affords full coordination between joint regional field offices and the military joint task forces that might be established.

In the event of a pandemic, obviously, a close, synchronous working relationship with HHS is absolutely essential. Our national public health and medical resources will unquestionably be taxed, probably beyond capacity. And DHS will do everything in its power to assist HHS with its mission.

As our department's Chief Medical Officer, I am and will be the primary point of interface with HHS, as well as being Secretary Chertoff's advisor on all medical issues, including pandemic influenza.

Implementation of the national strategy announced last week contains over 300 action items with very aggressive timelines. Dr. Agwunobi's department has 199 that they are responsible for primarily. We have 58, and we are supporting other departments in another 84 items. We are prioritizing them and figuring out how we can best carry them out.

As the committee understands, the department has many competing priorities right now. But we are fully engaged to make sure that we are as prepared as we can be. In addition to our job as overall incident manager, we have some areas of unique responsibility to maintain the function of our Nation's critical infrastructures, border management, and DHS work force assurance.

We are also focused on identifying the economic consequences to our Nation during the pandemic. These issues are interrelated as we consider policies related to the transportation industry, the flow of trade across borders, and maintenance of the supply chain for food and other goods.

Mr. Chairman, as with any illness, prevention is by far the most effective method of dealing with this disease. We fully support the efforts of President Bush and the Department of HHS to improve our domestic vaccine production, to stimulate transformational change in vaccine technology, and to reinforce the capacity of State and local public health organizations, as well as educating the public on good health practices.

And one last point, Mr. Chairman. I want to make the point that the best way to prepare for a pandemic is to strengthen the institutions that we use every day, namely, the public health medical and emergency services, as well as the support of medical science for new vaccines and therapeutics.

The collateral benefits that we gain will improve our Nation's quality of life as well as our preparedness for any biological incident, whether it's man made or through a terrorist action.

Thank you, Mr. Chairman. I will be happy to answer any questions.

[The prepared statement of Dr. Runge follows:]

Statement for the Record

By

The Honorable Jeffrey W. Runge, MD

Acting Under Secretary for Science & Technology
and Chief Medical Officer

U.S Department of Homeland Security

Before the

Committee on Government Reform
United State House of Representatives

May 11, 2006

Good morning Chairman Davis, Congressman Waxman and Members of the Committee on Government Reform. I am pleased to have this opportunity to appear before you today to discuss the current threat from Avian Influenza and how the Department of Homeland Security (DHS) will coordinate the Federal response if an influenza pandemic were to occur in the United States.

Like members of this Committee, the Department of Homeland Security and our Federal partners recognize that an influenza pandemic in the United States could trigger severe public health and economic consequences, catastrophic loss of life, and disrupt our nation's critical infrastructures. DHS is working closely with its Federal partners, especially the Department of Health and Human Services (HHS), the U.S. Department of Agriculture (USDA), the Veterans Administration (VA), the Department of Defense (DOD), and the Homeland Security Council to prepare and to ensure that we are coordinated in our response.

The Role of DHS

As we coordinate, we recognize that each Department has responsibilities that are unique as well as some responsibilities that overlap. The DHS responsibilities are clear, pursuant to the Homeland Security Act of 2002 and Homeland Security Presidential Directive-5 (HSPD-5). As the domestic incident manager, the Secretary of DHS will coordinate the overall Federal response to a pandemic in order to ensure the continuity of our government, maintain civil order, preserve the functioning of society and mitigate the consequences of a pandemic. The Secretary of DHS serves as the principal Federal official for overall domestic incident management. In this

role, during a pandemic outbreak, the Secretary of Homeland Security is responsible for the coordination of Federal operations and/or resources, establishment of reporting requirements, and conduct of ongoing communications with Federal, State, local, tribal, private sector, and nongovernmental organizations.

Our Federal partners are also quite capable of fulfilling their respective roles in managing outbreaks of avian influenza, from well confined outbreaks in birds to a full-scale pandemic, and we are fully coordinated with them. The USDA, working with its state agriculture counterparts, has ample experience in managing an outbreak in the bird population. HHS has the responsibility and expertise to plan public health and medical preparedness. We all recognize that there is still significant work to be done to ensure the Nation is adequately prepared to respond to an outbreak in humans. As the *National Strategy for Pandemic Influenza* says, "Preparing for a pandemic requires the leveraging of all instruments of national power, and coordinated action by all segments of government and society." This need for coordination of our National instruments is part of the reason that DHS exists. A pandemic could threaten the ability of the health and medical sector to manage all the consequences, which could likewise threaten the functioning of society and the Nation's economy. It is the responsibility of DHS to coordinate the Federal response to manage those risks.

The NRP is the primary mechanism for coordination of the U.S. Government response to terrorist attacks, major disasters and other emergencies, and will form the basis of the Federal pandemic response. If a pandemic influenza were to present grave social and economic problems for the United States, the Secretary would—in consultation with other cabinet members and the

President—likely declare an Incident of National Significance and ensure implementation of the appropriate NRP coordinating mechanisms to ensure a coordinated Federal response.

The NRP supports the concept that incidents are handled at the lowest jurisdictional level. However, a pandemic will ultimately require a concerted national effort. Under the National Strategy and the NRP, Federal departments and agencies have assigned roles and responsibilities to support all incidents to include a biological incident.

The Secretary will consider the following four criteria set forth in HSPD-5 when making the determination to declare an Incident of National Significance; however, he will not be limited to these thresholds and may base his decision on other applicable factors:

- A Federal department or agency acting under its own authority has requested the assistance of the Secretary of Homeland Security
- The resources of State and local authorities are overwhelmed and Federal assistance has been requested by the appropriate State and local authorities
- More than one Federal department or agency has become substantially involved in responding to an incident, and
- The Secretary of Homeland Security has been directed to assume responsibility for managing a domestic incident by the President.

DHS will work collectively with the interagency to establish the appropriate multi-agency coordinating structures when the situation warrants, even before a full scale outbreak. The Secretary may consider activating elements of the national response, including designating a

Principal Federal Official, standing up the Joint Information Center and Joint Field Offices. The Secretary has already identified a candidate to become the national PFO for pandemic influenza. This individual will be intimately involved in the planning and exercising of our contingency plans.

The Secretary would also set up a national planning element composed of senior officials of relevant Federal agencies to coordinate strategic-level national planning. The Secretary would also likely establish as many as five Regional Joint Field Offices that would be staffed and resourced with a Deputy PFO in charge of each Regional JFO to work directly with state & local entities. This framework provides a coordinated response for all level of government, non-government and volunteer organizations (NGOs), and the private sector. This system also affords full coordination between the regional joint field offices and military joint task forces that may be established. Last month, Secretary Chertoff asked his fellow Cabinet members to identify senior officials to coordinate planning and operations among the Federal departments before a pandemic would strike. The list has been compiled, and we look forward to working with these individuals as we plan and train together with our pre-designated PFO and Deputy PFOs.

In the event of a pandemic, a close, synchronous working relationship with HHS is essential. Our national Public Health and medical resources will unquestionably be taxed, probably beyond capacity, and DHS will do everything in its power to assist HHS with its mission to prevent illness and mitigate the consequences of the anticipated widespread morbidity and mortality. The DHS Chief Medical Officer is the primary point of interface with HHS and is responsible for advising the Secretary of DHS on all medical issues, including avian influenza. The DHS Chief

Medical Officer is also responsible for directing and overseeing the planning, policy, training, and operations to protect the health of the DHS workforce in the event of a pandemic in order to maintain critical DHS operations. We are taking advantage of assets across the Department to accomplish this goal, especially the expertise of the U.S. Coast Guard medical officers.

Federal Preparedness for Pandemic Influenza

The National Strategy for Pandemic Influenza, issued by President Bush on November 1, 2005, provides the framework for the Federal government's response to the influenza pandemic threat. It presents a high-level overview of the Federal government's approach to an influenza pandemic, emphasizes the importance of the full participation of State Local, and Tribal Governments, the private sector and critical infrastructure components, the public, and the international community to prepare for, prevent, and contain influenza.

The National Strategy makes it clear that while the Federal government will pursue all avenues available to it to thwart an influenza pandemic, it is essential for the States and communities be fully informed and engaged as well. The resources of the Federal government alone may not be sufficient to prevent the spread of an influenza pandemic across the nation. Preventing, minimizing and mitigating the consequences of an influenza pandemic requires a coordinated and integrated national effort that includes the full participation of all levels of government and all segments of society.

The *Implementation Plan for the National Strategy* announced last week contains over 300 action items with very aggressive implementation timelines. DHS has the lead in 58 of these actions and participates with other departments in 84 additional items. The Department is currently prioritizing these actions and is attempting to identify resources to carry them out. The department has many competing priorities, but is fully engaged in planning efforts for our own departmental plans as well as fulfilling our responsibilities enumerated in the *Implementation Plan.*

While the Plan directs that departments and agencies undertake a series of action in support of the Strategy, it does not describe the operational details of how the departments will accomplish these objectives. Each department will devise its own planning documents that will operationalize the *Implementation Plan* and will address additional planning considerations that may be unique to each department.

The DHS Pandemic Influenza Implementation Plan

The DHS Pandemic Influenza Plan is structured around the three pillars of the National Strategy: Preparedness and Communication, Surveillance and Detection, Response and Containment. In order to support these pillars, the DHS plan focuses on the overall Federal incident management of a pandemic, as well as our unique responsibilities to manage our borders, protect our Nation's critical infrastructures, ensure the health and safety of the DHS workforce, and find ways to mitigate the overall economic impact tour Nation.

Since December, DHS work groups comprised of representatives from across all components of the Department have been working to accomplish these goals and have been developing contingency planning documents. The DHS Office of Infrastructure Protection has developed plans and exercises to maintain the function of the 17 critical infrastructures, working closely with the private sector and our Federal partners. In conjunction with its interagency partners, the Department will release a Critical Infrastructure and Key Resource Pandemic Influenza Preparedness, Response and Recovery Guide. This guide will assist the private sector in business continuity planning efforts to cope with business disruption and high rates of employee absenteeism that would accompany a pandemic. Our overall incident management workgroup is developing playbooks with the directorates and components of DHS, and has focused efforts on synchronizing operation centers from across Federal and State governments and developing a common operating picture methodology so that real-time communications are optimized. The workgroup on Entry and Exit Policy and Border Management has been working very closely with our Federal partners and the Homeland Security Council to determine the best policy to delay and limit the introduction of a pandemic into the U.S. through effective screening of passengers, travel restrictions and border controls, supporting the CDC's quarantine stations at our major point of entries, and providing training to our front line workforce. The Workforce Assurance workgroup has been working closely with the CDC and the Occupational Safety & Health Administration to devise scientifically sound policies for personal protective equipment and training protocols to minimize disruption to our workforce. They have also been developing contingency planning for Continuity of Government and Continuity of Operations to deal with disruptions in our workforce due to absenteeism or caring for loved ones. The Economic Consequences workgroup has been working with Federal partners and the National Laboratories

to identify and inventory the economic modeling capacity in order to drive policy decisions that would minimize economic disruption to our nation during a pandemic. Examples are policies related to transportation industry, the flow of trade within and across borders, and maintenance of the supply chain for food and other goods.

DHS Expenditures: Pandemic Preparedness

As part of the President's supplemental appropriations request to fund the National Strategy for Pandemic Influenza, DHS received $47.3 million to increase the readiness and response capabilities of the department in the event of an influenza pandemic. The Supplemental Funding Plan allocates funds in six key categories that include:

- Preparedness Planning: The Plan targets $12 million in funding for preparedness planning. This effort is aimed at preparing for the significant implications that a pandemic influenza would have on the economy, national security and the basic functioning of society. It includes developing the capability to anticipate the impact of the disease on absenteeism across multiple sectors and how this will affect the continuity of essential functions in support of the Federal response. Conducting modeling and simulation to predict the impact of pandemic flu on critical infrastructure; engaging in international negotiations for screening protocols, procedures and quarantine authorities; and participating exercises to test readiness are part of this effort.

- Training Development and Deployment: The Plan calls for $10.7 million to be allocated for the protection of border and domestic air and maritime travel. These funds will be used for readiness assessments of high risk airports and ports and training related to the use of quarantine stations and the isolation, handling, and transportation of potentially infected individuals. The experience of HHS and CDC training exercises will add value to DHS training activities, which will involve personnel of the U.S. Coast Guard, Immigration and Customs Enforcement, Transportation Security Administration, and Customs and Border Protection.

- Personal Protective Equipment (PPE): The Plan sets aside $16 million for the acquisition of PPE for approximately 145,000 high risk and mission critical personnel. DHS will develop the requirements to provide these personnel with appropriate PPE and establish respiratory protection programs, which include respiratory fit testing, medical clearance and PPE related training.

- Rapid Influenza Assay Study: The Plan provides $1.5 million to support system studies and define operational requirements for a rapid diagnostic tests, working in coordination with HHS. This test could provide more effective screening prior to departure and entry, especially in situations when infected persons may require isolation. This could have broader applications in the transportation sector, the workplace, or for continuity of government purposes.

- Isolation Systems: The Plan dedicates $4.4 million to support infrastructure changes and construction of isolation systems at ports of entry or other major transportation hubs. Currently the CDC has only 18 quarantine stations among over 320 ports of entry, few of which have adequate facilities for isolation and containment of infected travelers.

