

**ASSESSING PUBLIC HEALTH AND THE DELIVERY
OF CARE IN THE WAKE OF KATRINA**

JOINT HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
AND THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
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COMMERCE
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ASSESSING PUBLIC HEALTH AND THE DELIVERY OF CARE IN THE WAKE OF KATRINA

THURSDAY, SEPTEMBER 22, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH, AND THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:35 a.m., in room 2123, Rayburn House Office Building, Hon. Nathan Deal (chairman of the Subcommittee on Health) and Hon. Ed Whitfield (chairman of the Subcommittee on Oversight and Investigations) presiding.

Members present, Subcommittee on Health: Representatives Deal, Hall, Bilirakis, Upton, Gillmor, Shimkus, Shadegg, Pitts, Ferguson, Burgess, Barton (ex officio), Brown, Waxman, Gordon, Rush, Eshoo, Strickland, DeGette, Capps, Allen, and Dingell (ex officio).

Members present, Subcommittee on Oversight and Investigations: Representatives Whitfield, Stearns, Ferguson, Burgess, Blackburn, Barton (ex officio), Stupak, DeGette, Schakowsky, Inslee, Baldwin, Waxman, and Dingell (ex officio).

Staff present: Bud Albright, staff director; Chuck Clapton, chief health counsel; Brandon Clark, policy coordinator; Melissa Bartlett, majority health counsel; David Rosenfeld, majority health counsel; Nandan Kenkeremath, majority health counsel; Mark Paoletta, chief oversight and investigations counsel; Andrew Snowdon, oversight and investigations counsel; Chad Grant, health legislative clerk; Jonathan Pettibon, oversight and investigations clerk; Michael Abraham, oversight and investigations clerk; Edith Holleman, minority professional staff; Voncille Hines, minority research assistant; Jessica McNiece, minority research assistant; John Ford, minority professional staff; Chris Knauer, minority professional staff; Amy Hall, minority professional staff; Bridgett Taylor, minority professional staff; Purvee Kempf, minority professional staff; and Chris Treanor, minority intern.

Mr. DEAL. Good morning. The subcommittees will come to order.

As everyone is now aware, Hurricane Katrina devastated the lives of countless thousands of people living along America's Gulf Coast and decimated much of the public health structure in the areas that were hit by the hurricane.

The purpose of today's hearing is to focus on the current situation on the ground in terms of public health and the health delivery infrastructure, and to focus on how we can improve our preparation and response to similar natural disasters in the future.

A broad list of public and private sector organizations are working together in efforts to improve the lives of people affected by Hurricane Katrina, and I am proud to say that many of these groups are represented here today on our panels.

We have two panels of witnesses appearing before us, and I believe they certainly can help shed light on the current situation in the affected areas and on the direction we need to take in the future to lessen the impact of similar natural disasters.

We look forward to hearing the testimony of both panels, and on behalf of the American people, we applaud you and the efforts that you have made in light of the Katrina disaster.

I would also like to thank my good friend from Kentucky, Mr. Whitfield, and his staff on the Oversight and Investigations Subcommittee, for joining me and my staff in preparing and conducting today's hearing; and we will alternate. Since this is a joint meeting of both subcommittees, I'll be presiding over the first panel and then I will turn the gavel over to Mr. Whitfield at that time for his presiding over the second panel.

We, of course, are all aware that Hurricane Katrina is not maybe the last on our list of hurricanes to be concerned about today. We originally, of course, had scheduled to have Stewart Simonson, the Assistant Secretary of the Office of Public Health Emergency Preparedness, with us, but in light of the fact that as of about 6:50 last night the National Weather Service announced that Hurricane Rita was the third most intense hurricane on record and was apparently headed for the Texas and Louisiana coast, and had been categorized as a Category 5 hurricane. And warnings had been issued, and I think—my understanding is, approximately 1.3 million people in the States of Louisiana and Texas have been ordered to evacuate.

Certainly in light of that and in light of his capacity in that regard, he has asked that he be allowed to attend to that emergency rather than a hearing here before these subcommittees; and certainly we have consented to that. We want him to be where he needs to be to do his job, and that is the reason for his absence.

But we are pleased to have Dr. Gerberding, who is the remaining panel member for the first panel.

[The prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON
HEALTH

The Committee will come to order, and the Chair recognizes himself for an opening statement.

At 6:50 p.m. last night, the National Weather Service announced that Hurricane Rita became the third most intense hurricane on record. As a storm-weary Gulf Coast braced for another hit, Rita grew in strength with frightening speed, becoming a 165-mph, Category 5 nightmare in a matter of mere hours. A hurricane warning has been issued from Port Mansfield, Texas, to Cameron, Louisiana, prompting more than 1.3 million people in the states of Texas and Louisiana to be ordered to evacuate by authorities who have learned painful lessons in the wake of Hurricane Katrina.

Hurricane Katrina devastated the lives of countless thousands of people living along America's Gulf Coast and decimated most of the public-health infrastructure in the areas hit by the hurricane. The purpose of today's hearing is to focus on the current situation on the ground in terms of public health and health delivery infrastructure and to focus on how we can improve our preparation and response to similar natural disasters in the future.

A broad list of public and private sector organizations are working together on efforts to improve the lives of the people affected by Hurricane Katrina, and I am proud to say that many of these groups are represented here today. We have two expert panels of witnesses appearing before us this morning that I believe will help shed some light on current situation in the affected areas and on the direction we need to take in the future to lessen the impact of similar natural disasters. We look forward to hearing your testimony, and on behalf of the American people, we applaud you for your efforts.

I would also like to thank my good friend from Kentucky, Mr. Whitfield, and his staff on the Oversight and Investigations Subcommittee for joining me in preparing and conducting today's hearing, and I now recognize him for five minutes for the purpose of making an opening statement.

Mr. DEAL. At this time I will turn to my colleague from Ohio, the ranking member of the Health Subcommittee, Mr. Brown, for his opening statement.

Mr. BROWN. Thank you, Mr. Chairman.

Welcome, Dr. Gerberding, back to our subcommittee.

Hurricane Katrina has left Americans with more questions than answers. We want to know how to respond, we want to know what happened, we want to know what could have been done better, we want to know how to prevent such catastrophic effects in the future.

The public health arena is no exception. We see the images emerging from the Gulf Coast, we hear the stories and watch the death toll grow, we wonder what we could have done to save people trapped by illness or by infirmity.

As policymakers, we must temper our grief with the firm resolve to understand what happened and correct our mistakes. That will no doubt prove a challenge. It is not enough to be ready for another Katrina. Preparedness for one type of disaster does not translate into preparedness for another; we learned that the hard way. It is not enough to look at short-term needs; we must look at long-term investment.

This Nation has not only witnessed the traumatic effects of Katrina, we've witnessed—if only for a few days, we've witnessed the insidious effects of poverty. We're paying a steep price for neglecting basic government functions, for ignoring the hardships around us.

Public safety is not an option; it's an imperative. When tax cuts trump public safety, when tax cuts trump public safety, government is shirking its most basic responsibility. That is short-sighted. That's reckless. We need to invest in CDC and FEMA and HRSA and other agencies that promote public health and safety. This Congress learned that the hard way.

Impoverished communities in a wealthy nation are not an inconvenient reality; they are a failure of government. We need to invest in the services that help Americans bounce back after a crisis and build better lives, services like Medicaid, like food stamps, like public education. It would be easy to ignore that piece of the Katrina puzzle; it would also be unethical.

I hope this hearing answers a number of questions about the response to Katrina and what needs to be done before the next disaster strikes. And the resources that we've allocated in the past, for example to HHS for bioterrorism preparedness, proved useful in responding to Hurricane Katrina. What did Katrina teach us about preparedness for other disasters, not just from floods of another

hurricane, but from a pandemic flu outbreak, from a bioterror nuclear attack.

What is a realistic timeframe for crafting an effective disaster response, one flexible enough to accommodate a range of possible disasters in our Nation's geographic, demographic, and socioeconomic diversity?

As we consider these questions, it is important to remember the other public health issue left unconsidered. We can't ignore Medicaid and claim—not to mention cut Medicaid—and claim to be stewards of the public health. Public health rests in prevention, it rests in detection, it rests in treatment. Medicaid means treatment for Katrina victims and for millions of others in need.

What are we going to do to ensure access to Medicaid for Katrina's victims when their home States were already in crisis prior to Katrina, and their host States were overwhelmed prior to Katrina? The Bush administration has graciously agreed to ensure that Mississippi and Alabama and Louisiana pick up the tab if one of their residents seeks health care in a host State. Coupled with the President's desire to cut Medicaid \$10 billion and continue to pursue more tax cuts, that's not hurricane relief, it's a collection service.

In a democratic society, every member is equally important. The government's role is to promote society as a whole by protecting and empowering every member. Katrina forced us to acknowledge that government is not doing its job.

I am pleased the Energy and Commerce Committee is taking a step to move in the right direction.

Thank you, Mr. Chairman.

Mr. DEAL. I now recognize the chairman of the Oversight and Investigations Subcommittee, Mr. Whitfield from Kentucky, for his opening statement.

Mr. WHITFIELD. Mr. Chairman, thank you very much. And I want to thank you and your staff for proceeding with this hearing with Oversight and Investigations. We welcome the opportunity to work with you on this critical issue.

The extent of Katrina's devastation has been truly unimaginable, and the impact of the storm, we know, will be felt for years to come.

Just as Katrina's winds and floodwaters tore apart homes and lives, they also exposed numerous vulnerabilities that must be identified and remedied so that the next disaster does not have such tragic consequences.

The Oversight and Investigation Subcommittee has a long history of tackling important public health issues. We've had oversight work on such issues as bioterror preparedness, the safety of the U.S. Blood supply in the wake of 9/11, readiness questions posed by the SARS outbreak, and the availability and safety of vaccines, among others.

Unfortunately, the devastation wrought by Katrina has spawned an array of public health and health care issues that are unprecedented in their scope and magnitude. Our Federal public health authorities face an enormous task and complex task not only with this vital step to deliver care and supplies to those in need, but the equally important task of rebuilding infrastructure and ensuring

the future habitability of New Orleans and the devastated Gulf Coast communities.

Many aspects of this undertaking will require congressional oversight, and we intend to embark upon an ambitious schedule of hearings, examining key public health and emergency management issues involved in the Katrina response and rebuilding effort. For example, we will seek to learn about the evacuation of health care facilities, as well as the public health and cleanup problems presented by environmental contaminants.

We will also be focusing on how departments and agencies within the committee's jurisdiction plan to spend and monitor their respective portions of the billions of dollars going to the Gulf Coast region, in order to ensure the money be spent as efficiently and effectively as possible.

Today's hearing will focus on the critical issue of Katrina's catastrophic impact upon the health care infrastructure of the Gulf Coast. Hospitals, clinics and community health centers throughout the region have been severely damaged or destroyed. Moreover, contaminated flood waters, toxic mold, an incalculable amount of debris are just a few of the public health problems that confront the devastated region both today and for the foreseeable future.

Our witnesses today will speak to these issues and to the state of affairs on the ground as well as what we might expect in the months and years ahead. At the outset, I want to thank Dr. Gerberding for taking the time to be here in the midst of what must be an exhausting schedule, and we look forward to your testimony and those of all the witnesses.

And I yield back the balance of my time.

[The prepared statement of Hon. Ed Whitfield follows:]

PREPARED STATEMENT OF HON. ED WHITFIELD, CHAIRMAN, SUBCOMMITTEE ON
OVERSIGHT & INVESTIGATIONS

Thank you, Mr. Chairman. The Oversight and Investigations Subcommittee certainly welcomes the opportunity to work with you on this critical issue. I would like to express my deepest sympathies for all of the individuals in the Gulf Coast region affected by Hurricane Katrina—a disaster of epic proportions. The extent of Katrina's devastation is truly unimaginable, and the impact of this storm will be felt for years to come.

Just as Katrina's winds and flood waters tore apart homes and lives, they also exposed numerous vulnerabilities that must be identified and remedied so that the next disaster—and there *will* be a next disaster—does not have such tragic consequences. Katrina should serve as a wake-up call to all agencies and departments at all levels of government, and I have no intention of allowing *this* call to go unanswered.

The Oversight & Investigations Subcommittee has a long history of tackling important public health issues. In recent years, it has been at the forefront of efforts to ensure the nation's public health infrastructure can manage emerging threats—with oversight work on such issues as bio-terror preparedness; the safety of the U.S. blood supply in the wake of 9/11; readiness questions posed by the SARS outbreak; and the availability and safety of vaccines, among others.

Unfortunately, the devastation wrought by Katrina has spawned an array of public health and healthcare issues that are unprecedented in their scope and magnitude. Our federal public health authorities face an enormous and complex task, not only with the vital steps to deliver care and supplies to those in need, but the equally important task of rebuilding infrastructure and ensuring the future habitability of New Orleans and the devastated Gulf Coast communities.

Many aspects of this undertaking will require Congressional oversight. It is our obligation to make certain that people are getting the care and help necessary to put their lives back together. Accordingly, over the course of the next several weeks and months, this Subcommittee intends to embark upon an ambitious schedule of

hearings—examining key public health and emergency management issues involved in the Katrina response and rebuilding effort.

For example, we'll seek to learn more about the evacuation of healthcare facilities, as well as the public health and clean up problems presented by environmental contaminants. We will also focus on how departments and agencies within the Committee's jurisdiction plan to spend and monitor their respective portions of the billions of dollars going to the Gulf Coast region, in order to ensure the money is spent as efficiently and effectively as possible.

Today's hearing will focus on the critical issue of Katrina's catastrophic impact upon the healthcare infrastructure of the Gulf Coast. Hundreds of thousands of people have been displaced, a great many of whom have been separated from their medicines, healthcare providers, and medical records. Hospitals, clinics, and community health centers throughout the region have been severely damaged or destroyed. Moreover, contaminated flood waters, toxic mold, and incalculable amounts of debris are just a few of the public health problems that confront this devastated region both today and for the foreseeable future. Our witnesses today will speak to these issues and to the state of affairs on the ground, as well as what we might expect in the months and years ahead.

At the outset, I would like to thank Dr. Gerberding for taking the time to be here in the midst of what must be an exhausting schedule. While we certainly do not want to do anything that might interfere with the relief effort, it is essential that we hear from those who are most knowledgeable about the situation on the Gulf Coast and in New Orleans in a timely manner.

With that, let me welcome all the witnesses. I look forward to an informative hearing and yield back the remainder of my time.

Mr. DEAL. I thank the gentleman.

I now recognize the ranking member of the Oversight and Investigations Subcommittee, Mr. Stupak, for his opening statement.

Mr. STUPAK. Well, I thank both of the chairmen for holding this hearing on health care and Hurricane Katrina. I also want to thank all the witnesses for testifying today, many of them on very short notice.