- Program Support: The Plan allocates $2.7 million for technical, management, financial, and integration functions relating to the implementation of the Plan. This includes the coordination of requirements from DHS components for workforce protection, environment, training, staffing restrictions and protocols as well as documentation and tracking of requirements and plans.

Conclusion

Since the reorganization of DHS under Secretary Chertoff's 2nd Stage Review and the formation of the Office of the Chief Medical Officer, a tremendous amount of our focus has been on pandemic influenza planning, supplemental budget development and coordination, coordinating with other Federal agencies on policy matters, and participating in the writing of the *Implementation Plan*. DHS senior officials have been present with HHS at nearly every one of the 50 State Pandemic Summits.

The Department of Homeland Security is in the process of making recommendations to further clarify the National Response Plan to better fulfill its incident management role. In collaboration

with our international partners, we are developing screening and containment procedures to decrease the likelihood of disease spread should sustained human-to-human transmission occur. We have been working with our federal government and private sector colleagues to provide business continuity guidance and recommendations, especially for critical infrastructure and key resources. Our own plan addresses workforce protection and continuity of operations.

The challenge to complete an effective contingency plan for DHS and realize an appropriate response to such a catastrophic incident is formidable. Carrying out the hundreds of actions in the Implementation Plan will require significant amounts of time, human resources, and budgetary resources. Even with the challenges, this effort will be worth it for the sake of our Nation's biodefense. It has become apparent that the newly found coordination among State, local and tribal governments, HHS, DHS, USDA, VA, and DoD, NGOs and the private sector will put our Nation in much better shape to deal with biological threats, regardless of whether they are natural or man made. The collateral benefits of pandemic planning are undeniable and are worth our department's best efforts and full engagement.

As with any illness, prevention is by far the most cost effective method for dealing with this disease. We fully support the efforts of President Bush and the Department of Health and Human Services to reinvigorate our domestic vaccine production, to stimulate transformational change in vaccine technology, reinforce the capacity of State and Local public health organizations and educate the public on good public health and ways to keep every individual and family safe.

The best way to prepare for and prevent a pandemic or any major catastrophic event is to strengthen the institutions that we use every day, namely public health, medical, and emergency services, as well as the support of medical science for new vaccines and therapeutics. They are also avenues to enhancing the quality of health care and the quality of life in our communities on a daily basis. We look forward to working with Congress as well as our State and local counterparts to ensure that the response is as efficient and effective as it can be.

Chairman TOM DAVIS [presiding]. Thank you very much.

Dr. Agwunobi, let me start with you. What lessons did HHS learn from Katrina and the 2005 hurricane season that can be applied to pandemic planning and preparedness?

Dr. AGWUNOBI. I think there's one broad lesson that I think is very clear. And that is that a pandemic is fundamentally different than what we saw in Katrina. In Katrina, I think we realized that an essential part of our response was the rallying to the needs of those communities by the professionals and the first responders of other communities from around the Nation.

In a pandemic, we envision that every community will be simultaneously facing the crisis of a pandemic and that there may be—in fact, it's probably guaranteed that there will be very limited ability for other States and other communities to rally to the aid of a community living through a pandemic.

I think other lessons are obvious, and that is that we need to collaborate and strengthen our ability to work with health professionals within every community. Medical Reserve Corps was one that we used during Katrina and are building upon now. This notion that practitioners from across the Nation can be prepared to respond to the needs of their own communities if you organize them beforehand, credential them beforehand, and train them beforehand. And we're doing just that with the Medical Reserve Corps.

I think, last, I'll just add that a great lesson learned and one that we will buildupon is this notion of a partnership between us and Homeland Security. The need to not only focus on the health and medical aspects of a pandemic, but also those other aspects of the community that might be affected, like critical infrastructure, electricity supplies, water supplies, and the like.

Chairman TOM DAVIS. But given the decentralized nature of the U.S. public health system, much of the pandemic preparedness really needs to occur at the State and the local level. One of the problems of Katrina, of course, is we never got a unified command.

How many State pandemic plans has CDC reviewed or approved?

Dr. AGWUNOBI. I believe the CDC has actually reviewed all of the State pandemic plans to date. Clearly, those plans change with time. They're constantly being improved at the State level, and CDC is constantly reviewing the updated versions as they are submitted.

Chairman TOM DAVIS. Is every State in compliance and has a plan at this point as far as you know?

Dr. AGWUNOBI. Every State does have a plan, and those plans are being improved on a continual basis.

Chairman TOM DAVIS. Do you have performance measures over these plans?

Dr. AGWUNOBI. The CDC guidance that is being prepared to date and will be issued with—along with funds designated to enhance preparedness and exercising of those plans will contain detailed performance requirements and expectations.

Chairman TOM DAVIS. The States found these guidelines helpful, do you think?

Dr. AGWUNOBI. I think we're hearing back from the States that planning and preparedness is well underway. They recognize that,

like every nation, that there's more that needs to be done. We're hoping and are beginning to see that these plans are going beyond the State, but they're now being developed into communities by local leaders, and that's very heartening.

Chairman TOM DAVIS. And let me ask you, to what extent are you and the Department of Health and Human Services planning to use telework during a continuity of operations?

Dr. AGWUNOBI. Our continuity of operations plan contemplates the need for telework and work at offsite settings. I fully expect that as we release our own implementation plan for the Department of Health and Human Services that it will contain in large part great plans for telecommuting.

Chairman TOM DAVIS. Dr. Runge, as you saw during Hurricane Katrina, the National Response Plan can be ambiguous. Individual authorities among agencies were not always clearly identified. How are DHS and HHS using the lessons learned from Katrina to fix deficiencies in the National Response Plan so that the country is more rapidly prepared for future disasters?

I will tell, in Katrina, not being there rapidly getting things together ended up costing lives and money. In this case, with a pandemic, time is critical and being able to move in. What have we learned here?

Dr. RUNGE. That's obviously a great question, and it's one that we spent quite a bit of time.

I had the—I would say it was a luxury, but it actually is not a luxury of joining the department after Katrina and working backward with my new colleagues who arrived on the scene after Katrina. And we were not happy either with the coordination that occurred with DHS and HHS, and we have taken tremendous steps in fixing that.

The deputy secretaries of both agencies, together with our counterparts, have spent many hours talking about how we're going to improve the coordination and function of the Emergency Support Function 8, as well as my chief of staff has spent the last week in the Gulf States talking about how we are better coordinated with hurricane preparedness, playbooks. We are coming together with a pandemic—a playbook for pandemic.

We've also, and I think you'll be interested in this, have been going department by department and talking about the importance of using the National Response Plan and that the plan is no good unless it's used.

It may be no surprise that the tenets of the National Response Plan, perhaps because they are a bit ambiguous and unusual for the nonmilitary, such as myself, that we actually have to sit down and discuss how to operationalize that coordination. And I think that we are well on the way toward a completely bolted together HHS and DHS.

The Office of the Chief Medical Officer was just created as a result of the second stage review, and they have a constant point of contact for all of these issues. I'm much more confident that we are better equipped not only for this hurricane season, but in the event of a pandemic.

Chairman TOM DAVIS. OK. Thank you very much.

To what extent is DHS planning to use telework during——

Dr. RUNGE. One of our workgroups, Mr. Chairman, is continuity of Government, continuity of operations. We have quite a bit of expertise in the department. We've got an integrated team working on that issue, headed by Coast Guard Chief Medical Officer, Admiral Higgins.

But I will say, in all fairness, that the other side of our agency, the Infrastructure Protection Office, has responsibility for the maintenance of the 17 critical infrastructures of which telecommunications is one, is looking very carefully at this issue.

It's one thing to say that we'll all go home and use the Internet for work. It's another matter to make sure that the backbone is in place, that the last mile of copper going into neighborhoods will, in fact, withstand the increased traffic.

Our Critical Infrastructure Partnership Office has had a couple of tabletops with the telecommunications industry involving this issue, and it turns out to be quite a more complex problem than simply saying, "Guys, go home and log on."

Chairman TOM DAVIS. Absolutely.

Ms. Springer, what happens if a Federal agency doesn't adequately incorporate telework in its COOP planning for a pandemic? In other words, what are the risks to that agency and the public if the agency isn't prepared to carry out its essential functions?

Ms. SPRINGER. Well, each agency, in my judgment, needs to have telework as a part of its COOP plan. And as the Comptroller mentioned, the GAO guidance is, in fact, exactly that, that is an important component. So it's hard for me to imagine that wouldn't be.

The telework statute, as it exists right now, does not authorize OPM to regulate the telework program. So we aren't in the position to actually direct agencies to include it. But working with FEMA, I think——

Chairman TOM DAVIS. Would you like to have that authority?

Ms. SPRINGER. I think someone needs to have it.

Chairman TOM DAVIS. OK.

Ms. SPRINGER. But I think certainly from an emergency standpoint, which is different than the routine type of telework, the day-to-day normal condition telework, but in an emergency situation, I think at a minimum, the FEMA direction needs to be that is a must component of COOP plans.

Chairman TOM DAVIS. OK. OPM and DHS issue guidelines and offer assistance in COOP and telework planning, but Federal agencies can take it or leave it. And according to GAO surveys, they often leave it. Frankly, the progress of Federal agencies in adopting COOP plans and implementing telework is not very impressive.

In fact, the White House pandemic implementation plan says nothing at all about requiring Federal agencies to develop COOP pandemic plans or incorporate telework in those plans. It also doesn't require DHS or OPM to review agency plans once they are developed.

So what steps can OPM take to ensure that other Federal agencies follow your guidance on COOP planning, especially in the face of pandemic? And what additional authority would OPM need to assure compliance, and do you think OPM is the right agency?

Ms. SPRINGER. Well, OK. There are several questions you asked there. Let me answer those because they're all important.

At this point, we think roughly half the agencies—or actually, this is our most recent telework survey. We're about to go out with another one, which I think is pretty timely. But about half the reporting agencies had included telework in their COOP plans. About another half were working to achieve that goal.

As you noted, we're required under the implementation plan from the White House to issue guidance. But to the extent that we want to help to ensure that guidance is actually put into practice, there are several things we can do. I've already arranged to meet with the inspectors general community, the PCIE, at their June meeting. And to work with them and encourage them, even though we don't have the authority to commit them to do this, but to put into place a protocol for practicing not just telework, but to make sure that there is a practice of those plans at their agencies.

I've asked our own inspector general at OPM to—at the right time to evaluate a test that we will be doing of telework. We may take a Saturday or we may take a week day or two and actually commit those who are going to telework to actually do that. And then we'll have our inspector general—so I think inspector general commitment and involvement is going to be helpful here.

I think that we will develop best practices. That will be one of the sets of guidance that we put out. Not just here's how telework can work, whether you need an agreement, what needs to be in writing, that kind of thing. But actually some best practices as a result of those tests and what we find at OPM.

So those are the things where I see us actually going a little bit beyond the strict task that we've been given under the implementation plan. Beyond that, we don't have any particular statutory authority. I think that would—that implementation role resides at this point more likely with FEMA than OPM.

Chairman TOM DAVIS. OK. What role will OPM have in this June's interagency COOP exercise Forward Challenge? Are there plans for an interagency COOP exercise based on a pandemic flu scenario? And how essential is it for all the Federal agencies to engage in Government-wide exercises for COOP?

Ms. SPRINGER. Well, the last question is the easiest to answer. It's essential for everyone to participate. We will be participating in that June exercise. OPM, as I noted in my opening statement, has to make sure that OPM is running as well. In addition to the Government-wide guidance that we provide, we are a guidance agency.

But our own planning has led to the key essential functions that we need to do, and about a third of those are internal functions or infrastructure, keeping things running, telecommunications, things like that. But then there are others that are more externally focused. So we'll be testing those in the June exercise.

Chairman TOM DAVIS. All right. Ms. Koontz, let me move to you. One of the criticisms from GAO was that FEMA didn't provide adequate guidance to agencies to prepare for telework in the case of emergencies. Now the White House pandemic implementation plan directs OPM to issue guidelines for agencies on COOP planning criteria for a pandemic and to update its telework guidelines. Do you think that is an adequate response?

Ms. KOONTZ. We're encouraged that there's now a timeframe for issuing this kind of guidance. But what I'm not sure about at this point is whether the guidance will actually include the specifics on what agencies need to do to make sure that they are able to use telework effectively when—during an emergency situation. And that includes everything from testing to communications to technological capacity.

Chairman TOM DAVIS. If an agency already regularly uses telework, why does it need to test its COOP telework capabilities?

Ms. KOONTZ. I think as other witnesses have indicated, that testing is just critical of every part of continuity planning. But under an emergency, particularly a pandemic, you may have a lot more people teleworking than normal. And it may be—it's probably important to make sure that you actually have the technological—you have the communications capacity to do this. You have the software licenses that you need to do this.

Frankly, you don't know what you don't know. And what an exercise does is that it shows you those kinds of things, and you can feed them back into your continuity planning.

Chairman TOM DAVIS. What do you think is the most important thing agencies can do to prepare to continue operations during a pandemic?

Ms. KOONTZ. There are many things, but I'll touch on a few from the continuity perspective. And that is, first of all, they need to have a robust telework program that includes all the necessary preparations.

And then also I think agencies need to strengthen their basic continuity planning, and that includes identifying essential functions, identifying the interdependencies, identifying what resources you need, and then testing to make sure that it all works.

Chairman TOM DAVIS. Yes, but for agencies that have already begun planning to use telework, what should they do to ensure that the capability will be there in emergencies?

Ms. KOONTZ. We outline a full list of the practices that we think need to be present, but I'll highlight several. One is, is that they need to make sure that agency personnel understand that they are expected to work during an emergency using telework and understand what they're supposed to do in that scenario.

They also need to make sure that we have the technological capacity, including telecommunications, and we also need to test to make sure that we're able to do that.

Chairman TOM DAVIS. OK. Well, we have a vote on the floor. Unfortunately, somebody didn't get their amendment made in order on the defense authorization bill. So they are getting up and moving to adjourn every few minutes.

I think they think that by doing that, they will get maybe their amendment next time. I am not sure if that works that way or not. So I think at this point, I am going to let this panel go.

I want to thank you for your testimony. You know, we will stay in touch with you on this. It is just very, very important. We will take about a 10-minute recess while we go vote, and then we will swear in our next panel.

Thank you all very much.

[Recess.]

Chairman TOM DAVIS. Everybody take their seats. We are going to move to our second panel. It is a very distinguished panel.

We have Mr. Scott Kriens, who is the chairman and CEO of Juniper Networks. We have Paul Kurtz, the executive director of the Cyber Security Industry Alliance, and I think we have Alonzo Plough, who will be out in just a minute.

Let me just say it is our policy that all witnesses be sworn before you testify, and he will be here—oh, here he comes. Just raise your hand and say "I do." Will you please rise and raise your right hands?

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you, and be seated.

Mr. Kriens, we will start with you.

STATEMENTS OF SCOTT KRIENS, CHAIRMAN AND CEO, JUNIPER NETWORKS; PAUL B. KURTZ, EXECUTIVE DIRECTOR, CYBER SECURITY INDUSTRY ALLIANCE; AND ALONZO PLOUGH, BOARD OF DIRECTORS, TRUST FOR AMERICA'S HEALTH

STATEMENT OF SCOTT KRIENS

Mr. KRIENS. Thank you, Mr. Chairman and members of the committee.

I'd just like to make a couple of comments today in light of what we heard earlier. And I will skip over the alarming statistics, because I've certainly personally heard plenty of those, and get to the question of what can we do here? And how can we make this better?

Because the real risk of the pandemic is not in the although tragic consequences of the pandemic itself, the real risk of loss is going to be in how well we do or do not handle it. And we have a great tool here. The Internet itself was, as many of you know—and I know you know, Mr. Chairman—was born from research work done by the Government in the 1960's.

But sometimes what's not known about that is it was actually founded on the concern in the cold war days that centers of communication and through threats from other enemies we would be disrupted as a Nation. And the Internet and the structure of its design was meant to recover communications in the event that major centers were disrupted and were out of service. And here we are, 40 or 45 years later, with an opportunity to see that vision help us through other crises.

And yet, while we can do that, we also have evidence presented earlier from Mr. Walker that isn't what is happening. While we have 9 of 23 agencies expected to be able to respond to telework and to be able to continue operations in the COOP planning that's been spoken about, only 1 of those has notified, zero have really demonstrated the readiness, and only 3 of 23 have tested to be prepared for teleworking.

So while we have plenty of evidence—certainly not only in our company at Juniper, but throughout Silicon Valley and in other examples across the country and private industry—there are literally millions of people capable of teleworking and prepared and using technologies to do so, we somehow find ourselves mysteriously

underprepared to see the same kind of continuous operations in command and control exhibited either in the face of a pandemic or other concerns. So it isn't what is happening, even though it can be.

And yet, in Afghanistan, Jim Vanderhoff, the CIO of the State Department, has deployed telework capabilities for our staff, both military and civilian, in Afghanistan, who are using telework and remote capabilities to protect themselves from the dangers in a country that remote with difficulties of that magnitude in order to save life and limb, in order to continue operations there.

So while we see ourselves less prepared than we should be in our own country, we also have examples in locations as remote as Afghanistan where teleworking and the benefits of it and the ability to operate through difficulty continues.

So in light of that, I'd like to make just a couple of recommendations. And in doing so, perhaps we can use the alarm of this pandemic to make something good come out of something that may be, in fact, very bad. And the first of those recommendations is, in fact, to start at the top.

This is a capability that can be deployed today, and we need to set an example. And our first recommendation I would make and offer to the committee for consideration is that the executives and the leadership in Government are those who should adopt teleworking as a primary priority and as an example to set for others.

And that with those proven examples, we have the ability to then start a wave of acceptance. Not so much by staff reports and by guidance and by hope and prayer, as was said earlier, but by actual examples set by senior leadership.

Using telework today to conduct operations before the pandemic and before the crises so that when it does happen, it's a capability that is proven and tested and that we're all comfortable with. So that would be probably first and primary recommendation would be let's start this at the top and let's make it work.

The second is to rely on the proven examples. There is proven capability, and my colleague Mr. Kurtz will speak to some of this in a moment about the ability of technology to authorize, to authenticate, and to demonstrate the legitimacy and the safety and security of this use.

It's protecting our troops in battle. It can certainly protect our leaders in Government in our own country as a reliable tool. So we should rely on the safety, security, and proven capabilities of the technology.

And finally, to call for open standards in the implementation. These are systems which have been proven, which must and do interoperate today. And to any extent possible the committee can provide that kind of open requirement and guidance in the specifics that it drives to us in industry to deliver these technologies, it will be enormously valuable.

As a final thought and perhaps a reference, again, to where this capability has been used, one of the primary directives in engaging with the enemy is to be able to move, shoot, and communicate. And we have a very dangerous enemy facing us in this pandemic threat, and we must be able to move. We must be able to pick the targets that we are going to attack, and primarily to enable that, we must

be able to communicate as a Nation and for the Government to communicate across its leadership in order to make these capabilities a tool and a weapon in the battle that we face.

So, with that, I would like to thank you, Mr. Chairman and the committee, for the time to come and speak with you today. And certainly I look forward to answering any questions you might have.

[The prepared statement of Mr. Kriens follows:]

Juniper Networks Testimony

Statement by Mr. Scott Kriens
Chairman and CEO
Juniper Networks, Inc.
Before the Committee on Government Reform

May 11, 2006

Mr. Chairman, Congressman Waxman, members of the Committee. It is a great pleasure to testify here today about continuity of operations in the event of a serious pandemic.

A mutation of the much publicized bird or avian flu virus, one that precipitates and accelerates human-to-human transmission, is almost unimaginable to most of us here. Over crowded hospitals, quarantined communities, millions of lives at risk, our national economy crippled, stand in sharp contrast to the comforts of this room, our homes and our workplaces today.

Of course, one year ago who among us could have imagined New Orleans under water just a few months later? Five years ago, no one imagined human beings would actually hijack commercial aircraft and deliberately crash them into the World Trade Center or the Pentagon. The tsunami in Indonesia, bombings in the United Kingdom and Spain, a world at war, and the United States as the world's only superpower, stands at center stage both for its own domestic crises and for world crises as well.

In light of these catastrophes, Americans recognize the importance of emergency preparedness by the U.S. government, the private sector, and individuals, in times of national crisis. Being prepared translates into the ability of essential employees to communicate and execute their responsibilities 24/7 anywhere, anytime. This capability is known as continuity of operations or COOP. When working with our enterprise customers to prepare for such a "perfect storm" scenario, we at Juniper Networks believe in insuring they have a secure and resilient infrastructure. The cornerstone of this round-the-clock COOP capability is a technically robust and cost-effective telework system that can deliver instant, highly secure access to every remote user – where and when they need it.

Telework, or remote work, is a concept that has gained much attention as a means for improving the productivity of the workforce while addressing pressing environmental and transportation challenges for American society. In the commercial world, private sector companies have been taking advantage of telework for years. Business managers realize that telework is a way to get optimal performance from their workers, allowing employees to get work done from home or the road, providing the operational flexibility that our modern economy demands. I find it ironic that many government managers reportedly equate telework with reduced employee work hours and lower productivity,

believing in the outdated management philosophy that "if I can't see you, I can't manage you." Business sees it the other way around, as a means of maximizing worker productivity, with the added benefits of lower commuting costs and improved quality of life as motivators and morale-builders.

Beyond these issues of day-to-day telework applications, it is our task in the context of today's hearing to concentrate on the critical linkage between telework and national security, and to provide the most effective telework capability for COOP given limited resources. It is worth noting that the internet was first conceived and created by the Defense Advanced Research Projects Agency (DARPA) as a means for sending information over a skeleton communications system in the case of a nuclear war. So from its genesis, the internet was envisioned as a communications system to support COOP in a national emergency. Today the internet is a pillar of our national economy and government operations at all levels. Executive branch agencies need only take technologies and management practices that are readily available and bring them to bear on this task to ensure that essential personnel can perform their vital duties in the case of a pandemic or other national crisis.

The Executive Branch agencies are not alone in needing to enhance their remote work plans for COOP. My bet is that Congress could benefit from an improved remote work plan, as could state and local government and American industry. There is no question that all of us can and must do a better job of COOP planning generally, but remote work planning especially.

At Juniper Networks, telework is not only a critical component of how we work as a company, but also how we think about our customers and develop our products. I offer this Committee four recommendations that I hope will prove helpful as you consider how the government needs to prepare for a potential pandemic.

1. TECHNOLOGY IS AVAILABLE TODAY - FOR EFFECTIVE CONTINUITY OF OPERATIONS THROUGH TELEWORK

We are all personally familiar with the connectivity to the workplace the Internet affords us. It has changed our lives. With email and web access, we are able to log on and accomplish work from out of the office that we would never have dreamed of until a few years ago. Achieving the connectivity and control that is necessary to maintain government operations in a crisis, however, offers a much more technically demanding set of requirements than simply surfing the web. Cutting edge technology enables us to meet these requirements. With the hardware and software currently on the market, we can create a network of remote users who, using phone, internet, and an array of collaborative tools could continue to execute essential government operations from remote locations.

What are the requirements we must meet to establish an effective remote work system for COOP? At the most basic level, there are two.

First, there needs to be an integrated and intelligent infrastructure that provides for the ready transmission of data, through close "integration" of all the components of the system and the right "intelligence" to help make this happen. The teleworking infrastructure is most likely the same one we use on a daily basis to communicate from our homes, consisting of the wires, fiber, and transmission towers that we all rely upon. For more challenging scenarios, however, emergency communications systems that rely on satellite communications may be required. Data flow is the essential requirement, and whether it moves through wires, fiber, or the air, it will have to be robust enough to function through a crisis.

The second requirement is network security--guaranteeing end-to-end security across the teleworking infrastructure as that remote user is gaining access to critical resources.

For example, a telework system for COOP will require virtually 100 percent confidence that the system can remotely authenticate who is accessing and using what information, and ensure that they access and use only information for which they have authorization.

Users must be able to access files securely and share information from a headquarters location anywhere, anytime, on multiple products operating on multiple platforms. The system must provide high confidence that computing technologies it uses also are authenticated as to their "trustworthiness" vis-à-vis viruses or other security breaches.

The products needed to establish and maintain just such a secure system are available now, waiting on the shelf for deployment. So the question is not whether we can establish a trusted and secure teleworking environment to support COOP, but rather how and when the system is put in place.

2. FOCUS ON CRITICAL EMPLOYEES

In our view, the best place to launch an effective telework implementation for COOP is to start with our Nation's leaders, senior and critical executives. These are the individuals who must be able to plan, organize, and execute their agencies responses in disaster or emergency situations. Their ability to work is essential. They will set the example for how their agencies will be able to expand remote work to all of their employees to maintain operations in emergencies. Moreover, a successful COOP system will demonstrate the viability of remote work for telework during day-to-day operations as well.

The equipment and installation costs for establishing the COOP system will not bust agency budgets. The functionality the system would provide is well worth the investment in terms of the capability for COOP the system will provide. Perhaps the most challenging aspect of making the remote work system effective is putting policies and procedures in place that support orderly operations and that complement the ability of today's technologies to allow secure, auditable information sharing. While this is a challenge, it is crucial for the system's success, and therefore worth the effort.

I think it is important not to focus this effort solely on Executive Agencies, but on Congress as well. You as Members, and Congress as an institution, should write a plan and establish a remote work system. Putting a system in place and conducting, say, quarterly exercises yourselves and with your key staff would make the plan operational and allow you to identify and implement improvements to the business rules and technical environments that make it work. If you had possessed such a system back in 2001 during the anthrax attacks, when the House office buildings were shut for over a week, and the Senate Hart Building was closed for over three months, it would have made an enormous difference to your ability to continue your vital work.

Imagine if this were done among essential employees across the Federal government as well. I believe the result would be improved preparedness certainly, but more importantly, I believe local and state jurisdictions and American industry would better appreciate the problem and would follow the Federal lead.

3. MAINTAIN THE INTEGRITY OF THE NETWORK–BY AUTHENTICATING AND AUTHORIZING END USERS

Effective remote work plans have two significant components: business rules to determine who has access to what information and under what conditions, and the technical environment that supports the business rules. It is the technical environment that constitutes Juniper's expertise and it is my intention to show you that information can be securely and effectively managed and tracked from multiple remote locations by any number of authorized users. The key is to have qualified guards at the gates of your critical information, guards that authenticate those seeking access and the equipment they are using to gain that access. These "guards" are technologies that easily reside on your network and navigate user and equipment access according to rules set by the governing organization. We call this comprehensive "network policing" of end user/equipment Unified Access Control.