This is a critical issue, both in terms of what went wrong in preparing for and responding to the hurricane, and how the health care infrastructure of the affected areas of the Gulf Coast is going to be rebuilt and who is going to pay for it.

I am, however, very disappointed that the Department of Health and Human Services yesterday, at the last minute, pulled Stewart Simonson from testifying in front of us today. Mr. Simonson is a lawyer, who is head of the Office of Public Health Emergency Preparedness within HHS. His office, on paper at least, is responsible for putting in place a health care system that would work during a major disaster.

Mr. Simonson could be called the Michael Brown of HHS because, like Mr. Brown, he has scant experience in public health and emergency preparedness. He was legal counsel for Governor Tommy Thompson in Wisconsin, and then worked for Amtrak before receiving an appointment to serve in HHS as counsel to the Secretary, and then to his current role.

He is best known to the public for two recent faux pas: his attempt this summer to stop publication of the paper on the insecurity of the milk supply, and his statements to Senator Grassley about the effectiveness of an untested Anthrax vaccine. Senator Grassley later forced a public retraction of that statement. His lack of experience showed in his office's actions during Hurricane Katrina.

For example, I would like to have asked Mr. Simonson if he was the HHS official that held up for several days a FEMA contract with Kenyon International Emergency Services to recover bodies in

New Orleans because he wanted a chaplain to retrieve each one of them. As a result, body retrieval was further delayed. And I would have liked to ask him why HHS was unable to mobilize 40 250-bed emergency medical shelters, called the "Federal medical contingency stations," that were promised to the Gulf Coast.

On August 30, after Katrina hit land and the levees were breaking, Mr. Simonson told health care leaders, and I quote, "We do not have all the assets and supplies which are needed to stage up these facilities; and so we are, at this very moment, in the market purchasing necessary supplies, medication, consumables, cots, IV poles, all the things like that to go into health care," end of quote. What have we been doing with all this preparedness money and training if HHS had to purchase supplies after the hurricane hit?

Mr. Chairman, let me conclude by saying that there are many other issues involving Katrina that the Oversight and Investigations Subcommittee needs to look at. Mr. Dingell and I sent you a letter listing a number of them, but none is more important to our Nation than the energy supply for the coming winter.

Yesterday, CNN cited experts that said any further refinery damage resulting from Hurricane Rita could result in \$5-to-\$6-a-gallon gasoline.

Mr. Chairman, the U.S. Energy Information Administration's dire predictions of an increase of up to 77 percent in natural gas prices, as well as a 33 percent increase in home heating oil, and an additional 43 percent for propane costs in the Midwest has many of my constituents wondering how they will be able to afford to keep their homes heated this winter. Many of them are already living paycheck to paycheck or Social Security check to Social Security check.

These constituents have already been forced to decide between buying food, buying medicine or gasoline for their car. Many are breaking their medications in half and not receiving the proper medical treatment. Now, with skyrocketing home heating costs, their finances will be spread even thinner, and I fear many will be pushed over the brink. All of this will occur while big oil companies continue to post one record profit on top of another.

The impending increases in heating costs will surely force many in my district to turn their heat down to dangerously low temperatures, which will, in turn, result in increased illnesses among the elderly and poor. This will then place additional burdens on the Medicaid and Medicare systems, which are already overburdened.

Cooler fall weather is already settling into my northern Michigan district. In some places, we will receive well over 200 inches of snow this winter. I had a constituent call my office earlier this week after he was told that he could not receive assistance with his electric bill because the money in the Low Income Home Energy Assistance Program—LIHEAP, as we know it—had been reprogrammed to the Gulf area due to Hurricane Katrina. In fact, \$27.25 million was sent to Louisiana, Mississippi, Alabama and Florida.

Mr. Chairman, my district is not unique; every district faces significant energy price increases. I hope that we will truly begin to investigate some of these more pressing areas and hold necessary hearings. These hearings cannot merely be briefings where wit-

nesses come with little notice and prepare testimony about what they are going to say very late into the night the day before the hearings. Our hearings must be based on real investigation with in-depth field work and interviews.

I have directed the Oversight and Investigations Democratic staff to start talking to oil and pipeline companies and refineries, so that we can understand and prepare for what may be ahead. I would hope that your staff would join me in this effort.

I am hoping that this general briefing that we're having here today on health care will signify a starting point and not an end to an active, aggressive effort by the Oversight and Investigations Subcommittee. We owe it to our constituents and the American people.

I yield back the balance of my time.

Mr. DEAL. The gentleman's time has expired.

It is regrettable that we've already deviated from the purpose of this hearing today and are getting into politics. As I said in my opening statement, Mr. Simonson is doing his job. I think it would be regrettable if we had someone who was here testifying before this subcommittee today in the wake of the third largest hurricane about to hit our coast, instead of doing his job of preparedness; and that is what Mr. Simonson should be doing. He shouldn't be here; he should be doing his job, which is what he's doing.

If the gentleman wishes to submit the questions he said he wanted to ask, certainly with the permission of this subcommittee chairman, he may do so in writing. And I am sure Mr. Simonson and his department will respond accordingly. But I would keep in mind for all of us that the purpose here is a legitimate inquiry as to where we are on the ground and what we can do to avoid these incidents in the future.

We will now begin with opening statements from other members of the two subcommittees. I would remind everyone that if you choose to waive your opening statement, you get 3 additional minutes with regard to questions of the witnesses on the panels themselves.

I believe Mr. Bilirakis would be our next person for an opening statement.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. I am also pleased you are holding this hearing.

Certainly, it will take some time before we fully realize Hurricane Katrina's true human and economic impact. We must not, however, delay assessing the health of those impacted by this storm and ensuring that its victims get the care they need in as timely and appropriate manner as possible. The residents affected by this tragedy, those who remain in damaged areas, as well as those who have been relocated elsewhere, including my State of Florida, must be informed of the possible health risks they face and given increased access to corresponding health and medical services.

I believe it's imperative that we learn from our response to Hurricane Katrina, so we can both help its victims and improve our disaster preparedness in the future, especially since another massive hurricane is bearing down on Texas's Gulf Coast. It seems that we are always reacting to something that happens, rather than

being ahead of the curve, and I would hope that maybe we will learn our lessons one of these days.

I also want to highlight, Mr. Chairman, legislation that I've talked with you about, that I introduced to better coordinate health, human services and other relief efforts which I believe would be helpful in the aftermath of disasters such as Hurricane Katrina. Congresswoman Eshoo and I introduced this legislation which we're calling the Calling for 211 Act, which would establish a Federal grant program to help States implement 211 telephone service for their residents. This service has proven to save time, money and improve the delivery and coordination of help and other services vital to communities around the country.

I believe enactment of that bill, H.R. 896, will also expand the essential role that 211 service can play in crisis preparedness as a response to it.

I would hope that given the fact that the bill has bipartisan support from members of this committee, we would consider including the Calling for 211 Act as an essential element to any Hurricane Katrina or Hurricane Rita, or whatever the case might be, relief package that this committee may consider in the coming weeks.

Thank you, Mr. Chairman. And I again commend you for calling this very timely and critically important hearing.

Mr. DEAL. I thank the gentleman.

We are pleased to have the ranking member of the full committee, Mr. Dingell, with us, who is recognized at this time for his opening statement.

Mr. DINGELL. Mr. Chairman, thank you, and thank you for scheduling this hearing.

All of us have been shocked by the destruction, human suffering and loss of life brought by Hurricane Katrina. The full toll in terms of physical and mental illness and premature death attributable to those events is yet to be known, but it's clear it's considerable.

What brings us here today is the virtual universal acknowledgment that some of the death and destruction wrought by Hurricane Katrina was avoidable. Some of her victims could have been spared if adequate local, State and Federal preparedness and response programs had been in place and executed in a timely and competent fashion. We have now seen that the human costs of inadequate funding and incompetent management are severe.

Today, we lack final information, but in these hearings and in future hearings this committee should be examining what happened and what the Federal Government and others can do better next time.

That brings us to the fact that today we must assess the current and future health care needs of the people in areas affected by the storm and its aftermath. None of us wants to compound the problem with ineffective or inadequate measures to rebuild the public health infrastructure or by skimping on the true costs of delivering health care to a displaced and needy population.

I note that it is at times like these when we have a chance to see how efficient the Medicaid program can be and how critical it is to the people's health. Every hour of every day there is someone having trouble getting access to medication, to a doctor or health care because they lost their job, their income, their identification,

their assets and more. Providing 100 percent Federal Medicaid reimbursement for people in States devastated by Katrina will result in immediate relief delivered in an efficient fashion. These people need to know today that they will have access to basic health care, not tomorrow or next week, while the Federal Government tries to work out a new and more complex system.

I welcome this hearing as a good start in the process of examining what went wrong. We need to look at what needs to be done now and how we can do better in the future.

I look forward to the testimony of our witnesses, and I commend you for holding this hearing, Mr. Chairman.

Mr. DEAL. I thank the gentleman.

I recognize Mr. Shimkus for his opening statement.

Mr. SHIMKUS. I will pass, Mr. Chairman.

Mr. DEAL. I thank the gentleman.

I recognize Mr. Upton for an opening statement.

Mr. UPTON. I will pass.

Mr. DEAL. I thank the gentleman.

I recognize Mr. Ferguson for an opening statement.

Mr. FERGUSON. Thank you, Mr. Chairman. Thank you for holding this hearing. I thank both of the chairmen for holding this hearing, and Dr. Gerberding and others for being with us to provide testimony and share their thoughts and expertise.

Another monster hurricane is bearing down on the Gulf Coast as we speak, and it is necessary, of course, that we review and revise our response procedures to better serve the areas of devastation after a disaster, both those wrought by nature or at the hands of a terrorist or some other disaster.

In Baton Rouge, several days after the hurricane struck, I was able to see firsthand some of the response, particularly the medical response to Hurricane Katrina and the medical care that was being administered to many of the evacuees from New Orleans and around that area. In the River Center, the biggest shelter in Baton Rouge, I saw health care professionals and volunteers and Red Cross personnel and so many others working to help their fellow Americans who were in need.

I even saw one of our own colleagues, Dr. Phil Gingrey, who was there volunteering as well, who was administering care and helping to coordinate response efforts with organizations like the Red Cross and others. It was amazing to see the response of health care professionals from all around the country who were making sacrifices to provide health care to those who were in such need.

It is crucial, though—and that's the point of this hearing today—it's crucial that as we look forward to any kind of an emergency like this in the future, that we learn lessons from what has happened over the last several weeks. Obviously, we have another hurricane bearing down on the Gulf Coast right now. There is always the possibility of another terrorist attack, and certainly, representing northern New Jersey, it is something that is constantly on our minds.

There are issues like pandemic flu, which we need to always be thinking about and concerned about; it's something that you and I have talked about in the past.

There are always situations that we need to be preparing for, and I am pleased today that we will have an opportunity to hear from Dr. Gerberding and our other witnesses to hear about what lessons we are learning from the past several weeks and what actions we're taking to better prepare for emergency situations in the future.

I thank both the chairmen for putting this hearing together, and I again thank our witnesses.

I yield back.

Mr. DEAL. I thank the gentleman.

I recognize the gentlelady from California, Ms. Eshoo, for an opening statement.

Ms. ESHOO. Good morning, Mr. Chairman. Thank you for having this hearing. And to the witnesses that are here today, thank you for coming.

There are so many things that I want to say. I am, more than anything else, extraordinarily frustrated.

I know, Mr. Chairman, that you've worked hard to put this together. Our first distinguished witness, Dr. Gerberding—most frankly, her department is not the problem at all, at least not in my view. The Secretary of HHS should be here. If we are going to examine what fell apart in terms of health care and the entire system for our fellow citizens, in my view that should—HHS should be here to answer those questions.

But be that as it may, they are not, and so we have got to direct our questions, I think, toward that department, and also to see what happened—to ask good questions about what happened on the ground of people that are representing the organizations and the institutions that were there.

I can't help but think that, No. 1, volunteerism is just as much a part of America as our flag is. When I watch the news and see where doctors that went in to volunteer on an emergency basis were turned back by the military and others, we have to find a way to integrate them into our emergency response system.

There was a program last night on CNN where doctors actually had come in and all of these human beings that were so fragile and being shipped to the airport, they wanted to help, and there wasn't any way for them to enter the system. So I hope that we can address ourselves to things like that because they are important.

And I think that no matter what we do in the future, there is always going to be a need for the medical professionals to be able to come into the system. And they are not always going to be the ones that—you know, that we think of in a very set way, when there isn't a catastrophe. Remember that there are professional volunteers that need to be integrated.

I want to call attention to—and my friend and colleague, Mr. Bilirakis did—to the 211 system. We're inviting people to be a part of that. I think that it's an important step.

We are all frustrated. We want to launch something that is good. Only 40 percent of the Nation has access to this; we should make it 100 percent.

Now this is going to be a little tough, but yesterday the Republican Study Committee came out with a summary, an explanation of offsets to the spending for—I think for what is projected the

Congress needs to do on the heels of Katrina. One of the most disturbing items in this is to reduce funding for the CDC, and it's \$25 billion over 10 years.

So what I would like to ask Dr. Gerberding to do is to tell us what \$25 billion, in terms of cuts, is going to do to the CDC. I mean, if these things—I hope these things are brought to the floor of the House, because the American people should see, you know, what some of these choices or suggestions are.

I think \$25 billion, if we really value the CDC, is—we think communities have been gutted? Watch CDC being gutted. But I want Dr. Gerberding to comment on that.

So, Mr. Chairman, what I hope will come out of this are some very practical things that the Congress can do. And I hope that you will consider bringing in the representatives from HHS, because again, you know, we value highly what Dr. Gerberding does and the CDC. They're not the problem; we've got problems elsewhere, and I think that they need to answer for it and help us come up with some of the ideas to address them.

So thank you for having the hearing, and I look forward to the witnesses. And I hope in the future—I understand that Dr. Simonson—is that his name, or Simons—couldn't be here today. But invite him back.

He is doing what he is doing and has to do, I can appreciate that, but he is a valuable person for us to hear from, so I hope you will invite him back. Thank you.

Mr. DEAL. Thank you, gentlelady.

We recognize now the chairman of the full committee, Mr. Barton, for his opening statement.

Chairman BARTON. Thank you, both chairmen, for holding this hearing.

Today, we're here to talk about some of the health impacts of Hurricane Katrina, and it's a very important hearing; and I am going to ask unanimous consent to put my statement into the record on that.

We are now dealing—gearing up to deal with another major hurricane. It's almost biblical, like the seven plagues; and if we knew who the Lord wanted us to let go, we would let them go so we wouldn't have these hurricanes hitting our country. But Hurricane Rita is headed into Texas, and the aftermath, what is going to hit the southern part of my district if it hits in the Galveston area; as we try to learn lessons from Hurricane Katrina, hopefully, we can apply some of those very quickly to Hurricane Rita.