Just a few years ago, the security of information could only be secured by equipping computers with software and component hardware that required expensive and routine maintenance and upgrade. Today, your network can function as the guard at the gate, performing that same function, more effectively,

at lower cost and with greater ease for the user. Access and information management protocols are set within the network in accordance with the business rules that are established. The network will determine whether your home PC, hotel business center or other access tool meets network standards to access information resources. And remember, unified access control ensures that the individual seeking access also is authorized.

The bottom line is that today, through your network, you can authenticate the user seeking access to ensure appropriate authorization and the equipment being used to protect against viruses, intrusions and other breaches.

4. OPEN STANDARDS ALLOW USE OF BEST-OF-BREED TECHNOLOGIES AND LOWER COSTS

In an emergency, communications necessarily will come from many sources. Technologies that govern information access and authentication must be able to recognize and interoperate with a spectrum of these technologies. The governing technologies themselves should be as interoperable as practicable with technologies from any number of manufacturers. This not only allows implementation of the best-of-breed solutions and increases operational efficiency, but also leads to lower operating cost.

CONCLUSION

To summarize, "top down" remote or telework planning and execution is critical for dealing with the grave impacts of a national crisis like an avian flu outbreak. We must get our Nation where we need to be in terms of a 24/7 essential employee, work anywhere, capability. We, as a country can be prepared for this impending perfect storm, by working together to ensure a secure and resilient infrastructure is in place and ready throughout our government; and we can start right here. The ability to effectively manage information and authorize and authenticate remote users *and* their equipment is both possible and practical today.

The President's Implementation Plan for the National Strategy for Pandemic Influenza speaks to the need to improve telework capability to maintain COOP during a pandemic. It specifically requires the Office of Personnel Management to update its key telework management documents to include guidance for how best to use telework in support of COOP. I recommend that to the extent possible, this guidance focus on applying telework practices and procedures used by agencies on a daily basis to support the special circumstances of a pandemic outbreak or other emergency. A specialized telework system that is used only during an emergency will run a higher risk of problems and failures than a system that is familiar to the workforce through use on a daily or weekly basis.

Finally and just as importantly, an added benefit of "top down" remote work planning is that expansion of telework, and hence the broader benefits referenced earlier, are more likely and achievable when senior management experiences firsthand the processes involved. The United States then gains not only critical COOP advantages, but also the potential for the most advanced 21st century workforce anywhere.

I look forward to assisting the Committee in every possible way as you move forward. I would be pleased to answer any questions you might have.

On behalf of Juniper Networks, thank you for the opportunity to speak before you today. I look forward to answering your questions.

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Chairman TOM DAVIS. Thank you very much.
Mr. Kurtz.

STATEMENT OF PAUL B. KURTZ

Mr. KURTZ. Mr. Chairman, it's a pleasure to be here today. And beginning, I wanted to recall the little quote on the front of your report on Katrina, which talked about the five frogs sitting on a log. And four of the frogs decided to jump off, and how many are left? And the answer was five.

And I think that's the theme of what I heard earlier today. There's a lot of, if you will, people deciding, but not doing. A lot of guidance, but no action. And I think the flu pandemic planning that we all must go through is an opportunity to fundamentally change the way we do business in the Federal Government.

Obviously, my comments will focus on one of the White House's key goals of sustaining the infrastructure and mitigating the impact of a flu pandemic. I note in 1918, there was an ad in a Canadian newspaper, Canadian Bell, which talked about only using telephones for emergency use. Obviously, IT has a much wider use today. It's integral to our society. So it's much more than just emergency use.

We know from what's happened over the past several years that we need to take an all-hazards approach to emergency preparedness. We need to have a more resilient society. So with that in mind, I want to cover four areas today.

First, investing in the capability to distribute—to have a distributed Federal work force. Second, using the flu pandemic to break down Federal barriers. Third, addressing the burden that a flu pandemic could have on the overall information infrastructure. And fourth, offer a few recommendations.

The scenarios that play out that we see on various network TV shows, I don't think we need to recall necessarily what could happen during a flu pandemic. But the reality is that today's Federal work force, most of the contingency plans are designed for a maximum downtime of 2 or 3 days. And if you actually look at the circulars that are put together, they go out to, if you will, 30 days.

Ensuring the continuity of Government operations for an extended period is a central responsibility of this Government's leadership. Moreover, when you look at the continuity plans as they exist today, often they have people moving from one facility together to another facility. And as we know from the White House plans, that's not going to play out right in a flu pandemic.

The private sector has been pursuing telework for a long period of time. In fact, with the events of September 11, a lot of the financial industry, if you will, moved their physical facilities outside lower Manhattan. Now they're going one step further, and they're actually dispersing their personnel, enabling them to work from a variety of locations. They call this a distributed work force capability.

AT&T, prior to the merger, of course, had a very aggressive telework program where a variety of employees involving managers, if you will, essential and nonessential employees were able to telework on a frequent basis. The benefits are, if you will, well known and widely accepted in the private sector. But we have

roughly one tenth of the Federal work force that is able to telework today, where you have at least 20 percent in the private sector.

When we look at the barriers to a distributed work force, I think there are a number of issues that would come to mind. In large part, they're systemic. I think it's interesting to note there was a lot of conversation earlier today about guidance. But just this March, GSA issued guidance which had a few very key points in it.

First, agencies now are able to pay for broadband installation and monthly access. Second, they can provide new or excess equipment for people to use. Third, they can provide help desk support so we can keep on having task forces, if you will, that talk about issuing new guidance, or we can actually implement the guidance.

I note that Emergency Preparedness Circular No. 65, which was recently redone, also includes a reference to telework. So the guidance exists today for Federal agencies to do more in telework.

I do want to note, before I move on to my recommendations, that we do need to think about the burden on the overall information infrastructure during a crisis. We saw this after September 11th. We saw it in Katrina. I know your committee has looked at this. But we need to think more widely about what would happen. We need to get the appropriate private sector folks involved from whether it's the NSTAC or NIAC, which are both Presidential advisory committee.

If I can look at recommendations, I would say, first of all, we need a top-down approach from the White House involving the Office of Management and Budget and the Homeland Security to push down into Federal agencies the need to telework and to set strict metrics.

Second, as I mentioned, I think NSTAC and NIAC, these Presidential advisory committees need to look closely at the issue of the burden on the information infrastructure.

And third, I would encourage Congress to pursue a three-pronged strategy. A, look at what statutory barriers there might be to the expansion of telework. For example, I understand from my conversations that agencies, if you will, don't have the incentive to pursue telework because any gains they may make or—excuse me, savings they may make have to be returned to the Treasury.

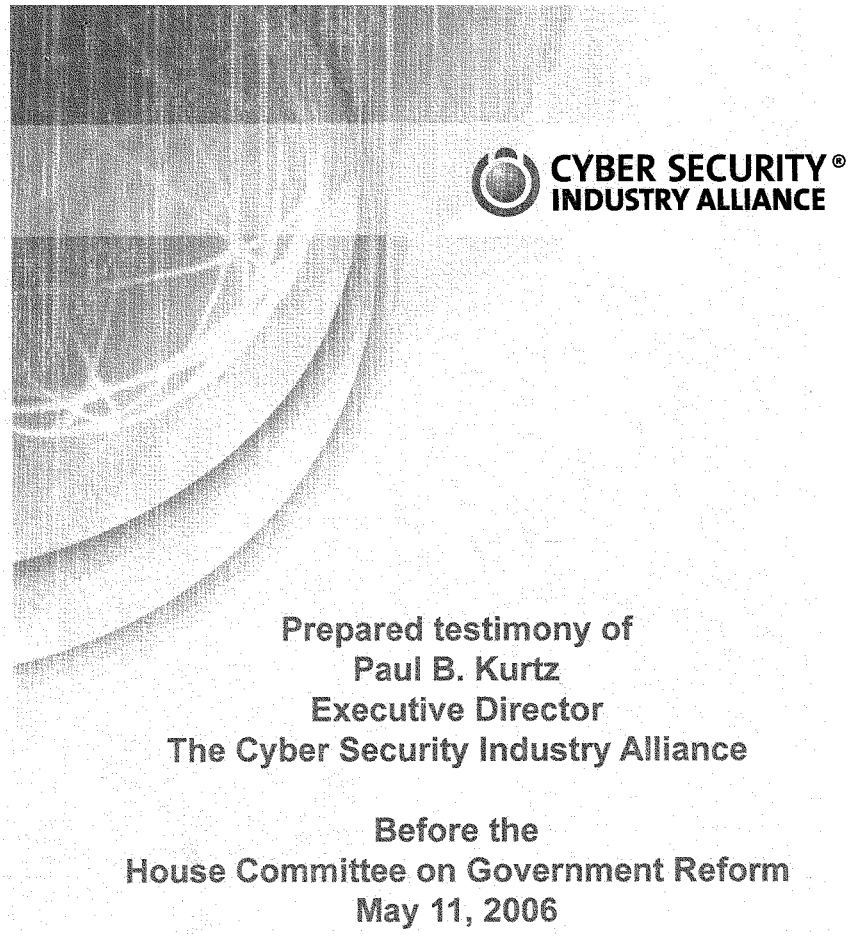
Also there was a recent study that was done that talked about FISMA being perceived as a potential barrier to telework. I think it's worthwhile exploring that issue as well.

And then, finally, I think we ought to think about, if you will, a carrot and stick approach. Incentivize agencies so they can win at telework.

Finally, to close, Mr. Chairman, I know last year at this time, you talked about the need to decentralize Federal agency—Federal agency operations. And I really don't think, you know, since last year, even since September 11th, we've really had that change in mindset, to change from brick and mortar mentality to a decentralized Federal Government operation.

Thank you.

[The prepared statement of Mr. Kurtz follows:]



Prepared testimony of
Paul B. Kurtz
Executive Director
The Cyber Security Industry Alliance

Before the
House Committee on Government Reform
May 11, 2006

Chairman Davis, Ranking Member Waxman and members of the committee, thank you for the opportunity to testify here today.

The Cyber Security Industry Alliance is the only advocacy group dedicated to ensuring the privacy, reliability and integrity of information systems through public policy, technology, education and awareness. The organization is led by CEOs from the world's top security providers who offer the technical expertise, depth and focus needed to encourage a better understanding of security issues. It is our belief that a comprehensive approach to ensuring the security and resilience of information systems is fundamental to global protection, national security, and economic stability.

Before joining CSIA, I served at the White House on the National Security Council and Homeland Security Council. On the NSC, I served as Director of Counterterrorism and Senior Director of the Office of Cyberspace Security. On the HSC, I was Special Assistant to the President and Senior Director for Critical Infrastructure Protection.

As I begin my remarks, I want to commend Representative Frank Wolf for his leadership in the area of telework. Congressman Wolf has been a leader in federal telework because of his passion to improve productivity and quality of life, to achieve cost savings and reduce traffic congestion and other important goals. He also recognizes that telework can enable continuity of operations regardless of disruptions like the attacks of September 11, the anthrax scare, Hurricanes Katrina and Rita, and whatever the future may hold.[1]

I also want to commend the White House for assembling the Implementation Plan for the National Strategy to battle and contain a pandemic influenza. My comments today will focus on one of the plan's key goals: sustaining the infrastructure and mitigating the impact of a pandemic on the economy and functioning of society.

In the early twentieth century, more than 20 million people around the world perished in the outbreak of Spanish Influenza. During this epidemic, technology played a key role in continuity of operations. An ad placed by Bell Canada in the fall of 1918 urged quarantined citizens to use the phone - which was relatively new at the time for the general public – for emergencies only: "You will thus be helping to keep the service intact to meet the urgent needs of the community in the present emergency." [2]

In the face of a flu pandemic today, information technology should not be for emergency use only, because IT is integral to our daily lives and business operations. IT sustains and fuels our economy, and in a crisis situation would not only help keep the public informed, but also enable us to continue working, remaining productive.

We've already seen, in just the past several years, the wide range of bad things that can and will happen to the United States: terrorists will strike; hurricanes and earthquakes will flood and flatten

1 Letter from Representative Frank Wolf to the President, September 15, 2005.

2 "Lessons of 1918-19 Spanish flu epidemic guiding preparedness" Bill Eekhof, October 5, 2005, http://www.mykawartha.com/ka/news/peterborough/

cities, major accidents will happen, and health epidemics will continue to appear. Resilience in the face of these challenges – an "all hazards" approach – encompasses protection, preparedness, and recovery. In our society, information technology holds the key to all three.

There are four areas I will cover today:

- First, the need to invest in the capability to distribute the federal workforce, by which I mean enabling Federal agency employees to function under normal and adverse conditions – not only at home, under the traditional definition of telework, but from anywhere at any time.
  The private sector has made great strides in this arena, for a number of reasons I'll go over in a minute, but the federal government is unfortunately well behind.
- Second, to use the process of planning for a possible flu pandemic as an opportunity to break down some of the institutional barriers that have prevented the federal government from keeping pace with the private sector in distributing its workforce. We have an opportunity here for a paradigm shift in the federal government, from a brick and mortar mentality to a more agile, efficient workforce. The technology exists today to do so securely. Doing so would pay significant, recurring long-term dividends to the government and taxpayers well beyond just crisis management.
- Third, to address the burden that a flu pandemic would have on the overall information infrastructure, including some of the challenges of the "last mile."
- And fourth, to offer recommendations for actions that the Federal government can take, in the near and long term, to make distributed workforce capability a reality.

Pandemic Flu – A Biological Winter

Leaving aside recent sensational network TV specials, I would like to emphasize the gravity of this situation by briefly describing some of the very real potential results of a flu pandemic or similar crisis.

According to the White House plan, a flu pandemic could take as long as 18 months to run its course. During this time:

- Many workers will be unable to report to their offices, either because those offices will be closed, or because they must stay at home to care for children (because schools will also be closed) or the elderly. The White House's plan recommends that government and the private sector start with the assumption that up to 40 percent of staff may be absent for two weeks at the height of a pandemic wave, with lower levels for a few weeks on either side of a wave.
- Travel restrictions will likely include multiple forms of mass transit, ranging from subways to air travel. The safest course for many people will be to simply not leave their homes, where eventually they may have to depend on the government to provide "last mile" delivery of food and other supplies.

- Many industries—particularly those in the service sector—will significantly reduce operations. Supply chains will be disrupted, production placed on hold. However, some industries ***must*** continue to function in order to avert social breakdown: basic utilities, of course, as well as banks, hospitals, grocery stores and so forth. Even as it comes under heavy strain at the onset of the pandemic, operation of the nation's telecommunications network will be essential for first-responders to do their jobs, and for law enforcement agencies to preserve order. This is a first order concern.
- The public will need timely, reliable information about ongoing developments, because a sudden sense of both catastrophe and isolation can quickly lead to mass panic. That, in turn would quite possibly spawn a vicious cycle of looting and destruction that increases suffering and makes ultimate recovery all the more difficult.
- Most importantly, the medical community simply must have access to secure, reliable communications systems if they are to save as many lives as possible. Front-line health care providers will need to coordinate treatment services, vaccine distribution and quarantines. Academic researchers will need to exchange test results and discuss new treatment modalities. The Centers for Disease Control will need to be able to track virus vectors and mutating strains and coordinate with their counterparts overseas. Much of this type of commnications traffic rides on today's public Internet.

The Value of a Distributed Workforce

Against this backdrop, the unforgiving reality of today's federal workforce is that most contingency plans for emergency operations are designed for a maximum downtime of two or three days. As the White House has said, pandemics play out over weeks and months. Ensuring the continuity of key government operations under that kind of an extended period is a central responsibility of the nation's leadership.

The private sector has already begun to move aggressively in this direction. In the financial community, for example, many firms moved quickly after the attacks of September 11th to disperse critical facilities outside of lower Manhattan. Now they have gone one step further, so that their workers can work any time, anywhere. Another example is AT&T. Thirty percent of management works outside traditional offices, another 41 percent are regular teleworkers, and 91 percent of salaried employees are teleworkers. Productivity by teleworkers increased by 12.5 percent, or one hour per day. AT&T calculates $150 million in annual benefits through productivity, lower overhead, enhanced retention and recruitment.[3] Note that AT&T's efforts are not limited to "essential personnel" only.

A distributed workforce helps in all hazards – a terrorist attack, a natural disaster, or an accident. As the White House Implementation plan states, during a flu pandemic, "systems that facilitate communication in the absence of person-to-person contact can be used to minimize workplace risk for essential employees and can potentially be used to minimize workplace entry of people with influ-

3 Telework at AT&T, Annual Surveys in 2004 and 2003.

enza symptoms." During a crisis, ordinary Americans' primary and immediate concern will surely be for the safety and health of their loved ones. As the initial shock wears off, however, the ability to continue meeting their primary professional responsibilities will offer many people solace, comfort and hope.

Fortunately, as Scott Kriens explained in detail, the technology exists to make this all possible. Much of the private sector has already adopted collaborative, secure, mobile technologies – there are various options – that allow employees to work wherever they need to, be it at home, at an Internet café or on the road. There are also technologies available that do not require a wholesale change in infrastructure, for example through secure remote access. In many cases companies have had no choice; the world is an increasingly difficult and dangerous place to do business, and they have had to adopt new technologies to ensure that they can weather any storm that comes along. But there are also widely recognized second-order benefits to workforce distribution: productivity increases, reduced traffic congestion and gas consumption, a cleaner environment, greater personal flexibility and a higher quality of life. These benefits are well documented by such organizations as the Telework Consortium.

A serious effort to develop a distributed work force capability in the Federal government will have a lasting impact well beyond a possible flu pandemic. In other words, building out telework is not a one time sunk cost. Happy employees are more efficient ones, something the Office of Personnel Management has noticed as it contemplates retention and recruitment challenges after the retirement of the baby boom generation. Workforce distribution holds the potential to simply make life better in countless ways. As frightening as a flu pandemic might be, it also provides us with the opportunity, and the impetus, to break down structural barriers to reform.

Barriers to a Distributed Workforce

So what are those barriers? The White House Plan raises the issue of telework and acknowledges its importance, and calls for updating guidance and establishing performance metrics. In fact, much of the necessary guidance exists already.

GSA issued a publication in March entitled "Guidelines for Alternative Workplace Arrangements." It covers telecommuting, hoteling, virtual offices, telework centers, and so forth, and affirms that for approved teleworkers, agencies can:

- Pay for broadband installation and monthly access fees;
- Provide new or excess equipment, including computers; and
- Provide helpdesk and technical support.

There is also Federal Preparedness Circular (FPC) 65, from FEMA, which focuses on emergency scenarios and the potential value of telework in continuity of operations planning. But despite this guidance, the various federal telework programs remain fragmentary and uncoordinated. Just over 100,000 employees, or less than ten percent of the civilian federal workforce, teleworked according to

a GAO analysis in July 2004. By contrast, more than 20 million people, or almost 20 percent of the adult American workforce overall, works remotely one or more days per month.[4]

The reasons for this disparity involve the budget, statutory limitations and management.

The structure of the Federal budget may be the biggest obstacle to the expansion of telework. We understand that there is little incentive for agency leadership to adopt telework, as any savings resulting from reduced overhead are returned to the Federal treasury and cannot be applied elsewhere in an agency's operations. Enabling agencies to realize such savings appears to atleast require the intervention by the White House's Office of Management and Budget (OMB), and possibly a change in current law. In addition, a recent CDW survey indicated that 55 percent of IT managers believed the Federal Information Security Management Act hampered the expansion of telework.[5] Finally, telework would require changes in the ways that managers interact and evaluate employees. Many supervisors insist on having "eyes on" employees, and as we all know, change is hard. There are technologies available today that help with the management of telecommuters. Technologies help managers understand who signed on when and accessed what applications, and for how long. The private sector has already demonstrated that they work, and work well.

That is why, as frightening as a pandemic influenza might be, it also provides a real opportunity to fundamentally change the way the Federal government does business – the kind of opportunity that doesn't come along very often. As a kind of action-forcing event, it makes the kind of structural reforms possible that might otherwise be strangled by bureaucracy.

But only Congress, in partnership with the White House, can set this kind of process in motion, with a combination of statutory requirements, incentives, deadlines and evaluation criteria.

One thing worth reinforcing before I move on is that, of all the barriers to a distributed workforce, security is not among them. Again, as Scott explained, private industry has led the way. Two types of security are crucial for securing telework. They include network security for interagency communications and connections used by teleworkers, and physical security for data on mobile devices. Devices for telework that require protection include notebook personal computers, desktop personal computers used at home, handheld personal digital assistants, telephones (regular, cell, and voice over IP (VoIP)) and desktop video conferencing. Technologies to secure these devices exist today, including, encryption, virtual private networks, authentication and access control technologies.

Burden on the Information Infrastructure

That said, there is another factor that must be taken into consideration. Little empirical evaluation has been done of the ability of the Internet infrastructure to support the traffic created when large

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4 2004 American Interactive Consumer Survey conducted by the Dieringer Research Group and data from the International Telework Association and Council (ITAC)

5 "CDW Survey Reveals Increase in Telework," Rob Thorneyer and Roseanne Gerin, Washington Technology, March 6, 2006

numbers of employees—from both public and private sector—suddenly attempt to log on. There will surely be a spike in telecommunications traffic overall at the first onset of a crisis.

The continued operation of the information infrastructure deserves critical attention as it underlies so many aspects of the White House's Plan. The Plan states that the Federal Government has primary responsibility in a number of areas, including containment efforts overseas, guidance related to protective measures, modifications to law, regulation and monetary policy in order to mitigate the impact of a pandemic. The Plan pointedly does not identify the backbone of the information infrastructure as an area of primary responsibility for the Federal Government. This is proper given the private sector owns and operates the vast majority of the critical information infrastructure. However, the government must play a leading role in coordinating its continued operation during a flu pandemic, as the same pressures that would affect the nation would also affect the people who operate the Internet.

We simply do not know about what the impact would be if, for example, even *half*of the 60,000-plus employees of the Department of Health and Human Services – who help coordinate the entire national health care system – were to attempt to work offsite. We do know that any limitations on their ability to do their jobs would have a cascading effect throughout the medical system, and at the worst possible time, when large numbers of Americans are in need of emergency care.

Thus we must act to ensure that the basic information infrastructure itself is robust enough to handle the surge of, potentially, millions of teleworkers. If we do not, we run the risk of creating a virtual beltway that is stuck in traffic jams for twelve hours a day.

Recommendations

There are a number of strategic options that could help move the federal government toward workforce distribution capability, and strengthen America's Internet infrastructure so it is there when we need it.

- President Bush has made clear that he is in charge of overall crisis response. Given the burdens and afflictions currently facing DHS, the role of other federal agencies should be closely examined, particularly by the Office of Management and Budget. OMB, in coordination with the Homeland Security Council, should convene a task force to aggressively expand telework. The Federal government's efforts should not be limited to enabling "essential personnel." They should be far more aggressive in seeking to encompass as many Federal employees as possible. As I mentioned earlier, telework within the Federal government is less than ten percent, compared with more than twenty percent in the private sector. This makes no sense; in fact, it is exactly backwards considering the critical nature of many federal programs to many Americans' day-to-day lives. The Federal government should at the very least seek to match the private sector's capabilities, even if it takes a crash program to do it.
- The President's National Security and Telecommunications Advisory Committee and National Infrastructure Advisory Council should undertake an immediate review of the burden that a flu

pandemic would have on the information infrastructure. Recommendations and plans for "surge" capability in the opening phase of a pandemic should be assembled and ready to activate.

- We should all learn from what works. In preparation for the 2004 Republican and Democratic National Conventions, the Office of Personnel Management conducted emergency preparedness surveys in Boston and New York, and used them to develop program training, in partnership with other agencies, to reduce the number of employees who had to report to work in the secured areas. The project was an unqualified success. This illustrates why the Federal Government should test existing distributed work force plans now, by designating both essential and non-essential employees to work from home for a day or two. Through such exercises, managers will be able to make better informed policy and procurement decisions. Inviting participation from the private sector would also help analyze the potential impact on contract support.
- Congress should seek to remove any real or perceived barriers for Federal agencies to pursue telework by pursuing a three-prong strategy. First, it should consider legislation that enables agencies to win by participating and deploying teleworking programs. In particular, agency budgets for FY '07 should allow the flexibility for agencies to retain savings from teleworking and deploy them elsewhere, so they are not punished for their success. Second, Congress should also wield a "stick," creating the means to cut budgets for failing to take the "carrot." Finally, Congress should also seek to address any perceived barriers FISMA has on the expansion of telework.

A year ago, at a hearing just like this one, Mr. Chairman, you stated that "The decentralization of federal agency functions inherent in a healthy telework strategy can greatly increase the survivability of those agencies in the event of a terrorist attack or other disruptive crisis. Federal governmental agencies need to be prepared with a plan to continue doing the most important tasks to serve the American people under any circumstances."

I wish I could sit here and testify that this goal had been met. It is true that many agencies have made strides within their own internal operations and continuity of operations planning. But they have a long way to go before they are ready to work together in a crisis like an outbreak of avian flu.

Preparing for a pandemic influenza that could last up to 18 months means the Federal government must ensure employees can provide essential services for an extended period of time in a distributed and resilient manner. And doing so requires an information technology infrastructure robust enough to handle the job. We do not have the workforce distribution capability that we need today, Mr. Chairman, and ultimately only Congress can ask the hard questions, and use both the carrots and the sticks necessary, to make telework happen.

With that, I would be happy to answer any of your questions.

Chairman TOM DAVIS. Thank you very much.

Dr. Plough.

STATEMENT OF ALONZO PLOUGH

Mr. PLOUGH. Thank you, Mr. Chairman and members of the committee.

On behalf of Trust for America's Health, I really appreciate this opportunity to testify on this critically important issue of pandemic influenza preparedness.

I am here representing Trust for America's Health, where I serve on the board of directors. I'm currently vice president for the California Endowment, a private philanthropy in the State of California also focused on these issues. But my comments are really with my hat on as a board member.

My comments are really gleaned from my 20 years of experience, though, as a local public health official—the last 10, as of last July, as director of the Seattle and King County Department of Public Health. And that on-the-ground perspective of what it means to be an effective responder in communities in disasters are the contexts that I'm drawing on today.

Recently, the public is catching up with the concern we have had in the public health community around pandemic influenza. It's something that we have warned about for years, but I think recent events and certainly the visibility of these hearings and the visibility of the recently released report, not to mention heightened media coverage and made-for-TV movies, has raised these concerns to new levels.

The question is, how do we make sure that we have operationalized these responses on the ground that can serve the public well in the event of a pandemic?

Trust for America's Health and other health organizations actually hear, and I heard a lot when I was a local health official, of frustration from individuals and businesses that actually believe that little or nothing can be done. And certainly a sense of fatalism does not lead to the kind of collaboration needed to develop a good response to pandemic influenza.