And on the health consequences, there are lessons to be learned.

So I want to thank both my subcommittee chairmen for holding this hearing and ask unanimous consent that my full statement be put in the record.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Thank you, Chairmen Deal and Whitfield for holding today's hearing on health care issues raised by Hurricane Katrina. When Katrina smashed into the Gulf Coast, it uprooted hundreds of thousands of people and destroyed much of the health care infrastructure across an entire region.

People were up to their necks in water, but had none they could drink. Sometimes the water and the air around them were poisonous. And among the precious property that Katrina washed away were thousands of critically important personal medical records.

Right now in the Gulf of Mexico, another monster storm threatens to inflict more of the same destruction, danger and misery on new victims in Texas.

The challenges are daunting, but America is responding. Our people opened their homes and their hearts to help those who lost everything to Katrina. The outpouring of government, corporate and individual assistance runs into the billions of dollars, and it has barely begun. The greatest challenge we now face is how to get the most help to those who need it most. We cannot permit red tape to slow the flow of aid, and we'd better be sure that none of it is wasted or stolen. Today we will hear first-hand accounts of what is being done to provide care and meet the medical needs of those in the devastated region. We will learn about the efforts of private doctors, hospitals and pharmacists who are volunteering their time to assist the victims of Katrina. We will also hear about the efforts of public health officials from the Department of Health and Human Services, who are working to assess health risks, coordinate care and rebuild the health infrastructure in the areas worst hit by the hurricane.

We should all applaud these efforts, and in particular, the leadership shown by HHS Secretary Mike Leavitt. I hope this hearing will highlight these efforts and also help us identify what more needs to be done.

Regrettably, we won't have much time to learn the lessons of Katrina before Hurricane Rita hits the Texas coastline. As I told the governors of Louisiana and Mississippi last week, the Energy and Commerce Committee stands ready to do everything in its power to help.

This morning, I say to my home state's governor, Rick Perry, whatever you need that is within our jurisdiction to provide, count on it. I also want to ask that everyone who hears these words take a moment today and say a prayer for the people who are in the path of Hurricane Rita. Thank you.

Mr. DEAL. I thank the gentleman.

I now recognize the gentlelady from California, Ms. Capps, for an opening statement.

Mrs. CAPPs. Thank you, Mr. Chairman. I want to thank all of our witnesses for being here today, and especially welcome to the second panel, the President of the American Nurses Association, Barbara Blakeney.

These committees need to devote considerable time to reviewing what happened when Hurricane Katrina hit the Gulf Coast. This is the first, but should certainly not be the last hearing on this topic.

The response of the Federal Government was uneven at best. The Coast Guard was, and is, admirable, the CDC also has done well. But the response, as we all know, of FEMA was pathetic, and it cost lives; and there is no one here to speak for them. As we analyze what went wrong, we do so to be able to change what we are doing now for the future.

Many of the failures that surrounded Katrina came because of inadequate funding and misplaced priorities. The majority insists that we need to continue on with the budget reconciliation process as if nothing has happened; this would be, if it happens, irresponsible, incompetent and immoral.

Hurricane Katrina has shown us the true face of poverty. It has shown us exactly what we're talking about when cutting safety net programs like Medicaid is proposed. We can talk all we want about protecting the victims of Katrina from these cuts, but what about the people just like them living in poverty in other States? And what if the victims of Katrina are forced to remain on Medicaid for years to come? The simple truth is that we must learn from this

disaster and abandon the heartless notion that \$10 billion can be chopped from Medicaid.

I am also stunned by the complaints surfacing now by many about paying for the emergency relief that Congress has dispersed and is committed to dispersing. For 5 years the majority has stacked tax cut upon tax cut to create the biggest deficit in the history of our Nation. Nearly \$200 billion has been spent on the war in Iraq which, while claiming the lives of 1,900 brave Americans, shows few signs of improving America's national security.

Through it all, many of us have urged restraint in order to keep our fiscal house in order and to prepare for times like these. We have been ignored by the majority, but now that real people need real help, many of whom have had little to start with and now have less than nothing, we have Members of Congress's leadership demanding that we cut other safety net funding to pay for it. Apparently, deficits are acceptable when we are paying off the wealthy, but unacceptable when we are helping the neediest in society.

As has been mentioned, one of their proposals is to cut \$25 billion from CDC. We need to address that in our hearing this morning. CDC is a major player in this recovery effort, and we still have the threat of avian flu, pandemic, AIDS, tuberculosis and, of course, the threat of bioterrorism. Cutting CDC by \$25 billion is as absurd as asking the poorest of the poor to pay more for the limited health care that they get.

The majority needs to rethink it is priorities.

I yield back the balance of my time.

Mr. DEAL. I recognize Ms. Blackburn for an opening statement—Dr. Burgess for an opening statement.

Mr. BURGESS. Thank you, Mr. Chairman. And I want to thank both of my subcommittee chairmen for holding this hearing today.

The witnesses, I also appreciate you being here. I know there are plenty of other important places you could be, and I commend you for your courage in having worked in the—many of you, in the disaster area, and for your perseverance of almost historic proportions.

I think all of us can agree that this has been a disaster that has put a challenge on the American people and on this Congress. And it's already been presented to us as a substantial public health challenge in the disaster area. In areas like my State of Texas, it has absorbed a significant number of people who have been displaced by the first hurricane and are now directly in the path of the second hurricane. Hospitals are working short staff, doctors have been displaced, infectious disease outbreaks are a risk, and the funding structure for patient care has been thrown into chaos.

Today, I hope this committee is able to learn the current safety and health status of the areas impacted by Hurricane Katrina and those due to be impacted by Hurricane Rita. I would specifically like to hear how the Federal Government has interacted with providers, the providers that remain behind and continue to serve their community. I would also like to determine what it would take, in terms of manpower and money, to get the public health system of this area back to a pre-Katrina and a pre-Rita level.

The lives of so many Americans will never be the same because of this disaster, and the residents of the Gulf Coast can look to rebuild their homes, schools, businesses and families, but our public health system needs to be ready to meet their needs in the future.

I am pleased that we have members here from the Joint Commission on the Accreditation of Hospitals. I would very much like to hear from you.

We had a terrible Tropical Storm Allison in Houston 4 years ago. We lost our generators in Herman Hospital, one of the first casualties of that storm, when the hospital basement flooded. I would like to know if you have incorporated in your hospital inspections the fact that the generators need to be located on a floor that will not flood, particularly for a hospital that's located below sea level.

I would like to hear from the people involved with the evacuation of those hospitals. Evacuation, medical evacuation, is one of the things this country does extremely well.

I have been fortunate enough to visit the country of Iraq several times, I have been to Bilad Air Base right in the center of Iraq; I've seen the air and medical contingency staging facility load our wounded soldiers onto air transports, stabilize them in the field, load them onto transports, send them to Germany, and then on to Walter Reed Hospital here in Washington, 27,000 patient transfers from a war zone, with one injured transfer death.

We know how to do this. What happened to us in New Orleans when we couldn't get those patients off the roof of a parking garage in New Orleans?

Evacuation works, that's the one lesson we did learn from the last hurricane; and from what I see on the television this morning, it appears that the people of Galveston and Houston are taking that to heart. But those who are poor, those who are frail, those who are medically compromised must receive the attention they deserve to get out of harm's way.

The short-term reciprocity of medical and nursing licensure, why can't this happen? Why are providers not allowed in the zones after they've been hit and hit hard? Why are there not doctors allowed in for respite care for those doctors who are literally working on their last fumes?

Mr. Chairman, again I commend you for holding this hearing. There are a multitude of questions that are going to have to be asked, and I hope answered this morning. And I also hope that this is only the first in a series of such hearings that we will hold.

Traditionally, the Committee on Energy and Commerce has had the obligation to—the constitutional obligation for oversight and investigations into things that happen in this country, within our shores; and I hope our committee and our two subcommittees take this very seriously.

I yield back.

Mr. DEAL. I thank the gentleman.

I recognize Ms. Baldwin now for her opening statement.

Ms. BALDWIN. Thank you, Mr. Chairman.

I join my colleagues in expressing shock at what we all saw in the Hurricane Katrina aftermath; and like my colleagues, our first thoughts were all of the victims of this tragedy. But now that we have had some additional time to reflect, my reaction turns more

into one of frustration, and this frustration stems from many of the unanswered questions.

Why in our age of technology were officials unable to communicate with each other? Why was the Federal response so slow? Why was disorder so pervasive? And from a public health standpoint, why were hospitals left to fend for themselves, especially in terms of evacuation, with only late or minimal evacuation assistance?

And why were we unable to get insulin to diabetics in the Convention Center or Superdome? And why were dead bodies left amidst evacuees? And why were volunteer nurses and doctors from my State and others unable to reach those in need in the South, especially the health care workers who had worked hours and hours and days on end without relief?

To have an experience like Hurricane Katrina and then not to learn from it would be the biggest tragedy of all. It's why I thank the chairmen for holding this hearing. And I associate myself with comments of others that we must not have this be the only hearing.

We need to ask and have answered a lot of questions. We must thoroughly evaluate our preparedness and our reaction. We must learn from this experience and work toward improvement.

So in looking forward and moving forward I ask, what steps can we take to better protect the public health in the face of emergencies? What proactive measures can we institute? What changes can we make in order to safeguard our health? And in light of Hurricane Rita's approach, what immediate improvements must we make?

In my opinion, one of the most immediate and obvious steps we can take to protect the public health is to preserve the Medicaid program and ensure that Katrina victims and any victims we may see of Hurricane Rita are able to access health care through Medicaid; and I hope that we will put aside our plans to slash funding to this program in this time of need.

I also want to join with my colleagues who have voiced their concerns over a Republican Study Committee recommendation to cut CDC funding in order to pay for Hurricane Katrina. I am also aware of that recommendation and feel that it would be very ill advised.

I look forward today to hearing the testimony of our witnesses, especially as it relates to the many questions that we have collectively posed in our opening statements. And I thank all the witnesses for coming today.

I yield back.

Mr. DEAL. The thank the gentlelady.

I recognize Mr. Shadegg for his opening statement.

Mr. SHADEGG. Mr. Chairman, other than to commend you for holding this hearing so we can get some real facts on the record in light of a lot of hysteria and a lot of misinformation that's been reported, I will waive my opening statement.

Mr. DEAL. I thank the gentleman.

Mr. Stearns for an opening statement. Mr. Stearns, do you wish to make an opening statement?

Mr. STEARNS. Thank you, Mr. Chairman.

I would like to just start out by saying that we've been pretty negative here and indicated that what happened in New Orleans and Louisiana and blame the—in many respects, the Federal Government.

But in my State we were through, Mr. Chairman, four hurricanes. We didn't have this problem; we didn't have the criticism that we are hearing this morning because the local officials—Governor Jeb Bush, the legislature, as well as the mayors and the police force and everybody—got organized early and evacuated. And you saw that in Miami and you saw that in the Keys. So I think we should concentrate also on remembering, there's a lot of States who have handled this well, and we should learn from those States and not just continue to dwell on what perceives to be the negative aspect.

You know, for example, a lot of the pharmaceutical companies have provided drugs free of charge, almost \$100 million and getting those drugs down to the pharmacists—and the pharmacists are using these drugs and dispensing them free. So a lot of people complained about there was no insulin, but the pharmaceutical companies provided it free of charge.

A question comes up that I hear people, doctors particularly, who were ready to go from my home county from parts of Florida to go into the State, but they could not get in. So to rapidly deploy professionals into a State, one State to another, how can we expedite this? This is perhaps one of the keys we should talk about today, this reciprocity arrangement.

In our State, we had—from Ohio, through the Midwest and the Northeast, we had power companies into the State ready to go before the hurricanes, to take down the trees. That's the kind of early response that was done in Florida.

So there are some success stories across this United States, and we shouldn't overreact at this hearing or with our legislation and think that just throwing a lot of money at this is going to solve the problem.

I think if we had the administrative procedures that we've had in States that have been successful, and we adopt those, Mr. Chairman, I think we will go a long way toward solving this problem without a huge Federal intervention and a huge amount of criticism of Federal officers who, they say, supposedly didn't react.

I've seen even in local States, in Maryland, Virginia, where they have sent physicians down into Louisiana to help out. So there are clearly some success stories here across the board. And I look forward to exploring these as well as criticism, Mr. Chairman, on how we can improve.

Thank you.

Mr. DEAL. I thank the gentleman.

I recognize Mr. Allen for an opening statement.

Mr. ALLEN. Thank you, Mr. Chairman, for convening this hearing. I look forward to hearing from our expert witnesses on the status of current relief efforts and the medical needs of the affected citizens.

This tragedy has tested our Nation's ability to deal with widespread devastation, placing a tremendous burden on first responders, hospitals and other health care facilities. Many medical profes-

sionals worked in hospitals without electricity or running water or in makeshift shelters without proper equipment. In many cases, these professionals continued to work even though their own homes were destroyed and their families evacuated.

We have witnesses today representing many of these first responders—doctors, nurses, community health centers and the American Red Cross. Our Nation owes a tremendous debt of gratitude to those members who served during the storm and to those now traveling to the Gulf Coast to volunteer their services.

I also want to acknowledge another group of health care professionals who successfully evacuated thousands of sick and disabled people from hospitals and nursing homes: air ambulance providers. Although flight operations were challenged by limited electricity, communications, ground support and access to fueling stations, civilian air medical programs such as Air-Evac Lifeteam from West Plains, Missouri; THI Air Medical from Lafayette, Louisiana; Angel One Transport from Little Rock; and Baptist LifeFlight from Pensacola, Florida, worked around the clock evacuating patients from local hospitals in the areas hardest hit by Katrina.

These efforts were largely informal and voluntary; there was no organized Federal plan to rapidly deploy nonmilitary medical aircraft in the case of medical disasters such as floods and hurricanes. Organized deployment of specialty team, critical care, medical aircraft to moving the critically ill and injured out of hospitals and nursing homes would allow the Coast Guard and military aircraft personnel to concentrate on search and rescue and material support for affected areas.

We do not have witnesses from HHS or FEMA with us today to discuss this issue, but I hope that the role of air ambulance providers in emergency preparedness and disaster relief will be considered in future congressional hearings.

In closing, this natural disaster bore most heavily on the working poor, many of whom had no health insurance. This Congress should abandon planned funding reductions to the Medicaid program and, instead, direct its efforts to rebuilding and strengthening the health care infrastructure and addressing the health care needs of those devastated by Hurricane Katrina.

Mr. Chairman, I yield back.

Mr. DEAL. I thank the gentleman.

Ms. Blackburn is recognized for an opening statement.

Ms. Schakowsky is recognized for an opening statement.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. And I thank both chairmen for holding this hearing and beginning what I hope will be an ongoing committee effort to understand what went wrong in public health preparedness.