We have gone over in the previous panel the frightening data on the infection rates and the absenteeism of 40 percent. When I was a public health official, I was always asked, "What keeps you up at night?" Pandemic influenza planning was the single factor that kept me up at night in the complexity of what I looked at in public health, mainly because a true response is a collaboration between Government at all levels, business, schools, faith-based organization, the medical community. We're behind the curve. We need to prepare now.

I'm very, very proud that Seattle and King County are recognized as among the most prepared communities in America for pandemic influenza, and I think it serves as an example of how a community can prepare, how the Federal Government can best encourage what local preparedness looks like. And I'm going to tell you briefly some of the things we did over those last 10 years to get to that position.

We started by defining clear lines of authority and accountability during health emergencies. The public health department is in charge in that jurisdiction, maintaining central coordinating role,

incident command role around all other governmental structures. This operational clarity is one of the—or lack of operational clarity is one of the weakest points of many other local plans, as well as the Federal plan.

Seattle and King County also benefit from having a unified public health department that includes emergency medical services. It serves both all the 40 cities in the county as well as the county as a whole. It means that public health, health care providers, first responders, trauma units, and hospitals are all connected on the ground in a way that is not common practice in most cities and counties across the country.

Additionally, Seattle and King County have an all-hazards approach to Federal preparedness. Despite of how the targeting of the funds might go, this health department thinks about what do we have to do to be ready for all kinds of threats? So clear authority, collaboration throughout the community, judicious use of Federal funds are the ingredients that led to our success and could be modeled across the Nation.

On May 3rd, the White House unveiled the detailed implementation plan for pandemic influenza. Three hundred activities already cited today—tied to specific accountability, measured in timelines—are part of that plan. And while we commend that plan in many ways, the real measure of effectiveness of a plan is its implementation and how it works on the ground.

And Trust for America's Health plans to actively monitor the progress of how this plan is actually carried out with the nuances of community responsibility, and through that lens, we've identified a few specific concerns.

Well, first, it's unclear what individual and which agency will lead the Federal response during a pandemic. The plan currently gives responsibilities to both the Department of Health and Human Services and the Department of Homeland Security without making clear which of these departments is ultimately accountable. We know that at a local level, you do need single accountability.

And Trust for America's Health strongly believes that HHS should be designated as the lead agency, with the Secretary charged with coordinating other Federal efforts. This is a health crisis, and health expertise should guide all of the decisions. It would mirror the structure that's worked so well in Seattle and King County.

Second, the plan does not adequately address the financial blow that the country would take during a pandemic outbreak. For example, once an effective vaccine is available, there are no measures in place to figure out how much it will cost, who will purchase the 600 million doses. We really cannot leave such important implementation decisions to the middle of a national crisis.

Beyond improving the plan, there are other steps that must be taken to ensure the Nation is prepared. Trust for America's Health has identified some specific recommendations that are detailed in my written testimony. Let me just highlight a couple of those.

Where you live in this country, shouldn't—rural, urban—where in the country shouldn't determine what your level of preparedness is. We need to be much more even on that. Right now, planning largely rests on State and local shoulders. It's unacceptable to leave

communities virtually on their own with respect to preparing for pandemic flu, particularly leaving communities with large non-English speaking populations, like in California, with fewer resources at higher risk.

Health and Human Service, in consultation with public health and medical professionals, should develop much more detailed guidance for State and local officials so this on-the-ground response matches the diversity of what preparedness means across our country. There should be priorities for—clear prioritization for the populations that are going to get limited vaccines, incentivizing mechanisms for health care workers, and equitable distribution of federally held stockpile.

Second point is that there will be ongoing life and activity after a pandemic, and we really need to ensure that the consequence management system is sound. The Government needs to take steps right now to ensure sustainability of the health industry.

This kind of response that hospitals and health providers will have to a pandemic could shut down our emergency care facilities just at the point when we need them most. People could not seek diagnostic care because they don't—can't pay for this. This is not a time to have individuals, because they are uninsured, also become high probability carriers of a flu in a flu outbreak.

So it's very important that we not let affordability of the health care be a barrier to people seeking treatment and not spreading this influenza. So Trust has proposed the creation of a standby Medicaid authority that would grant emergency temporary Medicaid eligibility to individuals who are uninsured. This really helps to preserve our hospital infrastructure and make sure that individuals get treated and don't spread the disease.

In conclusion, considerable progress has been made, really even since the 10 months that I have not been a health officer. Given where we were a year ago, I'm actually really shocked where we are today. This plan is a great improvement over the past, and a lot of progress has been made.

Lots of flaws to fix. A lot of specificity is needed. And Congress needs to really act now.

Thank you for letting me talk to you.

[The prepared statement of Mr. Plough follows:]

Written Testimony of

Alonzo Plough, MA, MPH, PhD
Member, Board of Directors
Trust for America's Health

Submitted to

U.S. House of Representatives
Committee on Government Reform

May 11, 2006

Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations

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Mr. Chairman, Ranking Member Waxman, and Members of the Committee, on behalf of Trust for America's Health, thank you for this opportunity to testify on pandemic influenza preparedness.

My name is Dr. Alonzo Plough. I am here representing Trust for America's Health, where I serve as a member of the Board of Directors. I also am currently Vice President of Program, Planning and Evaluation for the California Endowment but this testimony does not represent the view or policies of that organization. Additionally, my perspective is greatly influenced by my serving the last ten years as Director of the Seattle and King County Department of Public Health.

Increasingly, the American public is being made aware of the possibility of a flu pandemic. Media reports have detailed that spread of avian or bird flu across Asia, Africa and Europe. Recent television programs have documented past influenza pandemics and dramatized possible future pandemic scenarios. Sometimes this information is alarming and fear-provoking and leaves the impression that there is nothing anyone can do to prepare for or respond to a pandemic flu outbreak. That is simply not the case.

First of all, governments at every level -- federal, state and local -- have an obligation to prepare for a flu pandemic and anticipate the response to an outbreak. Last week, the Administration issued its implementation plan for pandemic influenza which builds on the National Strategy for Pandemic Influenza and the Department of Health and Human Services' (HHS) Pandemic Influenza Plan issued last November. State and local governments are refining their pandemic flu plans and beginning to exercise them. Governments worldwide are asking all sectors of society -- businesses, schools, faith-based organizations, and the medical community -- to prepare now for a health emergency that might result in infection rates of 30 percent in the general population and absenteeism rates of up to 40 percent over a period of months. In other words, the good news is that lot of attention is being paid to pandemic preparedness. However, the bad news is that if an influenza pandemic were to strike soon, no community in the nation would be adequately prepared. As a nation we need to ratchet pandemic preparedness and response to a new level and provide the financial and human resources to deal with a health emergency of this magnitude.

Seattle and King County: A Model of Preparedness

Seattle and King County are among the most prepared communities in America for a flu pandemic. But that does not mean they are fully prepared. Even so, Seattle and King County can serve as an example of how a community can prepare, and how the federal government can best encourage and support local preparedness activities.

A series of public health threats and potential vulnerabilities provided Seattle and King County a preview of what public health threats might be coming down the line and what might be needed to do to prepare. In December of 1999, Seattle hosted the World Trade Organization (WTO)

meetings. At that time, the possible threat of a bioterrorist attack at those meetings led the Centers for Disease Control and Prevention (CDC) to make Seattle the first recipient of new syndromic disease surveillance systems, which allowed real-time monitoring of diseases in the region's hospitals. In 2003, Seattle experienced the second largest number of suspected SARS cases in the United States. In 2004, Seattle and King County experienced a smallpox scare that was reported on a flight from Taiwan to the Seattle/Tacoma airport. These events tested the local public health system and helped government officials understand that in an infectious disease emergency, the public health department is in charge, and has a central coordinating role with other governmental agencies. In the case of a health crisis, in Seattle and King County there are clear lines of authority and accountability. This sort of operational clarity does not necessarily exist in other localities or at the federal level.

Seattle and King County also benefit from the collaborative structure of a unified public health department. The department serves both the city and county, and the Health Officer serves on both cabinets. This gives the department access to all the relevant government agencies and personnel. The Department is also responsible for the Emergency Medical Systems serving Seattle and King County, connecting it with health care providers in a way not common for other public health departments. Because of this arrangement, the public health department has a long history of interaction with first responders, trauma units and hospitals. The collaboration that comes from these relationships is essential to successful preparations and response. Other communities should build on this model as pandemic preparations are made.

Ultimately Seattle and King County preparations come from the smart use of federal funding. When CDC and the Health Resources and Services Administration (HRSA) provided funds to prepare for bioterrorism, local public health officials recognized that an all-hazards approach to preparedness would be the most effective use of those funds. Instead of focusing on hypothetical threats, the pubic health department used its resources to prepare for pandemic flu, knowing that based on historical trends, it was statistically more likely to occur than certain bioterrorism scenarios and that these preparations also would improve the response to smallpox, anthrax, or other public health emergencies. Seattle and King County leveraged its relatively small share of federal bioterrorism dollars and local resources to maximize preparedness across a spectrum of potential hazards.

Clear authority for the public health department, a history of collaboration within the community, experience responding to public health threats, and the judicious use of federal funding are the ingredients for Seattle and King County's success. These components of public health preparedness can be replicated by other communities and the federal government in their planning and response to a pandemic.

The National Strategy for Pandemic Influenza Implementation Plan

On May 3rd, the White House unveiled its implementation plan for pandemic influenza. This government-wide plan represents serious progress for our national readiness to respond to a pandemic flu outbreak. It recognizes that a pandemic would impact every sector of society, and a comprehensive response involves engaging every federal agency and constituency. Significant

thought clearly went into the plan's development, and its depth and breadth, including over 300 activities that are tied to specific accountability measures and timelines, should be commended.

We all know, however, the real test of a plan is how it is implemented. TFAH plans to actively monitor the progress of how the plan is carried out.

TFAH has also identified a number of specific concerns about the plan. First, the document is unclear about what federal official and which federal agency would take the lead in responding to a pandemic. As we saw during and after Katrina, any lack of clarity in this area can slow response time, hamper response efforts, and allow important activities to fall through the cracks. The plan currently gives responsibilities to both HHS and the Department of Homeland Security (DHS) without making clear which of these departments is ultimately accountable for pandemic response. This is too important a matter to not be resolved prior to onset of the pandemic. We, at Trust for America's Health strongly believe that HHS should be designated as the lead agency, with the Secretary charged with coordinating the work of other federal departments and agencies. This would mirror the structure that has worked so well in Seattle and King County.

Second, the plan does not adequately address the financial impact of the pandemic once an outbreak happens. The resources it will take to implement a comprehensive response effort will be enormous. For example, once an effective vaccine is available, will the federal government purchase the 600 million doses needed to protect Americans against the pandemic strain? If so, at what cost? If not, who will be responsible for the vaccine purchase? We must think through these kinds of problems now, when we have time. We can't leave such important decisions to be made in the midst of a health crisis.

Also, we need to take concrete steps to assure the sustainability of our nation's health care services in a pandemic. A pandemic won't discriminate between people who are insured or uninsured. We need policies that will encourage those who are uninsured to seek care to help contain the spread of the disease, and ensure that health care providers won't be bankrupted by providing this care. There will be life after a pandemic, and we need to take measures so our health care system will still be standing.

Government Progress in Preparing for Pandemic Flu

Beyond improving the plan, there are other important steps that must be taken to ensure we are prepared. TFAH has several specific recommendations designed to ensure that the U.S. is better prepared, regardless of when the pandemic occurs.

- **Funding**

  In FY 2006, Congress provided an important down payment of $3.8 billion towards adequately preparing the nation for a pandemic outbreak, and for that we are grateful. This funding has already helped jump start pandemic readiness efforts at a number of federal agencies, including the departments of Health and Human Services, Veterans Affairs, Defense, Agriculture, Interior, Homeland Security and State

However, these funds fall well short of the President's proposed $7.1 billion, leaving a minimum of an additional $3.3 billion to fulfill his request. The proposed FY 2007 budget proposal contains an additional $2.63 billion for HHS, $82 million for the Department of Agriculture, $10.6 million for the Department of the Interior, and $55 million for the United States Agency for International Development (USAID). The recent emergency supplemental appropriations measure approved by the Senate would accelerate the expenditure of the $2.3 billion allowance provided in the President's FY 2007 budget. TFAH urges House and Senate conferees to include these funds in the final conference report. Congress must do all in its power to provide full funding for pandemic influenza initiatives now so that investments in vaccine technology and manufacturing, state and local preparedness and adding medicines and equipment to the Strategic National Stockpile can be made.

- **Assistance for States and Localities**

Where you live shouldn't determine your level of protection against a pandemic in America. It is unacceptable to leave communities virtually on their own with respect to preparing for pandemic flu. A pandemic will not just strike individual states like Virginia or California or Washington. It will strike the entire United States of America, and our response must be as one. The federal government must take responsibility for many aspects of pandemic readiness, including setting a basic standard for preparedness across America. HHS, in consultation with public health and medical professionals, should develop more detailed guidance for state and local officials so that the pandemic response will be consistent and appropriate across jurisdictions. This should include guidance on prioritizing the population in the event of limited vaccine/antiviral medications; incentivizing health care workers to go to work during a pandemic; setting policies regarding isolation and travel that are uniform across the country; providing for equitable distribution of federally held stockpiles; and setting minimum standards of prevention, containment and care.

HHS, and more specifically CDC, needs to be quicker to release funds to state and local health departments. This is especially true when there are deadlines grantees must meet with respect to obligating funds. HHS should disburse 50 percent of the funds appropriated for state and local health department preparedness in no less than 60 days after this appropriation becomes available. However, this by no means should preclude the setting of conditions and performance measures for all funds provided to state and local health departments.

We also believe that a small amount of state and local preparedness funds should be withheld by HHS for the provision of technical assistance to state and local health departments regarding pandemic preparedness. An amount up to three percent of the funds appropriated should be sufficient.

- **State Pandemic Preparedness Plans**

Both the federal government and the states should be regularly testing their planning assumptions through exercises. HHS needs to conduct rigorous evaluations of state and local pandemic preparedness plan exercises and after-action reports. HHS should then provide

technical assistance and guidance to state and local health departments to address deficiencies in their plans.

The ability to rapidly distribute influenza vaccine is a critical element of pandemic response. To assure that rapid, mass distribution plans are appropriately exercised, states and localities should be able to use funding provided for pandemic preparedness to purchase and distribute seasonal influenza vaccine, provided the vaccine is used in the context of a pandemic preparedness distribution exercise.

- **Communications**

The public needs to be educated about the nature of a pandemic and how they can protect themselves, both before an incident and during an outbreak. Much more needs to be done in this area. Inaccurate or incomplete information will undermine any effort to control the spread of a pandemic. The response to Hurricane Katrina and the anthrax incidents here in Congress demonstrated just how far the government has to go with respect to communicating effectively before and during a crisis in the modern 24 hour news cycle.

Officials must do a better job of taking into account the likely real-world reactions from the public, media, and decision-makers. Planning must also take into account the shortcomings in the response systems and what will happen to these systems when they are overwhelmed in mass emergency events.

Currently, most public health risk communications plans focus on how to get accurate information about health threats to the public. They rarely take into account the way the media operate in the United States, which is freely and openly. The government will not be able to tightly control every message that the public will hear during a pandemic flu outbreak. The public will witness and hear accounts of what are often worst-case scenarios and unconfirmed rumors. They will also be exposed to criticism of the government's strategies and actions. These realities need to be factored into government plans to communicate about pandemic flu. The risk communications strategies must go beyond hourly press conferences and advisories on Web sites. The media can be an effective partner in transmitting proper information, but only if consistent and clear messages are pre-established and public distribution channels are pre-arranged.

To help fill the void, TFAH has produced a series of pamphlets entitled, *It's Not Flu as Usual*, aimed at educating various sectors of society on steps to be taken to better prepare for a pandemic. We have already produced pieces targeted at businesses, faith-based organizations and health care providers. I respectfully request that you accept copies of these publications into the hearing record.

- **Stockpiles**

In a pandemic, development of an effective vaccine will take months. Production and distribution on the scale that will be needed may take even longer. In the meantime, we will

be dependent on traditional infection control measures and on stockpiles of medications and equipment. It is critical that these stockpiles be sufficient.

States should not be expected to cover 75 percent of the purchase price for 31 million courses of antiviral medications, as the Administration's current plan assumes. A pandemic will be a national emergency that demands a national stockpile of medications that might mitigate the spread of the disease. Public health officials must have the flexibility to provide the medication where outbreaks are most severe, not based on a state's ability to purchase the medication. The current Administration proposal may lead to geographic inequities which could have disastrous public health outcomes.

Most health providers order and stock supplies on a "just-in-time" basis. They often have only a few days of reserve supplies, equipment like portable respirators, and commonly prescribed medications. Therefore, CDC should also stockpile medical supplies necessary to combat a pandemic beyond vaccines and antiviral medications. This should include many basic protective items, such as protective N95 masks, gloves, gowns, and clean hospital linens, many of which are produced abroad and may not be available during a global health emergency.

- **Sustaining Our Nation's Health Care Services**

The U.S. government must take concrete steps now to assure the sustainability of our nation's health care services in a pandemic. A pandemic won't discriminate between people who are insured or uninsured. We need policies that will encourage those who are uninsured to seek care to help contain the spread of the disease, and ensure that health care providers won't be bankrupted by providing this care. There will be life after a pandemic, and we need to take measures so our health care system will still be standing.

The extraordinary health care costs of an influenza pandemic could jeopardize efforts to control it. The potential for health care providers to be overwhelmed with providing emergency care, while forgoing revenue generating activities (such as elective surgery), could force hospitals and other health care providers to close down during or immediately after a pandemic. The uninsured and underinsured could delay seeking diagnosis and treatment because of out of pocket costs they might not be able to afford. Delayed diagnosis may eliminate the value of isolation or quarantine measures and render useless potential treatments. Providers should be guaranteed some level of compensation for the services they provide during a pandemic and individuals need to recognize that cost should not delay their coming forward for diagnosis or treatment.

TFAH proposes the creation of a stand-by Medicaid authority that would permit the HHS Secretary to declare a public health emergency and grant immediate, temporary Medicaid eligibility to individuals who are uninsured or underinsured during a pandemic. The federal government would guarantee payment for 100 percent of the costs – as these additional costs are probably beyond the capacity of most states to absorb in an emergency, at a time when tax revenues are likely to be reduced. The benefit would last as long as the state of emergency is in effect.

HHS should also require operational contingency planning for a pandemic outbreak and other health emergencies from all grantees and sub-grantees that provide direct services to individuals or families as a condition of funding. It is imperative that social, health and welfare services continue during a pandemic.

Conclusion

The government has made considerable progress in preparing for a pandemic, far more than some might have expected. But there is still much to do and there are flaws in the government's efforts that need to be corrected quickly.

The clock is ticking as the threat is growing. The Administration's strategy, plan, and budget request help move the country toward better preparedness. But, Congress must now act expeditiously to fill the remaining weaknesses and ensure that America is as prepared as possible to face this serious health threat.

Every level of government -- federal, state and local -- must prepare for pandemic flu. Every American must hold government accountable for ensuring that every community nationwide is prepared for a worst case flu outbreak. Americans must demand that elected officials provide the leadership, funding and public policies that will mitigate the spread of pandemic flu and provide medical treatment to all those who need it.

I thank you again for this opportunity to express TFAH's views on evaluating the U.S. readiness for the next flu pandemic.

Chairman TOM DAVIS. Thank you.

Mr. Kriens, you have to leave in a couple of minutes is my understanding. Is that——

Mr. KRIENS. We've extended a bit of time. So please.

Chairman TOM DAVIS. All right. Thank you.

Well, let me start. Why do you think that Federal employees have been slow to roll out or the Federal Government has been slow to roll out teleworking employees? Now that you are sitting there, both to ask you and Mr. Kurtz. And how can we get buy-in from senior management? How do you do it in the private sector?

I will start with you, Mr. Kriens.

Mr. KRIENS. It's, as you know, multi-faceted, Mr. Chairman. But if I were to put it in a commonly used phrase, I think we're trying to boil the ocean. And what we really need to do is to have use of teleworking spread in the same way the Internet itself developed, which was to sprout up in pockets and then have those pockets communicate with one another.

Ironically, as we sit here talking about pandemics, it's something we call "viral progress" in the deployment of communications and new technology. Because as people see the benefit of it through use by others and talk amongst themselves, it makes more progress in deploying these technologies than anything we can legislate or that we can dictate or that we can plan a report on.

So it's one of the reasons for our recommendation that, really, if this starts with the leadership, such as yourselves and others who are familiar with this and do use it, taking it to heart and spreading it from the top down, that will do more to motivate progress and acceleration than anything that we can do from the bottom up.

Chairman TOM DAVIS. We try here at the legislative branch. But ultimately, this is an executive branch function. We have continued—Mr. Davis has legislation moving, trying to get the Government to move on it. And it has just been very, very slow.

Mr. Kurtz, any comment on that?

Mr. KURTZ. Yes, I would—there are three factors that I intend to contribute. I think one is Cabinet-level agencies don't necessarily have the incentive to aggressively pursue telework. I know that in the GSA survey that was released last year, it talks about, you know, who has more telework versus less.

And it's very interesting to look at several of the senior agencies, including Labor, Treasury, and HUD. The actual number of people who are eligible for telework has gone down. So I think, you know, there is a budgetary issue that needs to be addressed.

Second, I think there is a perception among IT managers that perhaps FISMA is a barrier. I think that's probably misplaced. But FISMA could be used as, if you will, a reason as to why one cannot pursue telework.

I understand at DHS, at least, that they don't allow the use of wireless. Well, it's kind of hard to telework if you don't have any sort of wireless technology capabilities. There are technologies today to handle all of the security, the authentication issues associated with telework.

The third issue I think is basically managers wanting to have eyes on their employees. And once again, we have technology that

is available today that helps managers understand what their employees may be doing from afar. In other words, when I might come onto the computer, what applications I may access. Those type—you know, how long I'm on the system.

Those kind of issues, I think, combined, those three, create an environment where senior-level managers and agencies are not pursuing telework. You'll note that I have not said security is an issue. The technologies are out there today in order to have secure, reliable telework, and the private sector is case in point.

One final point that I think is fascinating, and you look at AT&T, the old AT&T, if you will, before the merger. Forty percent of their management was able to telework. When you ask that question of Federal executive managers, 30 percent are not allowed. That was the response, 30 percent are not allowed to telework.

And so, you know, set the standard at the top. Have managers themselves begun to telework. The guidance is in place. We don't need more guidance. It's just starting to do it.

Chairman TOM DAVIS. In fact, until I think a couple of years ago, when we passed legislation out of this committee, Federal contractors weren't allowed to charge telework back to the Government. And sometimes that is the most productive work.

Mr. Kriens, let me ask you the last-mile solution, such as residential broadband, will be relied on if the Federal civilian employees are to telework. How are these networks designed to ensure resilience?

Mr. KRIENS. The primary source of the resilience is actually in the dispersity and the breadth of the physical infrastructure itself. By the time one gets to the last mile, whether that's a copper wire or a coaxial cable or, in some cases, as Paul mentioned, a wireless access, the pure dispersion of that is the very diversity that we need.

Any one of those points or perhaps even a neighborhood can be affected, but the protection is in the dispersion of the work force across many tens or hundreds of square miles. And there are also for key executives or for key needs an ability to, by the very nature of the competing entities here as service providers, the cable operator and the wireless operator and the traditional wire line telephone company have built three separate infrastructures.

So in the case of critical executives, it's quite possible for literally $50 a month to duplicate redundant capabilities and facilities all the way into the offices in the home of critical executives. So it's a cost issue, but it's a very modest one in the case of protecting senior leadership from any physical diversity requirement——

Chairman TOM DAVIS. It has to be done now. I mean, you don't want to sit and wait until this thing is on top of us.

Mr. KRIENS. We cannot wait to put this in place when the work force has been immobilized. Not just the work force that we speak of, but those who must enable and go out and deploy and make those connections.

We have the ability to do that now. I think it's clearly within reach and within technical means without question. And so, now is certainly the time, and it's easily doable.

Chairman TOM DAVIS. And you don't feel that basically from that, that our agency employees that deal with sensitive and classified information, those are very resolvable if we stay ahead of the game?

Mr. KRIENS. Again, the best example of that is we're using the very same technology to protect our troops in battle with the ultimate reliability requirement. They are relying today in work we do with the defense agency, you know, we are relying on battlefield information as an alternative to deploying contingent troops and materiel in battle because we need that information to know the specificity and location and magnitude of enemy force.

And we are relying on it to that degree that we are keeping our men and women out of harm's way as a result of the use of this technology every day in conditions much more demanding than those that would be required to reach a given neighborhood in this country.

Chairman TOM DAVIS. Thank you.

Mr. Issa.

Mr. ISSA [presiding]. Thank you, Mr. Chairman.

I will be fairly brief. I realize that you are, even with an extension, on a short leash time wise. And Mr.—I apologize—Klines?

Mr. KRIENS. Kriens.

Mr. ISSA. Kriens. I apologize. I am a little concerned, though, about the statement you made on $50 a month. I telecommute relatively effectively, but—and by necessity. But you can't do it for $50 a month.

Are you saying that you think that the average Federal employee or health care provider, first responder will provide all of the software and hardware, and all we have to do is pay for the connection? Where do you get the $50 figure?

Mr. KRIENS. And let me clarify, Congressman Issa, the—I was really specifically answering the question of redundancy. So there is an initial cost, as you accurately described, for setting up the computing capability, the software and security. And that will vary depending on the amount of performance and processing power.

The $50 a month is actually probably more than it would cost to deliver the physical redundancy. So that if there were a capability via your traditional telephone supplier on a DSL line over copper and one were to seek a cable line for backup or wireless access for backup, the incremental cost of that access in various counties and States around this country is in the sometimes $29 to $30 a month range.

But I was really referring purely to the cost of the chairman's question on providing physical diversity. There's a cost, it would probably be more in the $100 range, which would be the establishment of the capability, maybe $150 if you wanted to amortize the equipment as well, in setting up the telecommuting/telework capability.

And then the additional moneys would be for providing the physical redundancy for critical need.

Mr. ISSA. And how many health care professionals do you think would be required? In other words, give me the gross number of people so we can do the multiple.

Mr. KRIENS. The gross number of people that would need to telework in an emergency?

Mr. ISSA. Yes.

Mr. KRIENS. I'm not sure one would be capable or I'm not capable certainly of predicting that here without having a guess as to the magnitude——

Mr. ISSA. More than 100,000?