I very much look forward to hearing from Dr. Gerberding about the CDC's efforts to protect the health of those evacuated from the Gulf Coast, as well as those working on reconstruction efforts and returning home to cities and towns that present serious health threats because of contamination. The lack of a functioning health care infrastructure makes the task even more difficult.

I do have two issues of particular concern, but first I have to comment on what has—what is a blueprint, in my view, for another disaster: a document presented by the Republican Study

Committee that really is the meanest proposal I have ever seen, an intentional attack on the poor, billions of cuts in Medicare, increases in—Medicaid; increases in Medicare premiums; new home health care copayments; elimination of loans to graduate students, which would include, I presume, health professionals; cuts in the CDC. And I hope that the Republican leadership will reject this cruel and counterproductive proposal.

My two issues are, though: I hope we can explore the response and needs surrounding the New Orleans public hospitals. Many reports suggest that Charity Hospital's patients were not evacuated as promptly as patients in other hospitals. It appears as if the health care disparities that existed before Hurricane Katrina may have resulted in disparities in emergency response.

I am also interested in hearing from Dr. Gerberding and the other witnesses how patients who rely on the public hospitals receive care once they return home.

Second, I hope this committee will look into the tragic treatment of nursing home patients.

Dr. Gerberding, I know that the CDC does not have authority in this area, but as the administration's only witness here today, I hope you will pass along my concerns to your colleagues. There is nothing more horrifying than hearing Jefferson Parish's President, Aaron Broussard, tell America about the elderly mother of one of his employees, a mother who drowned in her nursing home waiting for rescuers. He said every day she called and said, Are you coming, son? Is somebody coming? But nobody came.

We need to know why nursing home residents were not evacuated in time. Was it a question of inadequate staffing or neglect? Were residents too frail to be removed? If so, were they left to die on their own? What can we do to provide better emergency care for the frailest among us?

Fortunately, it looks as if nursing home residents are being properly evacuated in advance of Hurricane Rita. What are they doing that was not done in New Orleans?

And we're also beginning to hear about nursing home residents who were evacuated, but may have been sent to substandard nursing homes. I recently learned about one long-term care ombudsman coordinator who had expressed serious concern. She wrote, quote, I have to tell you that I am dealing with another side of the story, and I am really feeling sick as I see what's happening. I received word in the past few days of one adult home and one nursing home that are getting ready to accept evacuees. They are both for-profit facilities that had have empty beds because they have been penalized for providing poor care. Neither staff has the facility to be able to provide consistent and good care to their own residents, along with evacuees in need of lots of TLC.

I know I'm out of time, but I hope, Dr. Gerberding, that you will pass on this very important concern about decisions that are made, how and where to send nursing home residents. Thank you.

Mr. DEAL. I thank the gentlelady.

Mr. RUSH for an opening statement.

Mr. RUSH. Thank you, Mr. Chairman. And I want to thank you also for holding this hearing.

I hope that we will have a hearing on the environmental hazards that Katrina has imposed on the citizens of Louisiana and Mississippi as we have additional—contemplate having additional hearings. Given this committee's vast jurisdiction, we should have numerous hearings on the subject from many different policy angles. Given that Hurricane Rita has now developed into a Class 5 storm with the same devastating power of Katrina, I think it's now more important than ever to hold a hearing like this in our committee.

From this hearing I want to learn not just what the Federal Government is doing now for the affected populations along the Gulf Coast, but I want to know what went wrong and why so many people needlessly died.

Mr. Chairman, the public health emergency infrastructure and system failed the victims of Hurricane Katrina, and this committee needs to determine what went wrong and why it went wrong. I say this not because I'm a Democrat and am looking to score points against my Republican friends on the other side of the aisle. We need to be retrospective and determine what went wrong so that we can learn from history.

As I said, Hurricane Rita is now bearing down on Texas, as we speak, and we need to learn how we failed in the aftermath of Katrina if we are going to assure the people of Texas that they will not suffer from the same incompetence and indifference that the people of Mississippi and New Orleans suffered from.

Too many lives are at stake, and if we want to call it the blame game, so be it. I hope my Republican colleagues do not get defensive and engage in a full-fledged combative posture to protect an incompetent bureaucracy.

To my Republican friends I say, we need your inquisitive and critical minds, too. So forget dogmatically defending every aspect of this administration, and let's find some real answers to some real questions.

To my Democratic colleagues, I would ask that we engage in a thoughtful and deliberative investigation without needlessly accusing the administration of wrongdoing. Let's hold accountable those who were incompetent and indifferent, but let's not try to score political points by exploiting the suffering of the poor people of the Gulf Coast. We are all better than this.

That said, I too am deeply disappointed and profoundly perturbed that Mr. Simonson is not present today. Frankly, I was looking forward to hearing his agency's justification for his action, or lack thereof, during Hurricane Katrina. Let us get him in here, pronto.

And, Mr. Chairman, I would just like to address a couple of comments from my colleague from Florida. The hurricane was a necessary and sufficient condition for the compromise of the levee system in New Orleans, which is and continues to be a Federal responsibility. I might remind my friend from Florida that Florida does not share New Orleans' geographical configuration, nor does it share its levee system.

So you can't compare Florida to New Orleans. Thank you and I yield back.

Mr. DEAL [presiding]. The Chair recognizes the chairman.

Mr. BARTON. Thank you. I didn't give my full opening statement and use all my time because I thought we were trying to get to the witnesses. But I have sat here and listened to some of the opening statements, and I just want to make a few comments on the process. I think it is very important that committees of jurisdiction act in a timely fashion. And we have had one catastrophic hurricane, and we are in the process of possibly, hopefully not, but possibly of having another. So I want to tell my friends on the Democrat side we're not trying to whitewash anything. We want the facts before the American people, and we want them in timely way.

And hopefully, we want to put them forward in a nonpartisan way. The easiest thing to do right now would be to hold no hearings at all and let this select committee that hasn't yet been established do whatever it's going to do and then us come back next spring after the fact. But I don't think that's right. And I'm in close contact with Congressman Dingell as we try to prepare these hearings. This is our second one. I've instructed every subcommittee to hold a hearing in its jurisdiction as soon as possible.

Mr. Gillmor is going to have a hearing on some of the environmental consequences next week, hopefully. But in the process of doing that, sometimes some witnesses are not available because they are down in the area, either dealing with the aftermath of Katrina or preparing to soften the blow of Rita. But I assure everybody on this committee, at the appropriate time, there is no witness in the executive branch of this government, if there is a legitimate reason for them to appear before this committee, they will appear. We are not whitewashing or protecting anybody. But when you have an administration official who has the responsibility not just retroactively, but prospectively, you want them doing their job right now, hopefully to save lives and protect public health of potential victims of this second hurricane. But I have instructed the staffs and I have, you know, I have told very senior administration officials that they can't hide behind some pseudo reason that they can't be here. You know, we will have everybody before this committee that needs to be before the committee.

But we also want to make sure that we allow them to do their jobs while there's a job that of immediacy that needs to be done. And I have conveyed that to Congressman Dingell and he has assured me that he is supportive of that. I hope he will have enough faith in my chairmanship and the subcommittee chairmanship to know that the one thing we are about on this committee is getting the facts, getting the truth and doing it in a way that bring credit on the institution of the Congress of the United States. Lord knows we need some credit, given the general public opinion of the entire Congress. So there are times we need to be partisan. I understand that. But partisan statements, while within 3 weeks of one major hurricane, with another hurricane that I'm told is three times as powerful as the first, make it difficult to move the process forward. And with that I yield back.

Mr. BROWN. Mr. Chairman.

Mr. DEAL. Mr. Brown Mr. BROWN. Yeah. I only used 3½ of my 5 minutes. I just wanted to say one thing. I don't think it's partisan when members on our side hold up this document, signed by half the Republican members of this committee and a third of the Re-

publican members of this Congress, which cut CDC \$25 billion, which cuts Medicaid tens and tens of billions of dollars, I don't think it's partisan. I think it's something we want to put on the table to discuss.

Mr. DEAL. Well, the chairman didn't use his time either. I would simply remind Mr. Brown that's not the purpose of this hearing today. As we have a saying in the South of gone with the wind. We're looking at what happened in the result of what was gone with the wind and what was left and what we are going to focus on. So we will try to keep the hearing and the comments hopefully directed in that fashion. Ms. DeGette is the next one for an opening statement.

Ms. DEGETTE. Mr. Chairman, I'll waive my opening statement in order to have additional time for questions.

Mr. DEAL. I thank the gentlewoman. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Chairman I would just like to say at the beginning that I continue and I hope we all continue to be troubled by the fact that Americans died while they were waiting for water and food and emergency medical care in the United States of America in the year 2005. And we need to know why and how that happened and we need to make sure it never happens again. I would like to say a few words this morning about making Medicaid available to the survivors of the Hurricane Katrina. As you know, several States are delivering health care to survivors, including my State of Ohio. And in order to guarantee these evacuees continue to receive their care, we need to make sure that we are properly reimbursing the States. The National Governors Association has come out strongly in favor of the Grassley-Baucus relief package that provides 100 percent Federal funding for the health care needs of Katrina survivors. I hope that the witnesses will talk a little bit about that today and what this disaster relief package would mean to them and the importance of reimbursing the States in this way. I would also like to talk about the health care of our first responders, namely, our National Guard personnel. Immediately after Katrina hit, national guardsmen from across the country deployed to the Gulf Coast to begin relief efforts. As they return to their home States, it is my hope that we will monitor their conditions and adequately respond to any health concerns that arise. The Governors of this country have lent us their most precious resource, the men and women serving in their Guard. We must take care of them and we should honor their service. And that is why I will soon be introducing legislation to ensure that the health conditions of these guard personnel are appropriately monitored and that they will be able to receive care if they develop a health condition as a result of their service in response to Hurricane Katrina. Mr. Chairman, I want to thank you for this hearing and I look forward to hearing from our witnesses. I return the balance of my time.

Mr. DEAL. Thank the gentleman. Mr. Waxman is recognized for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. In Katrina, we saw our national emergency response system fail. We witnessed a horrifying delay in access to basic medical care for tens of thousands of people. Hospitals had no electricity, light, water and medication for

days. Thousands of people were stranded without even minimal medical attention in the Superdome, the New Orleans Airport and the Convention Center. Chronically ill patients died in their homes or on the streets. For a Nation that spends more money on health care than any other in the world, that has invested millions of dollars in medical emergency response, this failure is difficult to comprehend.

In the wake of Katrina, we are told that dozens of health centers serving the areas most medically underserved were devastated. These centers provide care to thousands of people who, in the absence of these facilities, will have to travel great distances to receive care or worse, will simply go without. The emergency and trauma care facilities in these areas have also sustained significant damage. Big Charity hospital, the larger hospital in New Orleans and the only level one trauma center in the Gulf Coast region, was forced to shut down completely.

It is imperative that we immediately provide the funding to rebuild these facilities and restore access to critical medical care in these areas. An immediate priority has to be to provide health care coverage for people affected by or displaced by Katrina. Medicaid is the program on the ground. That program can provide coverage and payment for care. Every State taking in evacuees has a Medicaid program in place that can immediately extend coverage to those in need. Our job is to give them the certainty that the Federal Government will provide full funding for the costs they incur by extending the Federal matching rate to 100 percent for those displaced by Katrina. The affected States that are taking in the people are already some of the poorest States in the Nation.

With their economies in shambles they must have a temporary assurance so that they can maintain services to their Medicaid patients and reimbursement to their health care facilities already reeling from the effects and demands of Katrina. This is not something that ought to be approached on a waiver basis dependent on possibly arbitrary Federal decisions with no clear source for the promised funding. Changing the law to assure Medicaid full Federal payment is a simple and most certain approach. Affected States and providers deserve this assurance.

There is a bipartisan bill introduced by Senators Grassley and Baucus in the Senate that would do just that. I hope our committee will do the same thing so the House can move in the same direction. The destruction resulting from Hurricane Katrina is unprecedented. Rebuilding health care infrastructure is unfortunately just one of the many tasks before us. I am looking forward to the testimony of the witnesses and I want to thank them for being here today.

Mr. DEAL. Well that concludes the opening statements of both subcommittees.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. BARBARA CUBIN, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF WYOMING

Thank you, Mr. Chairman, for calling today's hearing. Today, we will have the opportunity to investigate one of the most important issues involved in the aftermath of Hurricane Katrina. The inherent necessity of adequate public health care

is essential in the wake of any disaster, and today's hearing will clarify the current state of America's ability to react to these emergencies.

I'd also like to thank the two panels of expert witnesses who have joined us here today. Many of you have been on the ground, working directly to assist the victims of this terrible tragedy. I thank you for these efforts and look forward to hearing what my colleagues and I can learn from your experiences.

Hurricane Katrina is perhaps the most devastating natural disaster our nation has ever seen, and has presented the medical community with challenges of a magnitude we never could have predicted. The scope and variety of difficulties facing the public health care system in the Gulf States are staggering: there is a lack of health care providers, inadequate facilities, medical supply shortages, and infectious disease outbreaks, just to list a few. In addition, I have grave concerns regarding the administrative difficulties of delivering medical care to individuals who have no proof of insurance coverage and no medical records, many of which have been destroyed forever.

Though we hope and pray we never again see a disaster of similar magnitude, we are here today to ensure America learns as many lessons as possible from this tragedy. Natural disasters have the potential to strike unpredictably and without mercy, in any area of the country. It is my hope that today's hearing will generate discussion on what steps must be taken to insure that health care assistance could be quickly dispatched to even the most rural areas of America, which tend to be medically under-served even in the best of conditions. I am also particularly interested in hearing how individuals with immediate and ongoing health care needs, such as chemotherapy or dialysis patients, are being assisted.

Again, I look forward to hearing an honest assessment of the public health care system's response to Hurricane Katrina, and to hearing how Congress may help correct the inadequacies that persist. People across the country have opened their hearts Katrina's victims, and I hope this hearing will yield a practical work agenda for those who continue to serve the health care needs of their fellow Americans. Again, I thank the Chairman, and I reserve the balance of my time.

PREPARED STATEMENT OF HON. ED TOWNS, A REPRESENTATIVE IN CONGRESS FROM
THE STATE OF NEW YORK

Good morning. Today we are talking about a very important public health issue that has massively impacted the poor. The devastating effect of hurricane Katrina destroyed the lives, families and homes of some of the most vulnerable American citizens. Likewise, businesses and infrastructure were also dealt a lethal blow. The tragedy of the situation is the unnecessary loss of human life stemming from poor coordination and the lack of planning at the local, state, and federal levels. The government's delayed response to this public health emergency was unacceptable and unsatisfactory.

Today, I implore congress on behalf of our fellow Americans whose lives were devastated by hurricane Katrina to not allow any of our countrymen to undergo such a horrific experience because of the Federal Government's lack of preparedness. We have the resources and means to ensure this for all American citizens. What we need is the political will and heart. This is about our country and us coming together as Americans to rebuild lives. Because when we rebuild the lives of the Americans that survived hurricane Katrina we fortify our own. Thank you.

Mr. DEAL. We will now move to the first panel and I am very pleased to have Dr. Julie Gerberding, who is the director of the CDC and certainly not a stranger to our committee and our committee processes here. We thank her for her presence. Since this is a combined hearing of the Health Subcommittee and the Oversight and Investigation Subcommittee, and since the policy of that latter subcommittee under chairmanship of Mr. Whitfield is to swear the witnesses, I would ask him at this time to swear in Dr. Gerberding.

Mr. WHITFIELD. Thank you, Dr. Gerberding. I'm assuming you have no objection to testifying under oath. And I would like to advise you that the rules of the House and the committee, that you are entitled to be an advised by counsel if you so choose. Do you

desire to be advised by counsel during today's testimony? In that case I would ask you to raise your right hand.

[Witness sworn.]

Mr. WHITFIELD. You are now under oath and may give your 5-minute summary of your opening statement.

TESTIMONY OF JULIE GERBERDING, CENTERS FOR DISEASE CONTROL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. GERBERDING. Thank you. Thank you, Mr. Chairman, Chairman Deal. I'm very pleased to be here this morning. We are sitting in the middle of two of the largest hurricanes that I think any of us could imagine. This is my 23rd and 24th public health emergency since becoming part of the leadership team at CDC, and I can assure you that we have learned something every time we have had an emergency operation. This is also the largest national natural disaster our country has faced, and I think the scalability of our preparedness and response capabilities are really a part of what we need to be looking at in terms of lessons learned as we go forward. In order to deal with a disaster this large, a network of response capability at every level, at the Federal level, the State level, the local level, the private level, the public level and in particular in this case, the citizen level of all the volunteers who have done so much, and not just the affected States, but the States that are receiving evacuees, all of these elements need to work together in a synergistic fashion to get each of their roles and responsibilities accomplished.

But a response also requires a command and control environment. It needs leadership. It needs clear strategies and accountability for what's going on. And I feel very strongly that within the Department of Health and Human Services, we have had effective leadership on the part of Secretary Leavitt. We have been addressing four priority areas during this operation. Those include health care services, mental health services, the delivery of human services to the many disenfranchised people to require them immediately, and for the long run, and from my particular perspective, public health services. I wish I could provide more perspective and information about the overall departmental roles and responsibilities in this regard.

I'll have to limit my remarks to the public health sector because that's my area of responsibility and expertise. But I just do want to acknowledge a few remarkable contributions that my colleagues have made. Secretary Leavitt put the whole commission corps of the United States public health service on early alert. That involves more than 6,000 clinicians and other experts for response. And we have engaged in the largest deployment of the commission corps since the Korean War. More than 1,200 commission corps officers have been staffing the shelters and providing medical services to people in evacuation centers across the south.

In addition, we have deployed the strategic national stockpile in the State of Mississippi and provided more than 30 tons of medical equipment and materials in the State of Louisiana. We've also conducted the coordination of the vending operations to assure a supply line of medical materials and vaccines. And CDC has also used the authorities that Congress has provided us in terms of our air-

craft to, on short notice, deliver anti microbials, intravenous supplies, and I believe save lives by being able to get those materials into Louisiana very, very quickly.

The Department has also taken the leadership team to many of the shelters. Secretary Leavitt has actually been three times now to visit shelters and understand firsthand what the needs of the sheltered individuals are. But we have also visited our Federal medical contingency stations where we deployed more than 2,500 emergency equipment for 2,500 emergency beds in that regard, and deployed large contingencies of the commissioned corps as well augmented services from other medical centers across the United States to staff these shelters and provide these medical services. These and many, many other activities, I think, have been going on largely in the background of the lens of most of what's been discussed.

In terms of the Centers For Disease Control, currently, our operational mission is summarized here. We have 61 people who are doing surveillance for the emergence of disease and investigating those diseases with teams across the south. The largest force is in Louisiana at the moment. But we've had overall since the operation began more than 300 people supporting public health functions in the field. Again, I want to emphasize, these are broad spectrum of activities, including occupational health screening, environmental health services, vector control for mosquitoes, rodent control for the anticipated rodent and pest problems that will emerge and a variety of other public health functions to support and augment, in my opinion, some of the unsung heroes, the State health officials in the various regions, in particular, Dr. Kevin Stevens, the health officials from the city of New Orleans who spent time in the Superdome.

And I traveled with him to various shelters as he tried to locate his staff and figure out ways to get them back to New Orleans to begin the recovery and reconstruction responsibility.

I'm just going to present three very brief snapshots of what the medical experience has been. These data are provided by hospitals in the greater New Orleans area. These are just snapshots. These data haven't been elevated or confirmed. But what you can see here in terms of injuries and chronic diseases, yes, the hospitals are requiring services for people with their regular medical attentions. But injuries have emerged in all of the different environments as a consequence of people rescuing and cleaning up the debris. We also have noted several cases of carbon monoxide poisoning, which is something we anticipate after any disaster that involves the use of generators and we are working hard to try to get information and education to people to avoid that.

I have to emphasize the importance of mental health issues. The incredible immediate impact on people with pre-existing mental health conditions as well as long term mental health conditions is something that has engaged the entire department, and particularly SAMHSA, that has the lead for this activity.

And last, in terms of infectious diseases, we have not seen widespread outbreaks of anything unusual. We anticipated intestinal diseases and respiratory diseases in the shelter context and we have seen some problems with an organism called vibrio, which is

associated with the brackish water and some serious infections and death from that, but not the scale of infectious disease problems that one might anticipate. Environmental assessments are ongoing.

I'll be happy to answer questions about the environmental impact as it pertains not just to the city of New Orleans where there was flooding, but also in other regions of the south.

And last, let me just conclude by remarking on the incredible heroism that I've seen, not just among all the people in the country who are working hard to mitigate the consequences of this, but particularly to the survivors of this catastrophe, the stories that people tell about their own family heroism as well as the efforts that they made on behalf of others are heart warming, and I think what really leads us to have some hope, particularly as we look at Rita, but also as we go forward and try to strengthen our Nation's overall preparedness capacity. Thank you.

Mr. DEAL. Thank you, Dr. Gerberding. And I will begin the questions as this point. Before the hearing today, you and I had an opportunity to talk briefly about an issue that is of concern, I think, to all of us. We've heard it surface in several of the opening statements here today. And that is with regard to volunteer professionals, doctors, nurses, et cetera, from outside the affected region and their ability, or inability, as the case may be, to access and be able to be of service in the affected area. You outlined for me the program that is in place and the procedure for certification and verifying that. Would you be kind enough to do that briefly right now?

Ms. GERBERDING. Sure. I'll be happy to give a summary and provide additional background on that as we go forward. The overall health care service delivery in the context of preparedness is a modular program that relies on the commissioned corps of the public health service which has been engaged and relies on the national medical disaster system, which are teams of people from the civilian population who move into an area as a unit with the equipment and the materials necessary. Those are the people who, for example, worked out of the New Orleans Airport to support the evacuation efforts. Then there's an augmentation. We have a reserve corps in the commissioned corps of the public health service.

And importantly, in all of this are the health care personnel in the affected regions. They are providing the vast majority of the care. Beyond that, if the need is larger than those people can provide and importantly in this context, sustain, it is possible for voluntary health care workers to be temporarily licensed in the affected States. And that can happen by providing them status as temporary Federal employees. If you're a Federal employee, your license can apply in any jurisdiction in which you're working as a Federal employee providing medical services as long as it's within the scope of your license. Credentialling that is something that has happened. We've had more than 30,000 people volunteer. The credentialling is in progress for those people. And depending on the decisions by Governors and the involved health officials in the State we can Federalize volunteers. What we don't want is for people to flood in a disorganized way because then we end up having health care workers doing everything they can to help, but we don't have a comprehensive approach, leadership, management, supplies

and communication that really allows us to take the best advantage of this volunteerism.

So, it's an important component. And I know it's hard sometimes for people who really want to help to feel that their help is not being accepted. Believe me, there will be opportunities to help, and I think we can anticipate this volunteerism in the future and do a better job of planning for it ahead of time so that the step of credentialing is happening in advance, and perhaps people could be trained and offered the opportunity to prepare before they're actually requested to serve.

Mr. DEAL. Well, I thank you for that. And I would simply echo that last comment, that I think in light of what we learn here is that there are many people willing to help and willing to volunteer. And if we make the information available to them so that we can get the credentialing done in advance of a disaster, I would encourage movement in that direction, and I think this will make everyone more aware of the fact that there is a process, because as I understand it, licensure and credentialing carries with it the Federal Government giving protection from a liability standpoint and obviously, you do need to have some degree of say-so about who you extend that protection to. But I would hope that we would see that effort of credentialing continue and expand greatly.

Let me go to another subject. And the CDC Foundation that works in conjunction with the CDC, would you explain briefly what that foundation does and how it augments what you do at the CDC, and what has that foundation done in conjunction with Hurricane Katrina?

Ms. GERBERDING. Thank you. The CDC Foundation is a Congressionally authorized nonprofit foundation that exists to help CDC do more and do it faster. Beginning with the World Trade Center attacks, the Foundation has taken a special interest in supporting and augmenting our preparedness and response capabilities by creating special funds that allow us to make resources available at the front line. So in the context of Hurricane Katrina, we've had remarkable contributions from several foundations and individuals across the country that have allowed us to do things like provide housing for the public health workers in the city of New Orleans who wanted to work but couldn't afford to pay a hotel bill for their stay, provided laptops for front line people, eventually they will be able to have some of these services, but they need them right now and we don't have to go through the government procurement process.

The Foundation can put those tools in the hands of people on the front lines. It's been absolutely important. We've used it to get vaccine supplies in places where we needed to make an immediate buy and a number of other things that really have solved problems for the front line public health officials without having to go through a lot of red tape. So it's been a wonderful, wonderful support for all of us.

Mr. DEAL. And you multiply the dollars that the Federal contribution is. You multiply them many times over by the contributions from the private sector.

Ms. GERBERDING. Oh, absolutely. Absolutely. The Federal Contribution Foundation is very small compared to their overall ability to help.

Mr. DEAL. Thank you. Mr. Brown is recognized for questions.

Mr. BROWN. Thank you, Mr. Chairman. And welcome again, Dr. Gerberding, and thank you, Chairman Barton, and Chairman Deal for putting together this hearing. In the general sea of Federal incompetence that we saw in New Orleans and along the Gulf Coast the CDC really stood out as an agency that represents what the Federal Government should be, and we thank you for that. I think people on this subcommittee, or on the Health Subcommittee, and I think Mr. Stupak and Mr. Whitfield's subcommittee also are not surprised at the effort that the CDC's good work, not just in response to Katrina, but generally because most of us, I think probably on the subcommittee, have visited Atlanta and seen the CDC and seen the professional way that you carry your work out and not just you, but your entire top staff and mid-level and rank and file workers, and I think that's a lesson to us that when you hire competent professional people to run agencies, it means that those agencies carry out their work in competent professional manners. And that's something that we should remember whether, whenever we would both judge and evaluate what our Federal Government is doing.

Ms. Eshoo, and then Ms. Schakowsky and Capps and Baldwin, all mentioned the cuts, the proposed cuts to CDC. And I think they speak for themselves certainly, but my concern is not that this was one person proposing a huge cut in CDC, there are 435 Members of Congress and people do what they do. But when a large swath of a political party or a large swath of Members of Congress, 80-some members, put out a document that says we should cut CDC \$25 billion over 10 years, that's something we need to understand better and respond to and prepare for, in case they are able to keep tax cuts in place and make these huge cuts to CDC.

So I would like, if you could, Dr. Gerberding, tell us what these cuts, what they actually mean. What they would mean in terms of your day-to-day operations and what you do, everything from lead-based paints to obesity to health disparities to response to preparedness and what it would mean to your agency, those kinds of cuts in response to another Katrina or an attack, terrorist attack or something like that.

Ms. GERBERDING. I respect and appreciate the dilemma that Congress faces in terms of how to pay for these disasters. I am not a party to the discussions about the CDC budget cuts. This is really the first I've learned about them sitting here in this hearing today, and it is a sobering prospect. But I believe what probably happened, and I hope I have a chance to talk to the people who have considered cutting CDC, is that in our House budget this year, there is, on paper, the appearance of a \$1.8 billion increase in our budget because the Appropriation For Terrorism Preparedness that used to go to the Department of Health and Human Services is now in this budget directly appropriated into CDC's line.

So if you're just looking at last year's line compared to this year's line, it looks like we got a proposed \$1.8 billion increase. And I suspect that the proposed reduction was a misunderstanding that that

\$1.8 billion was an increase for some purpose, when in fact, it was a movement of money from one line item in the Department back to our own line item. So I'd like to have a chance to check on that and to get back to you if that's the explanation.

Mr. BROWN. I don't know if it is a misunderstanding. I look at other parts of this document and the cuts are huge in all kind of service areas, increase in Medicare premiums, cuts in Medicaid, even though the demands of Medicaid are greater and greater prior to Katrina and Rita, prior to, but because of layoffs and all that's happening and more people need Medicaid and all of that. So I don't know if that's the case. Talk to me, if you would, about—I mean, even if the \$1.8 billion is considered that way, \$25 billion cut over 10 years, by any multiplication factor is a significant cut. I really do want you to talk about what the demands on—I mean, I know you're a "political appointee," but I also know you're a professional and I trust you and I've watched you in all kinds of venues.

What would that mean to this country's public health if we have these kinds of, whether it is a—no matter what percent the cut is if you include or exclude the \$1.8 billion, it's still a significant reduction in a funding stream for a very crucial public health agency. What does that restrict you? What can you not do?

Ms. GERBERDING. I'm not prepared to answer that with accuracy right now. Obviously, it would be a very sobering set of decisions about prioritizing or reprioritizing our work and we would have to—

Mr. BROWN. Okay. I accept that. But would you, after consulting with the authors of this and after they clarify to you what you meant, would you respond in writing to me and to Mr. Stupak about what, in fact, that would mean to your agency?

Ms. GERBERDING. Absolutely.

Mr. BROWN. Thank you.

Mr. DEAL. I'll recognize Mr. Barton for questioning.

Mr. BARTON. Thank you, Mr. Chairman. Doctor, you've testified before this committee before and I appreciate you coming again. I want to ask, just for the record, what your role is in the overall hierarchy at health and human services in terms of setting some of the larger policy goals that HHS is responsible for. Do you participate in those discussions on Medicare and Medicaid and things like that? Or is your role strictly Centers for Disease Control and running that part of HHS?