Mr. KRIENS. More than 100,000 people?

Mr. ISSA. Well, if we look at every location in the Nation——

Mr. KRIENS. Uh-huh.

Mr. ISSA. And we look at every person that you would like to have this redundancy capability—and I am not trying to be unfair to your proposal. I actually want to embrace it. I am looking at when we try to turn, you know, it is like, you know, Dr. Plough?

Mr. PLOUGH. Plough.

Mr. ISSA. Plough. Thank you. Had—I am not doing good on names today.

Mr. PLOUGH. That's OK.

Mr. ISSA. But, you know, I appreciate that we need 600 million doses of X worldwide. But then there is X, Y, Z, A, B, C. In a recent trip to Geneva, one of the questions, you know, that you have to ask is, do we invest in the ability to quickly find or quickly refine and distribute in the future Z when it comes along, or do we stockpile A, B, C, D, E, F, G of various known? And what are the cost tradeoffs?

So I really believe, and you have Virginia's former secretary of technology right behind you. So he will smile when I say this. I really believe America needs to be connected from a redundancy standpoint in every home and that this has to be a basic capability.

Then the question is whether you are a health care professional, an AT&T executive, or a Congressman, or a school teacher, how do we analyze how much is going to be borne by our middle class citizens, and how much is going to be borne by potentially Government agencies?

Mr. KRIENS. It's an excellent point, and I have an affinity for practicality. So let me respond in kind. The actual physical redundancy requirement, I would believe, is actually quite limited because it's only the senior executive and senior leadership for whom that degree of accessibility on an uninterrupted basis would be required.

As the reports and various study of this has delineated, there are executive leadership, there is essential and potentially nonessential, or I would prefer to think of them as perhaps less essential, for whom the redundancy is not a requirement because there are others who could substitute. And the real availability, which is a different term, is borne by the fact that the dispersed work force is scattered over hundreds or, in the case of the country, millions of square miles.

So there is no effect that would likely take out more than a pocket of them, and there are others who could substitute and fill in and come from other areas. And as a result, there isn't a need for this kind of redundancy or additional expense other than for the senior.

And I would just start at the ultimate irreplaceable leadership. The President of the United States literally has a mobile cell that follows him across his ranch in Crawford, TX, and goes down into the gullies when he decides to go chop wood so that he is accessible, obviously, on a moment's notice.

From there, one could step down——

Mr. ISSA. And his is fully secure at the highest possible security level, too?

Mr. KRIENS. We spend a lot of time at Juniper making sure of that, as a matter of fact. But we can quickly move to a case where much of the leadership really can be substituted for or for which contingency planning could avoid the hard cost, and it certainly would echo your point that we have to be practical about this and reserve those kinds of duplicate costs for only the premium and really irreplaceable leadership requirements.

Mr. ISSA. And would that number be relatively similar if, instead of talking about a pandemic, we were looking at the next Hurricane Katrina?

Mr. KRIENS. It's an interesting thing. Yesterday, I'm in town also as a member of the National Security Telecommunications Advisory Committee that reports to the President, and we had our meeting yesterday. And one of the comments that was made was that Katrina itself actually replicates in many cases a nuclear threat example and certainly a pandemic example because the water didn't come in and go out.

Most hurricanes and floods and tornadoes and other events happen over the course of 24 or 48 hours, and then we are able to rebuild the infrastructure and recover. And Katrina is actually a fantastically frightening example of what can happen if the threat is sustained and carries over weeks and months. And there's an inability to reach infrastructure, to reestablish power, to reestablish communications, command, and control.

So it's quite an opportunity for us to learn about how we would conduct continuous operations, and the pandemic is going to be another example of that, if and when and to what magnitude it hits. Because we will have extended loss of access to facilities and resources, and we have the wherewithal to continue operations during that extended and very difficult condition.

Mr. ISSA. OK. I am going to not belabor this point, but is one that I am sure this committee was going to deal with in the future.

One last sort of the exit question that often we ask. When looking at the President's recent proposals, 300 and some items, if you were to break them down, how many of them are dual or multiuse and have relatively small cost other than the, if you will, the preparation, the thinking, the one-time cost of preparing versus what are the major, when you get to the other extreme, what are the major items that we have to look at—not in this committee, but in the Committee on Appropriations—that are significant, very significant dollars and not one time? If you would just touch on the key ones.

Mr. KURTZ. Maybe I'll try to come to your—let me try to come to your question a different way. I'm not going to position myself as being able to analyze the full plan that the President has put together. But in your previous question——

Mr. ISSA. Pick five or six. That would probably do it.

Mr. KURTZ. We're talking about cost.

Mr. ISSA. Yes.

Mr. KURTZ. And I think there are a couple of things that strike me when we talk about the area that I know best, and that is on a communications side. And first of all, just 2 or 3 years ago, we couldn't talk about having, if you will, Web-based applications. They're far more prevalent than there are today.

You made a statement that, you know, who's going to buy all the software? Well, the fact is, I can be at home now, and I can tap in through technologies that are available today that don't require me to have software on my computer. I can use a Web-based application to go in, to tap into the home bank or the enterprise, and see what I need to do and do my business.

The other thing—the other issue I'd highlight with regard to cost. A lot of the cost associated with the pandemic or planning a pandemic, if you will, may be one-time cost or a sum cost. That's not the case when you think about telework.

Telework helps us with routine activity every day, everyday business activity in the Federal Government. It also helps us with all hazards. It's not just a one-time sum cost to help us with a pandemic. It helps us with a hurricane. It helps us with a terrorist attack. It helps us with a blizzard. And so, if we can change our mindset to think more broadly about this, then I think it would be helpful.

And the final comment, if I can, is to think about scope. There's a lot of conversation about only essential employees. I disagree. I think we ought to dig deeper into the agency and think more broadly about who is included and just as a—as an estimate, you know, the top third or so of the agency.

So that when we look at contingency plans as the guidance that the Federal Government has today, it's 72 hours or so that you can exist on essential employees. Then you're dispersing to a location for like 30 days. It's only the top employees.

Well, when you look at the plan that the White House has put together, we're well beyond 30 days. So the essential employees are not—not—going to be able to keep the operation going for an extended period of time. So we have to dig down more deeply into agencies as we think about the flu pandemic.

Mr. PLOUGH. If I could just respond from the public health side?

Mr. ISSA. Yes, please.

Mr. PLOUGH. The President's plan builds multi-use capacity that is applicable to many kinds of infectious diseases, earthquake, floods, because it heightens the connectivity of first responders with community in a way that, if funded appropriately, is sustainable and builds a missing piece of our protective structure for public health.

So those—there are sustainable and multi-use components of this. Pandemic is one of the worst cases. If you are properly prepared for pandemic influenza, you are prepared for SARS, you are prepared for West Nile, you are prepared for an earthquake. You are prepared for a variety of public health disasters.

Mr. ISSA. Excellent. Well, I don't have any other questions.

The record will remain open for 5 legislative days for any additional questions from people that are not able to be at the dais and so you may revise and extend as your rather cogent capabilities allow you to think of things.

In addition, I would like to thank you very much for the generosity of your time, being here today, and the thoroughness, including the fact that no one is rubber-stamping somebody else and that we do have a very active debate because of this hearing between what happens on day 1 and what happens after day 30.

And with that, we stand adjourned.

[Whereupon, at 12:17 p.m., the committee was adjourned.]

[The prepared statements of Hon. Dan Burton and Hon. Darrell E. Issa follow:]

Opening Statement
Honorable Dan Burton
Committee on Government Reform
Hearing: "Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations"
Date: Thursday May 11, 2006 @ 10:00am
Room: 2154 Rayburn Office Building

Mr. Chairman, thank you for holding this important and timely hearing on our public health system's pandemic flu response capabilities at the federal, state, and local levels. As the Committee has rightly observed, the past few annual influenza seasons, as well as recent avian flu activity in Asia, raise disturbing questions about whether the U.S. is truly prepared to deal with the threat of a flu pandemic and whether our country is capable of working through a pandemic should one strike.

Health professionals around the world remain deeply concerned about the continued spread of the deadly avian H5N1 virus which has swept across eastern Asia and has started to be seen in the Middle East and Europe. The virus is highly virulent – more than half of the people infected with the H5N1 virus have died – is rapidly being spread across the globe by migratory birds; can be transmitted from birds to mammals and in some limited circumstances to humans, and, most importantly, like other influenza viruses, it continues to evolve. Many scientists and health professionals believe it is only a matter of time before H5N1 mutates into a virus capable of human-to-human transmission, sparking a global pandemic. The Spanish Flu pandemic of 1918-1919 killed 40 to 50 million worldwide and some scientists predict that an avian flu pandemic could be as severe. I think it is safe to say that all of us here today fervently hope that a pandemic never happens but it is also fair to say that we would be remiss in our responsibilities if we did not do everything in our power to prepare our nation for that eventuality.

Last fall President Bush unveiled his National Strategy for Pandemic Influenza – a $7.1 Billion plan built around the three pillars of preparedness and communication, surveillance and detection, and finally, response and containment. I applaud the President for his leadership on this issue and I believe the Administration's three-pronged approach is basically sound. However, the devil is always in the details, and I look forward to hearing from our witness today about how the Administration proposes to turn strategy into action.

Back in November of 2005, I expressed deep concern that the Administration's Strategy did not go far enough to address one critically important question; namely what do we do if a pandemic flu vaccine causes dangerous side effects and ends up injuring millions of Americans? The reality of vaccines is that rare and dangerous events may not come to light before licensure. Even when there is sufficient time to study a vaccine for potential side affects – and the vaccine manufacturer has done everything legally required to ensure a vaccine's safety – sometimes safety issues can only be detected following vaccination of a much larger and more diverse population. Unfortunately, in a pandemic

flu situation or bioterrorist attack the risks increase because we will not have the luxury of time to uncover all the potential side affects of an experimental vaccine before we are forced to start inoculating people.

I firmly believe that our avian flu preparedness plan will fail miserably if the American people do not trust that the vaccines and drugs they may receive to protect them may in fact harm them instead. For example, recent studies have indicated that more than half of pediatricians are already encountering at least one family a year that refused all vaccines, while 85 percent say they'd had a parent turn down at least one shot. Whether it's because of fear that mercury used as a preservative in vaccines causes autism, or that the dangers of immunizations far outweigh their benefits, or that there is a conspiracy by drug companies, doctors and vaccine makers to conceal the harm, the facts are clear, more and more American families are fighting immunization.

We also saw this pattern unfold when we attempted a smallpox vaccination program for first responders in 2003. First responders and other health care workers balked at being vaccinated because the compensation programs we put in place was neither clear enough nor adequately funded enough to overcome their concerns about the financial well-being of themselves and their families if they were injured by the vaccine. Under those circumstances our first responders were faced with a very difficult choice; either refuse to take the vaccine or take it and be prepared to sue the vaccine manufacturer if something went wrong. In the end, the vast majority choose not to take the vaccine.

We as a nation are about to repeat the smallpox vaccination mistake again, but this time in spades. Because this time around people won't even have the choice of suing the vaccine manufacturers thanks to a provision contained in the Fiscal Year 2006 Department of Defense Appropriations bill. This provision granted vaccine companies sweeping legal protections for pandemic countermeasures; almost blanket immunity except in the case of clear and convincing evidence of willful misconduct. Granted the appropriators did include another provision creating a pandemic vaccine compensation fund but the fund was a paper tiger, it contained no money.

Let's be very clear, without a fully-funded compensation component in place, we are asking the American public to trust the pharmaceutical industry to keep them safe. And if that trust is broken – recent cases like celebrex and vioxx come to mind – we have left Americans with no place to turn for a remedy – no access to the court system and no access to appropriate compensation when they or their loved ones are injured or killed by a covered countermeasure.

I hope you will agree Mr. Chairman that this is an unacceptable situation and I hope this Committee can work with the appropriate authorizing and appropriations committees to install rigorous safeguards on the manufacture of pandemic vaccines or medical devices and fully-fund the compensation program created by the Department of Defense bill. I also look forward to hearing from our witnesses about what steps the Administration can take or is already taking to close this glaring loophole in our pandemic preparedness plan. Thank you.

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HOUSE POLICY COMMITTEE

Opening remarks by Congressman Darrell Issa to the House Committee on Government Reform for May 11, 2006.

Thank you Mr. Chairman and Ranking Member Waxman for holding this important hearing on "Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations." I also want to thank the witnesses for taking time out of their busy schedules to testify before the full Committee.

In the event of an outbreak of pandemic flu, a coordinated response between our federal, state and local authorities - from the Departments of Homeland Security and Health and Human Services to public health offices and emergency response teams in the smallest of American towns - will be the key to ensuring the health and safety of the American public.

The administration should be commended for their foresight in planning for a pandemic and their development of both the National Strategy for Pandemic Influenza and the Implementation Plan. Not only will these plans be essential for mitigating loss of life, but also easing the potentially devastating effects that an outbreak of pandemic flu could have on our nation's economy. It is crucial that we do as much as possible to ensure that the American people will be able to continue working and maintain, as much as possible, their way of life.

Integrating health information technology into the response plan can help to ensure the health of the American people. President Bush has been pushing to stimulate health IT for the past 5 years. Transitioning to an electronic form of records will allow HHS to determine in real time what response is required to a pandemic outbreak. Obviously, we should address this issue now, rather than after a pandemic flu hits the United States and demonstrates our weaknesses and devastates us through our failures.

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