Ms. GERBERDING. My primary role is public health and the Centers For Disease Control in prevention. There are many important intersections between the work we do at CDC and other parts of the department, including Medicare. For example, the fact that the new Medicare Modernization Act includes prevention benefits that never before existed in Medicare is something that CDC has worked very hard to encourage for a long time. And we feel that the Medicare modernization process is an excellent opportunity for us to do what we do, which is to protect health through prevention services.

Mr. BARTON. So you do have some input and some interaction with the secretary and some of the other assistant secretaries and

the people at CMS and some of the larger policies, is that fair to say.

Ms. GERBERDING. It is fair, and in areas where our expertise is complementary or helpful.

Mr. BARTON. Okay. So now while we couldn't have some of the witnesses that we had initially hoped to have today, one in particular who had to go down to Texas, and I know some of these questions are not directly in your jurisdiction, but since you just said that you have some input, I want to ask a few questions on some of the larger issues. What is considered within HHS right now, the No. 1 health issue as a consequence of what's happened with Katrina? If there was one issue that the Secretary and the other assistant Secretaries and yourself are most concerned about, that directly, as a cause of Katrina, what would that be?

Ms. GERBERDING. I don't want to speak for the Secretary. But I believe the restoration of health services is the big picture here. We need those systems to support the delivery of services, whether it's care for chronic medical conditions, care for mental health conditions that are present or emerging, or the sort of support services that people need to get their feet back on the ground.

Mr. BARTON. So there's not a concern, I mean there is a concern, but it is not as high a priority, some sort of an infectious disease because of contaminated water supplies, or environmental damage, some of the petrochemicals leaking into the groundwater, those are serious issues. But the No. 1 issue is just restoring the basic health services. Is that fair to say?

Ms. GERBERDING. I would say that would be at the top of the list. The other acute problems that you've mentioned are things that are certainly very important issues for the CDC and we are very vigilant about doing what we can to prevent infections, prevent exposures to these toxins, prevent vector borne diseases and help restore the public health infrastructure which was fragile in many of these areas before the hurricane and is going to be a challenge to restore after the hurricane.

Mr. BARTON. So within the No. 1 issue of restoring health services, what is the discussion right now about the Federal role, and should we—should the Federal Government come in as a providers of last resort and put money and manpower, regardless of the profit, nonprofit State-Federal-local relationship? Is it the feeling that we should just go in and do whatever needs to be done and have the Federal Government pick up the tab for it? Or is there some feeling that there should still be some sort of a partnership and we should look at the historical relationships and try to provide immediate short-term assistance while trying to maintain some balance of the historical relationships?

Ms. GERBERDING. No, my understanding from the participation in these discussions that I've had is that we all recognize that, again, sort of that network concept, that we're going to have to work effectively in partnership with a wide variety of enterprises, including the private sector, and that no agency or no government or no individual is really going to be able to affect a solution here standing on their own. I would be happy to get more information and clarity on this point from Secretary Leavitt for your record.

Mr. BARTON. Well, I understand that we didn't get some of the witnesses and some of these questions I'm asking you would be better directed to somebody that had a direct policy role day-to-day in these areas. But we're dealing—what should we do on Medicaid? Should the Federal Government step in and provide 100 percent Medicaid assistance for everybody in the affected regions, or should we provide short-term Medicaid assistance in the historical Federal-State sharing relationship? What should we do with for-profit hospitals? Should we rebuild a for-profit hospital right now or should we provide this assistance only to nonprofit hospitals? These are the kind of policy questions that honorable people can disagree on what the, you know, what we should do.

The humane short-termed compassionate response is let's just do it. Let's don't worry about who pays for it. Let's just do it. When you look at the financial consequences long term on the American taxpayer, the Federal Government just stepping in and doing all right now, some of the numbers get to be pretty big pretty quickly.

So you know we'll do some other hearings on this as soon as we can get the right people to come forward. I want to thank you for your, first, for your work in the current situation. I want to echo what Congressman Brown said. You've done an outstanding job.

And I encourage you to do that good work as this second hurricane gets ready to hit our coast. I've just been told that my hometown, which is 320 miles from the coast of Texas, is now—the interstate Highway 45 is one way all the way from Galveston through Ennis, Texas. That's amazing. That's over 300 miles, one way getting out of there. Thank you, Mr. Chairman.

Mr. DEAL. Thank the chairman. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. And Doctor, if the No. 1 goal or No. 1 issue in your eyes is the restoration of health services to these people, many of them are displaced, then would the bipartisan legislation introduced by Senator Grassley and Senator Baucus, which is a bill which really provides immediate health care assistance to Katrina survivors through Medicaid and 100 percent Federal funding to any State that enrolls survivors in their program, in other words, the money would follow the person no matter where they ended up, whether it's Texas, New York, Washington or Michigan, this approach is simple. It's immediate. It's equitable. It will not require the complexity of negotiating separate deals or Medicaid waivers by the administration with over 25 States that have taken in Hurricane Katrina survivors.

Also the bipartisan Senate bill would also guarantee full funding for all low income Katrina survivors. And it does so in a program that States already know and work with. So would this legislation then meet the needs of your No. 1 issue, the restoration of health services?

Ms. GERBERDING. Thank you. I'd like to make a couple of statements of principle that we are planning on in the Department. One is that we want people to be able to access their services quickly in the most synergistic and customer-friendly way possible, wherever they are when they need them. And the second principle is that whenever possible, to use existing programs and services to be able to provide things in a familiar environment with people who are already expert in administrating those program. But we are all

looking for flexibilities in authorization and ways to make these programs work more rapidly. I can't comment on the specific legislation, and I'm not familiar with the details. But I'm sure others in the Department can respond to your question.

Mr. STUPAK. But with those goals the approach is simple, it's immediate, equitable. If you start going through waivers it's going to take time to deliver these services, right, because those all have to be—

Ms. GERBERDING. I can't, I just can't comment on that.

Mr. STUPAK. All right. Let me ask you this. Were there areas in New Orleans and throughout the Gulf area, not hospitals, but were designated as evacuation sites for individuals who had medical needs?

Ms. GERBERDING. There were evacuation plans that the city had put forward, and I believe had even had a recent exercise of those evacuation plans to account for people with special needs. I'm not sure the plans adequately addressed some of the concerns that were raised earlier about long term care patients and others that would find it difficult to avail themselves of an evacuation services.

Mr. STUPAK. Well, was CDC then aware of these other designated areas as evacuation sites for people with medical needs? Were you aware of it before Katrina hit?

Ms. GERBERDING. The CDC is not responsible for that specific activity, and I would have to make a determination whether or not we in the Department had that information.

Mr. STUPAK. So you didn't know then that like the Superdome, which was one of those evacuation sites for people with medical needs. You wouldn't have known that?

Ms. GERBERDING. Superdome is what is known as an evacuation center of last resort. It was never designed or intended to be a medical center. It was a place where, if everything else fails, if people are at risk of drowning, it was known to be able to survive a category 4 hurricane. But it was never intended to be—

Mr. STUPAK. Here in the city plans, it says some will be housed at the Superdome, the city plan, the designated shelter in New Orleans for people too sick or infirm to leave the city. So I would see it more as just a—that's what we are trying to get at and those were people who were sick. If we knew they were at evacuation sites, whether it's the city plan, the Federal plan, or the State plan, our question then is why, if everyone knew about it, they were in these plans, how come the medical supplies weren't there.

Ms. GERBERDING. Again, it was not in the pre-event planning intended to be a medical center. We wouldn't think of a large auditorium like that as being a place where we would have the kind of medical capability that turned out to be required.

Mr. STUPAK. Sure. But as you indicated it was in the city's plan.

Ms. GERBERDING. I can't comment on the mayor's plan.

Mr. STUPAK. Okay. Let me ask you this. What changes have been made in the way—I'd like to ask HHS, but again they're not here. Well the CDC, what changes have been made in light of Katrina to get you ready for Rita?

Ms. GERBERDING. Thank you. We are doing several things. I'll just give you a couple of concrete examples. In addition to forward deploying personnel which we did prior to Hurricane Katrina as

well, we have just done an inventory of the communications system that we are responsible for. CDC owns a wavelength of the high frequency communications system. We have 14 bands in there. We know that, we have tested in Texas frequently, prior to the hurricane, the activity of that high frequency communication system that allows us to communicate with public health officials. In the past, it was up to public health officials to be able to connect with the relevant care providers in their community. But we are reaching forward to be sure that we deploy antenna, batteries, and other equipment to make sure that our back up communications system is intact in the State of Texas.

Mr. STUPAK. Well, did you have that communication system in New Orleans?

Ms. GERBERDING. As a matter of fact it did exist in New Orleans, but they didn't have gasoline for the generator and they didn't have the battery supplies to be able to reliably use it.

Mr. STUPAK. Who is they? You or CDC?

Ms. GERBERDING. We are just in the process of understanding what the failure was in that high frequency communication system in that jurisdiction.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. DEAL. Mr. Whitfield next.

Mr. WHITFIELD. Thank you, Mr. Chairman. Dr. Gerberding, obviously, this hurricane did expose some vulnerabilities from the health care systems, even in the area that you're responsible for. And in your opinion, what are the major vulnerabilities that were exposed?

Ms. GERBERDING. I think there were issues around the anticipation of the predictable surprises. For example, we knew that any disaster would bring a requirement for rescue and relief workers to go into environments that weren't necessarily safe and that infectious diseases could be a problem there. We could have prepared our guidance for who needed what immunization prior to the event and not during the event so that we could have eliminated—nothing that caused a problem, but just one extra element of working one extra element the communication.

Those kinds of anticipatory recommendations under disaster circumstances are something that we're going through right now. We also learned that we were able to stand up 20 public health teams of 20 people each, excuse me, 12 public health teams with 20 people each with multi disciplinary support to be able to move in as a team into a region and we have used those teams across the south. The rostering of those teams revealed to us that our bench is not broad in some specific areas.

For example, we don't have a deep bench in risk communication. And in order to assure that we can scale up to a disaster this size, we need to not only be able to augment our own personnel, but we need to identify people from other parts of the country who would be willing to come in and volunteer or donate their time to be part of our teams. So we're already figuring out how to reach outside of CDC to link into a broader bench to help us when scalability is really the challenge.

Mr. WHITFIELD. You sent 12 teams of 20 people each into the New Orleans area?

Ms. GERBERDING. We comprised 12 teams. We also are sending people in without request, and so in some, for example early on in Mississippi, they needed 35 environmental health experts to help deal with things like water quality and food quality in the shelter environment, so we rostered 35 environmental health people there as a team. We have a full complement of public health experts right now in the city of New Orleans, sitting literally next door to the city health director, along with the Department of Defense and the Army Corps of Engineers and others.

They are really working on restoring the public health system in the city in a wonderful collaboration, actually a visionary collaboration of what really would be a better solution to the public health system in a community that's long had the challenges of health disparities and underinvestments.

Mr. WHITFIELD. And do you have the authority to just send these teams in without a request from local or State government?

Ms. GERBERDING. No. CDC cannot send personnel into anybody's State without permission. That is not part of our authority. We have to be requested by State health officials or local health officials for assistance.

Mr. WHITFIELD. And how timely was that request for assistant?

Ms. GERBERDING. It was, in my opinion, right on time. We are using our own command and control structure, which at least preliminary evaluation has revealed a much better system than some of our strategies in the past. We have a senior management official in each of affected States that is there with the FEMA task force, but also with the State health official. And they are the point of contact and the leader for all of the other CDC activities in that environment, so all of our field teams report back to our senior management official who's working with the overall disaster leadership.

And that allows us to know immediately when there's a need and to relay that need up and down the system. So I think the timeliness of our deployments has been exemplary. And again, not to harp on the CDC aircraft, but we were able to get people in and out of these areas at a time where we could never have been successful in the past because we could use the CDC plane.

Mr. WHITFIELD. So from your perspective, just the infrastructure that you had in place and the management team that you had in place was able to respond in a timely fashion. But you were weak in that you did not have adequate expertise in particular areas that you needed in these teams.

Ms. GERBERDING. I would not describe it as a weakness or deficiency. We just realized that if we were asked to do more than we were already doing, that we were going to be cutting into other important public health functions that are part of our agency's overall mission. We're not only a preparedness agency, we have other responsibilities like avian influenza and other key issues on the horizon. So for us, given that this operation is not short-lived, and we are seeing it followed on by another hurricane, we have to get the balance right between being able to provide an effective and sustainable response, and at the same time, continue our important public health mission.

Mr. WHITFIELD. So there was no weakness, but just not enough people in this particular area.

Ms. GERBERDING. A recognition that future planning will need to assure that we have a back up to the system.

Mr. WHITFIELD. Just one other question. On September 8, in an interview at CNN, you indicated that you were relieved at that point because you did not see any major disease outbreak. From your perspective, is that still the case or—

Ms. GERBERDING. We have seen outbreaks of expected problems in the shelters in Texas. There was a problem with a common viral gastroenteritis, the same thing that causes the outbreaks in cruise ships, sometimes called noro virus. CDC, along with local and State health officials, brought that problem under control remarkably easily, probably more easily than we have seen on cruise ships through extraordinary measures to help people improve hand hygiene and hand washing. We have seen this vibrio infection outbreak. Vibrio is a bacteria. One member of that family causes cholera. We certainly don't expect cholera in this area, but organisms in that family can also cause other very serious skin and blood-stream infections, and there have been some deaths associated with vibrio from people being injured, wandering in the water, and then getting infected.

Our most important public health focus right now in addition to just avoiding drinking the contaminated water in the greater New Orleans level is the concern that we have tracked down people with pre-existing infectious disease problems like tuberculosis that need to be treated even in this context, and we have accounted for the vast majority of patients with tuberculosis who were being cared for by their public health programs, but we haven't found all of them, and so we are very eagerly working across the United States to make sure that we have identified every single person who is supposed to be on tuberculosis medication and assure that they are on their treatment.

Mr. DEAL. Ms. Eshoo is recognized for questions.

Ms. ESHOO. Thank you, Mr. Chairman. I have a series of questions, but before I start on this much referenced report, "budget options summary and explanation of offsets by the RSC," the Republican Study Committee, under reducing funding for the Centers For Disease Control. It States under the House-passed appropriation level, the CDC's funding increased 25 percent over last year, a significant infusion given the current fiscal situation. Savings, \$25 billion over 10 years, \$9.7 billion over 5 years. So that gives you a taste of where they're going. All right. And—

Ms. GERBERDING. I would like to have a chance to understand this proposal. I have—it's obviously sobered my—

Ms. ESHOO. Well, certainly. And I understand your discomfort of commenting on something you haven't read. But I just wanted to read that into the record so that—because we've just been using the figures, and I'd like to ask that after having read this, that you send a letter to each member of the committee with your analysis of what these cuts would represent. I'd like to request that and I can't make you do it, but I think that it would be an important document relative to the health, the overall health of the Centers For

Disease Control. Let me ask you this: Of those left in New Orleans, have they received vaccinations?

Ms. GERBERDING. The people who are—the rescue and relief workers have been advised to receive vaccinations into the—

Ms. ESHOO. What about the population, any population that's left there?

Ms. GERBERDING. People who are presenting for care are evaluated to determine whether or not their specific environment puts them at risk.

Ms. ESHOO. Individuals have to make the determination as to whether they're at risk and then step forward?

Ms. GERBERDING. No. The vaccines that were especially recommended in those areas because we were concerned about people being in the water and rescuing and taking care of people, the people in the evacuation centers.

Ms. ESHOO. I understand. But both the search and rescue and from residents—

Ms. GERBERDING. The evacuees immunizations were based on the fact that they were in crowded conditions where they could transmit—

Ms. ESHOO. Not in water?

Ms. GERBERDING. The evacuees we were focusing on, particularly the children, the vaccine preventable diseases that they should have had as well as their tetanus shots. So there are really no special vaccines for regular people that are necessary. But a lot of these people were behind on their regular immunizations and so we want to catch them up. And that's really been the focus for the average person who is not putting themselves at special risk.

Ms. ESHOO. I am feeling less and less confident the more you try to explain this to me. I want to get it straight. Residents of the affected area that are still there, is there a team of people, whether it's CDC or any other organization that is making sure that they receive the kind of vaccines that search and rescue people have gotten?

Ms. GERBERDING. The people who, let's say the people who refused to be evacuated, is that who you're talking about?

Ms. ESHOO. Well, the people that are left there. People that didn't get out. People that are still there, whatever you want to call them.

Ms. GERBERDING. The people who are still there or who are returning are at no greater risk for special infectious diseases—

Ms. ESHOO. Not returning. There are some people who didn't leave. They're the ones that I'm asking about.

Ms. GERBERDING. It's not a one-size-fit-all answer. The purpose of the immunizations in the context of a disaster are to provide protection against special circumstances that emerge. If individuals are in an environment where they're—

Ms. ESHOO. Let me just go on, because I have two more questions. When did the teams that you referenced, these 12 teams of 20, when did they arrive in the area?

Ms. GERBERDING. They arrived at different times throughout the deployment, depending on the request of the State health officers. But generally, they arrived on the day they were requested.

Ms. ESHOO. Which was when?

Ms. GERBERDING. I can give you the details for all of various departments.

Ms. ESHOO. I think that we need to have that.

Can you explain to us how the planning that takes place at FEMA and Homeland Security includes you, so that there are not—I think if there is anything that we've learned from this is that we have separate smokestacks. Each agency is talking about what their team did or didn't do and how they planned. I don't have a sense that there was coordination that was so meaningful that they arrived at a time with the breadth and depth of teamwork from across agencies in order to address this catastrophe. So can you describe for us how you, how CDC is integrated in that.

Ms. GERBERDING. Under the current National Response Plan, and something called the National Incidence Management System and its annexes, right now CDC is not directly linked into Homeland Security or—

Ms. ESHOO. Do you think you should be?

Ms. GERBERDING. I think that is one of the things that I would like to look at, was there adequate health input into the decisions that were being made. The Department—

Ms. ESHOO. Dr. Gerberding, I mean, with all due respect, I mean we pick up the newspaper and we see bodies wrapped in white sheets on the front pages of our Nation's newspapers. So, you know, if we need to think out of the box, this isn't fault or blame, we've got to come up with a better way to respond, and this is—I don't want to pit a terrorist attack against a natural disaster. We are a great and wealthy and decent nation, so something is wrong here. And if you're left out of that, if CDC is left out of that—we see people going through these contaminated waters. I think that CDC needs to be part of the overall response team that hits the ground. I might be wrong, but since you're here, you're included and you're the lead witness in this hearing. We are going to need some real professional thinking coming out of the agency to help us do what we need to do. It seems to me that you should be integrated in those teams. I may be the only know that thinks that, but I think that should be a consideration. I really do.

Ms. GERBERDING. I think I misunderstood your question because I thought you were asking me about sort of the planning process and the kind of high level government process. On the ground we're very much integrated in the team. And we do have a desk in the operations center and we are there side by side with the other responders on the ground. So I apologize for misunderstanding.

Mr. DEAL. The gentlelady's time—

Ms. ESHOO. So are you satisfied with how your agency was able to do what it is supposed to do in this emergency?

Ms. GERBERDING. I'm never satisfied, and we can learn.

Ms. ESHOO. Neither am I, I'm never satisfied with myself or all kinds of things, because anything we can do we can always do better. But I'm asking you are you satisfied that what your responsibilities were—

Mr. DEAL. The gentlelady's time is expired. Can we conclude within 3 minutes over time, please?

Ms. GERBERDING. I believe that all of us should and could do much better, including the CDC and the health sector response. I'm just as horrified by some of the things that happened in these areas as you are, and I am very committed to making sure that my agency will do better next time, and I'm very committed to doing my part within our department to improve.

Mr. DEAL. We have a vote going on on the floor. The committee is going to stand in recess pending the completion of the votes, and I would encourage the members to come back as soon as possible so we can finish because we still have a multi-member second panel. We stand in recess.

[Brief recess.]

Mr. DEAL. The subcommittee will come back to order. We will resume with the hearing at this time, and Dr. Gerberding is still the first witness on the first panel. It is now in order to call on Mr. Bilirakis from Florida for his questions.

Mr. BILIRAKIS. I thank the Chairman, and I know that many of the folks who have been talking about this Republican Study Committee plan are not in the room. CQ Today, "Conservatives offer \$1 billion offsets plan but GOP leadership won't bite." And those of us who were in the caucus yesterday morning heard the GOP leadership not biting on this, so I think that should be a part of the record.

Doctor, you've heard a lot of frustrations up here today, and they're all with merit. There is no question about that in my mind. And yes, we are frustrated regarding what has happened or what hasn't happened or what hasn't happened exactly the way it should have, and things of that nature, and it's important that we learn from the past, we learn what has happened or hasn't happened so we can prepare better in the future. There is no question about that either. But my frustrations go more toward, you know, it's like I said in my opening statement. We seem to react. A disaster takes place, and we decide to hold hearings and react and what not, and when are we ever in really the richest country on the face of the earth, with all the intelligence we have here and what not, ever going to be prepared, really adequately prepared when these things happen? Sort of like the Medicare bill for years and years didn't have any provisions in it to keep a disease from taking place, it was just providing to take care of a person when they got sick.

And you heard me talk about 211, and as I understand it, it played a role down in the States of Louisiana and Mississippi. There are areas there apparently 911 went down and people went to 211. And I don't know whether 211 is available in all of the areas of those two States. Like in Florida there's neighboring counties that have 211 and other counties that can't afford it and don't have it and that sort of thing. That's why it's so critical—in my opinion, it's so critical to get it into place.

But maybe—I don't have that much time left, but maybe if you can address 211 and its significance. And then expand upon that if you can in the short time available, what would you do if you were king and you're frustrated too with the fact that these things happen and we're never adequately prepared. What should we do? Who is responsible? Who should be responsible? What would you put into place if you could do this and say that this has to be done?

Go ahead. Please proceed.

Ms. GERBERDING. I would like to answer the if-I-was-king question first.

Mr. BILIRAKIS. Queen, queen.

Ms. GERBERDING. The one thing that we have learned at CDC in our emergency operations is that you learn most in operation, but the second best way to prepare is to exercise. And there is nothing better than getting out there and rolling up your sleeves and either doing it or role playing the doing of it to inform you where your weaknesses are.

We learned from the 9/11 Commission about the failure of imagination. I think one of the things that CDC is learning in this operation is the challenge of scalability. So in order to prepare we have to be able to think of the scenarios that we are preparing for, and in our society and in our culture that's very challenging.

I've observed that people are resistant to imagining things that are really hard problems to solve, and so instead we pretend like they're not really going to happen. We have known for a long time a hurricane of this nature would be devastating in New Orleans, we've known for a long time that parts of our country are prone to earthquakes, and now we have the additional dimensions of emerging infections like a food pandemic or a terrorism attack.

We have to come to grips first with the fact that bad things happen, and the government is going to have to be providing a significant part of the leadership in that, but not the only leadership. So if I were in charge, I would exercise often, I would exercise without notice, and I would exercise repeatedly.

Mr. BILIRAKIS. But are the plans—Mrs. Eshoo said it all so very well. You talked about lack of coordination. As far as she was concerned it looked like there was a lack of coordination. So when you talk about exercising and that sort of thing without notice, et cetera, but there's got to be something in notion, there's got to be a structure there. Your folks—you can exercise within the realm of your jurisdiction and responsibility, but the way if it jives in with all of the other agencies and departments, et cetera, et cetera, is out of your hands.

So we have all this emphasis on some sort of a commission to find out what happened, and that is significant, I'm not belittling that, but should we be talking about maybe some sort of a non-partisan commission to sit down once and for all and try to really work out, with the proper people like yourself, work out some sort of a structure, of a national structure so we can be better prepared and everybody knows where all the pieces will fit when it happens?

Ms. GERBERDING. I'm not sure that that would be the first step. We actually have a new structure that is just in the process of being implemented, something called the National Incident Management System, which by law this September was supposed to be finalized and in operation in various Federal agencies. This is the first time we've ever operated under this structure, and I think it's a great platform. We will either learn that it could work but didn't for various reasons, or we will learn no, that's not the right structure and we have to reinvent it. I think it is too soon to say which of those answers is correct. But CDC is operating in the context of

that structure. It's an incident management module that's been used for a long time, but—

Mr. BILIRAKIS. Is everybody else operating within the content of that structure?

Ms. GERBERDING. Everyone is supposed to be. I'm pretty sure they're not at every level because many people haven't exercised it and it is just brand new. But the concept of knowing who is in charge, who is responsible, what the roles and responsibilities are, all of the important components of a response, that's critical.

One place where we've gone—and obviously there is a big difference between public health and the Department of Defense, but we've gone to look at how does the military conduct such complicated operations involving many disparate parts and sometimes working with many different nations like they did with the tsunami and they're able to make it work. But two things; one is you have a strategy and everyone knows it and, second, you exercise and you learn how to make these connections go.

A third thing that we have—

Mr. BILIRAKIS. My time is up. I don't know, Mr. Chairman, whether—

Mr. DEAL. Could you summarize right quick, please?

Ms. GERBERDING. I was just going to say, the third issue is leadership. And I would say that in order to effectively lead in this complex environment with multiple agencies and jurisdictions requires a set of leadership skills that are beyond those necessary to run an organization. You have to learn to work between organizations and really how to lead a network, and that's a new set of skills.

Mr. BILIRAKIS. Well, I would think maybe ONI, Mr. Chairman, it wouldn't be a bad idea to maybe look into that; or Mr. Whitfield coming here now, but we ought to learn a little bit more about that and whether that might turn out to be the ultimate solution.

Mr. DEAL. To make that DOD analogy, you probably need a few first sergeants. That might solve part of the problem.

Ms. Capps, you are recognized for questions.

Mrs. CAPPS. Thank you.

Dr. Gerberding, you had an agency that's respected throughout the world for the epidemiology you provide to many nations, and you are appreciated by the public health community I represent, and that every community owes a debt of gratitude to the CDC for the local support services that you provide, and I thank you for being here today.

I have three topics in my brief time, so I don't expect lengthy answers from you, but I want to focus on the emergency responders to Hurricane Katrina who have been and will continue to be exposed to extremely dangerous environments since the first day of rescue operations. Example, wading through contaminated waters filled with sewage and hazardous materials.

Now following 9/11, the Federal Government created a medical monitoring program for responders to the World Trade Center tragedy, and I'm wondering if the same long-term monitoring program for responders to Katrina, and now maybe Rita, is being set up.

Ms. GERBERDING. The program is not set up as a long-term program right now; we're concentrating on preparing people to protect

themselves, is the first priority, with the equipment and the immunizations that are necessary. We are assessing the hazards as we go. And we have NIOSH teams as well as the environmental health teams onsite to assist with those assessments. If that perspective indicates that yes, this is going to be issued for long-term health concerns, then I'm sure we will be getting recommendations about what and how we would go about them.

Mrs. CAPPS. So you could set up something to monitor as well?

Ms. GERBERDING. Yes, we could.

Mrs. CAPPS. And what about the population that moves back into New Orleans as the cleanup continues, would they also fall under this category?

Ms. GERBERDING. Well, different set of issues but a lesson learned from the World Trade Center. As people return they will have concerns about the environment. The first thing is to do everything possible to improve the environment so that there aren't exposures. The second is to try to assess what the hazards may be, and that work is ongoing as we speak with various people in the field. And then the third is to identify what, if any, are the long-term consequences of that, and to do what we need to do to address them. I think this is early in that process, and so we will be—

Mrs. CAPPS. You are just sitting it out there?

Ms. GERBERDING. Yeah. Mrs. CAPPS. Adults who move back in— or people who move back in and begin cleaning up their own property face a variety of health risks as they do that. I'm wondering if there is the capacity to vaccinate them in the same way that relief workers are being vaccinated.

Ms. GERBERDING. Yeah. I didn't have a chance to give a complete answer to this question before. There are two categories of immunization in play here. One is to catch people up with the vaccines that they should have had, and that is just part of providing health care services to people. Most of the evacuees are going to fall under that category.

There are special immunizations that we've recommended for people with special exposures. And some of the States have recommended even more than we at CDC feel is in evidence based on the approach right now. But for the majority of evacuees returning, their hazard that is relevant to immunizations is tetanus. And if they haven't had a tetanus shot in the last 10 years they need to get one. So that's the emphasis there.

Mrs. CAPPS. Good. Another topic, in 2002 this committee worked in a bipartisan way to produce bioterrorism legislation, and we deliberately made sure that that legislation covered all public health emergencies. Now we're seeing whether it works or not. The legislation created a program to assist cities and communities to plan and prepare for public health emergencies, and you were asked as one of those agencies to set benchmarks. In fiscal year 2003 this program, Bioterrorism Prevention Program, was decently funded, but the next year it was cut by \$100 million and then in fiscal year 2005 it was cut again by another \$10 million, and now the administration has requested another cut in the budget of \$130 million for next year.

I want to ask you, in the 3 years since this legislation was passed, would you say that every major city in the country has met the benchmarks that you established for planning appropriations?

Ms. GERBERDING. No.

Mrs. CAPPS. So I'm wondering if you have the funding, or what is the blockade for doing that, what is the barrier?

Ms. GERBERDING. It will be hard for me to give an accurate short answer, but I will try to hit the highs.

First of all, we're starting in the hole. The public health structure—

Mrs. CAPPS. The hole?

Ms. GERBERDING. In the hole. The Public Health System was neglected for decades, and so in order to bring it up to anything even closely resembling contemporary needs is taking a lot of investment.

Second, while—from the line item that says “money to States in the grant” there have been some reductions, there have been increases in other line items at CDC. So we learned that it wasn't making a lot of sense to put money out into 50 States to do everything 50 times. Some things we just needed to do and create a tool or a resource or a package and do once. And so the total investment has not been cut, but it's been moved out of Cooperative Agreement Program to be made available to States through other means.

Mrs. CAPPS. Thank you. And Mr. Chairman, if I could direct to you, this is legislation that we fairly recently—well, in 2002—passed, starting in this committee and through the House, that we find some opportunity to follow up, if we are finding this situation such as she was able to say just in the very brief time.

Thank you.

Mr. DEAL. Thank you.

Mr. SHIMKUS.

Mr. SHIMKUS. Thank you, Mr. Chairman. And I appreciate your waiting, and patiently, for us to get through opening statements and then in asking the questions. This is obviously an interesting time for our country in many aspects.

I'm involved with the NATO Parliamentary Assembly, and we had a strategic exercise last fall called Black Dawn put on by Sam Nunn and some think-tank, and it basically said what happens if a weapons of mass destruction—this case it was a small nuclear bomb went off in Brussels, and what happened was catastrophe: Overwhelmed first responders, no first responders, people fleeing, and very similar to Hurricane Katrina. They are very linked. And we, as a country, really need—you hit it in your last question that my friend, Mr. Bilirakis, asked about what do we need? What we need is the ability to respond; i.e., the military. I'm very biased, I'm a military guy, and when the military got on the scene things changed. The Coast Guard was on the scene for a long time, no one knew it. They were pulling people off 3 hours after the hurricane went through, and they have a military structure to be able to deploy assets. They're the only ones.

So in your look, as being suggested, as we try to get a handle on how are we going to respond to mass evacuations and mass casualties, we'll have to integrate our agencies in sync with probably

a military response, maybe change the focus of the National Guard to make sure—the military hospitals are in the Army Reserves right now, and the Army Reserves has a different deployment aspect than the National Guard does. Maybe we need to get National Guard away from flying fighter aircraft and back to infantry so they can roll trucks into an area and deploy.

So this a the very important debate. And your agency, along with others, we want to make sure that you've got your foot in the door so that you're not left out, because there is—and I'm going to follow up with questions that highlight your important role. Many of us, because of all the interconnections we have, either because of family or friends or—my pastor was down there—we're getting a lot of just firsthand information or secondhand information from visitors.

So I want to ask about the voluntarily first line responders who went down there, some at the request, some because they just packed up and went down. And one such group is the fire fighters. And so they've been working as long as they've been down there. And the question that I've been asked to ask, they have the ability to even inoculate themselves. What they have difficulty in is receiving the vaccinations they need to protect the first line responders who are there now from disease. What do I tell them?

Ms. GERBERDING. I would need a few more specifics, but I can say that first of all CDC has put forward with a fairly massive distribution what we recommend people do. We are bringing vaccine into the regions, and we are assisting with the administration of vaccine at any place that needs our place. So if there is a gap—

Mr. SHIMKUS. If we can follow up with you and point to someone in my staff and—my staff or theirs, Mo—and we can help coordinate with this particular—and there's probably disparate groups all over the place that—I mean, I think people—this is a huge disaster. And we keep beating up on FEMA, and to some extent FEMA is a check-writing agency. They go to disasters and they find a truck company and they give them a check to haul out, you know, the refuge that is just—but if you don't have a truck company any more, you can't hand a check to them. If you find a truck owner, he can't find his trucks. If he can find his trucks, they've been flooded. So that's why when the military came in, as we talked about before, and leadership, the deployment of assets, that's our real challenge on a major disaster, and we've got to figure out how we do that internally.

The other question deals with—it's kind of with the bioterrorism question. What is the status of Federal and State preparedness planning activities for vaccine and antiviral stockpiling, which was part of the issues that we've been trying to address? And if there is stockpiling in the area, unless it's been destroyed, are we drawing upon other stockpiles? Or where are we at as a nation in this whole issue of stockpiles of vaccines?

Ms. GERBERDING. Let me talk about the stockpile concept generically and then specifically. We have 12 locations around the country where we have something called a push pack, which is a very large cache, a 747 cargo hold full of medical equipment that was designed primarily to provide emergency care in the context of a setting like the World Trade Center or the day after the hurricane. It was not really designed to provide sustainable health care for

long periods of time, the kinds of requirements that have emerged during this particular disaster.

Mr. SHIMKUS. Well, was the plane—once the air field was available, did the plane ever get deployed?

Ms. GERBERDING. We leaned forward—

Mr. SHIMKUS. Leaned forward in the foxhole, good.

Ms. GERBERDING. We leaned forward, and when it was clear that the State of Mississippi needed it, we brought the assets to the location where they were needed. We put it on trucks, the trucks were ready to roll. It was all right there.

In Louisiana we predeployed, before the hurricane hit, about 37 pallets full of anticipated medical resources to a zone outside of where we expected the hurricane damage, and then those assets were made available, primarily at Baton Rouge, but at other locations throughout the State.

So in terms of the planning, I think one of the questions we'll need to look at is, is the content of the stockpile that's designed now adequate to meet all of the range of disasters that we would be required to support?

The second element of stockpile specifically relates to drugs, vaccines and other supplies that have a half-life that expire. And so instead of having them sit in a warehouse somewhere, generally those supplies are in the process called vendor managed inventory where there is a holding tank of them at the vendor. They rotate them or use them so that they don't expire, but when we need them, they have a cache place to instantaneously get our hands on.

With the vaccines per se, independent of this, we have a separate small vaccine stockpile, particularly vaccines for children as well as some flu vaccine. We have tapped into that replenishable resource. Also, we have looked for vaccine in States that have extra and so forth. So we've brokered the movement of a lot of vaccine around the country. I think you will hear more about that on the next panel.

Mr. SHIMKUS. And let me follow up real quickly on the issue, since there have been some public statements about seniors and the ready access for them to being first in line for the flu vaccine. Where are we at based upon the problems we had last year?

Ms. GERBERDING. So far the news this year is good. We have anticipation of four suppliers of flu vaccine. If Chiron is able to license the lots of vaccine coming off its shelves, as we expect, there will be able to be—we are not anticipating a shortage. But we have learned how unpredictable the vaccine supply is, and therefore we have made a very firm decision that we will immunize the people who need the vaccine the most first, and on October 24 we will then open it up for everyone else who wants a vaccine.

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

Mr. DEAL. Thank you.

Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

I have been intrigued with the last few series of questions relating to planning that has gone on, planning that will hopefully follow this hurricane efforts to integrate. I have a couple of questions along those lines.

First of all, my understanding is that FEMA conducted a 5-day exercise involving a hypothetical hurricane named Pam. As I understand it, Pam was projected to bring sustained winds of 120 miles per hour and up to 20 inches of rain in southeastern Louisiana, with a storm surge that topped the levees in the New Orleans area. It seems like the exercise used realistic weather and damage information to help officials develop response plans for a catastrophic hurricane in Louisiana. I'm wondering, did CDC participate in the Hurricane Pam simulation?

Ms. GERBERDING. The way these exercises run is they are designed to exercise the National Incident Management System, and there is a component of the National Response Plan called the ESF-8, which is the set of responsibilities that are health, and Health and Human Service has the lead for those responsibilities. Under that there are a set of activities that we are expected to be able to perform, and CDC has specific responsibilities under them. So in that particular exercise, I did not play in that exercise, but representatives of the health desk did play in conjunction with HHS.

Ms. BALDWIN. So CDC, but not you specifically, did participate in the simulation?

Ms. GERBERDING. I would be happy to define specifically for you who participated in which exercise.

Ms. BALDWIN. Okay. Can I ask you if you are able to, given your limited participation, answer whether public health threats were—well, were there public health threats that were encountered with Hurricane Katrina that were not projected in the simulation that was done with Hurricane Pam?

Ms. GERBERDING. I would like to get back to you with those specifics.

Ms. BALDWIN. Okay. Let me move on to then follow-up planning. And perhaps I think some of the other members of the panel share my frustration that we have heard both anecdotally and certainly seen the images on television that suggest that there were many, many problems. And we have you here today to ask questions to, and I think if you were to look at the organizational chart of who had responsibilities, you probably represent one of the agencies that responded most effectively, and I know you have room for improvement, et cetera. So I want to get answers to some of the questions I have. And I know you're not necessarily the appropriate person to ask them to, but what sort of follow up plans—you just said few minutes ago that you learn most in operation and second by role play, simulation, the role of imagination, realizing and following up on the challenge of scalability. Who will do follow-up planning? Who will be at the table, who will convene this group, and what recommendations will you make when you sit at that table?

Ms. GERBERDING. I will speak for CDC first. We have, as I said earlier, this is—Rita is our 24th emergency operation. And since anthrax, we have developed an activity called Team B, which is a set aside group of experts, scientists, knowledgeable people who aren't supposed to be participating in the operation, they're supposed to be watching us. And it's their job to challenge our dogma, it's their job to troubleshoot things that we are overlooking, it's

their job to reach out to the community and see if what we are thinking, we are doing is making sense to the people that we're working with and so forth. And we bring those Team B perspectives into our operation as we go forward.

This time last week we invited three people from the Department of Defense who do exactly this kind of operational learning support for the military to CDC. They spent a couple of days with us, explaining to us how they work—and they actually work by embedding their people in the operational field so that they're out there cycling the learning on a real-time basis instead of waiting until everything is done, then studying it and going back and trying to fix it in retrospect.

Both things are important, but what we are trying to do is adjust as we go, get the learning in the same time that we are doing it. It's fresher, it's more helpful, it's more immediate. Sometimes it's very tactical, but it is the kind of continuous quality improvement process that we think really, in the long run, serves as a more efficient operational organization.

I also—at the end of our operations we do do more comprehensive after-action reports for CDC where we try to strategically change things that we really felt didn't go as well as they should have and as we learn after every operation. I think those same principles are exactly what other governmental organizations do, learn as you go, but at the same time also do a comprehensive retrospective look. And probably there is a role for both of them as a government as well as the State and local and private sector people who are engaged in these operations. I don't have an evidence base for that, I just have an experience, but that's been my perspective.

Ms. BALDWIN. Thank you.

Mr. DEAL. I thank the gentlelady.

Mr. Ferguson.

Mr. FERGUSON. Thank you, Mr. Chairman.

I want to thank Dr. Gerberding for again appearing before our committee. You've been here many times, and you provide excellent testimony. You are extremely patient—

Ms. GERBERDING. Not always.

Mr. FERGUSON. Nor are we. But we certainly appreciate not only your testimony with the committee, but your excellent work at CDC. You provide a level of integrity and leadership there, which is so important to our Nation and to the people of this Nation, and we certainly appreciate both that work and your frequent visits here to share your views on a whole host of important topics with us.

Our discussion today has been centering around the tremendously large coordinated response between Federal and State and local officials that is needed to respond to a public health crisis. And as you and I have discussed on a number of occasions, I am particularly interested in obviously some of the lessons that we can learn from Katrina and the other many couple of dozens of crises that you have dealt with in your tenure at CDC, public health situations, what we can learn from those as we prepare for the future.

And when we talk about pandemic flu, it is really—everyone who knows anything about pandemic flu tells us that it's really not a

matter of if, it's a matter of when, and we have to deal with that eventuality. And the outbreak of pandemic flu, when it happens, will almost certainly cross State lines, it will cross county lines, it will cross many layers of government jurisdiction, which will virtually require a federally led response to that sort of crisis. Public officials were told for many years that a hurricane with the force of Category 3 would overwhelm the levee system protecting New Orleans, would cause flooding, would wreak havoc in that region. The same warnings are given to us frequently about the possibility and eventuality of a pandemic flu, so I think it is certainly within the scope of this hearing to talk about that a little bit.

Can you tell us a little bit about where we stand with the pandemic response plan—we've been talking about this for a year or more—and when you believe it might be released?

Ms. GERBERDING. Thank you. One of the things going on behind the scenes of Katrina is an enormous amount of effort on pandemic flu, Secretary Leavitt and I and Dr. Fauci and Dr. Gallin and others from the Department have systematically been briefing every Cabinet and every Cabinet secretary in government on their role in preparing for pandemic. We are working very hard to do the science to understand what our vaccine capabilities will be, what are the limitations of our antiviral treatment, investing aggressively internationally to improve detection, and a lot more needs to be done.

In terms of—the Department's pandemic plan was, as you know, put out in draft form a year ago, and what was missing from the plan at that time were the really tough decisions about how we would allocate scarce resources when we know no matter what, right now if it happened tomorrow, we won't have enough vaccine to go around for at least 6 months into the enterprise, and that process of getting the public and the public health community as well as the medical community and others, including decision-makers, to really articulate the strategy for allocating those resources is tough. And we aren't going to please everybody when we come out with these recommendations, but the dialog has been time well spent. I think we expect to have the plan within the next couple of weeks finalized and ready for a final public review.

I would also say that the plan is important, but the planning is much more important. In my experience, often plans aren't what you take out in the middle of a disaster. What you do take out are the relationships and the knowledge and the connectivity that you have built as a part of the planning process. And I think this time we've spent this year working on this at State and governmental levels, and also international levels, has been extremely helpful. Our plan is better because of it.

Mr. FERGUSON. And just very briefly, as my time is about to expire. Are you satisfied, given the experience that we've had in the last several weeks with Hurricane Katrina, are you satisfied at this point, or do you think more work might need to be done on the plan, the pandemic flu plan, with regard to coordination between local, State and Federal officials and responsibilities?

Ms. GERBERDING. I believe that if we are facing pandemic flu it will make Hurricane Katrina look very small. And while we are certainly challenged with this disaster, we recognize that a

pandemic disaster would encompass the whole global community. So it is very difficult to anticipate proactively whether your plan is going to have the capacity to solve and anticipate every one of those problems, I doubt it will, but it certainly creates a framework for decisionmaking and helps us identify our governmental strategy.

It is remarkable to me how much clarity we have achieved by simply defining that we are following a strategy of containment first, if feasible, and then subsequent components of that strategy that we are going to work on, building our vaccine capacity, we are going to work on building our drug capacity, and we are going to scale up the investments in our ability to detect and respond to cases.

We have a remarkable challenge in front of us, and probably one of my biggest concerns is that we are so easily distracted. Our focus shifts from one disaster to another. So while we are talking about hurricanes and natural disaster preparedness, I'm pleased that you would even ask a question about pandemic flu because it is very much on our plate. And we know it will be difficult to keep it on the plate in the minds of the public, but it's nice to know it's on the minds of the Congress, and I really appreciate that.

Mr. FERGUSON. Thank you again for being here. Thank you, Mr. Chairman.

Mr. STUPAK. Mr. Chairman, if I may. In light of that last statement, we've asked a number of times for CDC to come and brief us on pandemic because it is a major concern. And we've been asking and we get no response. So I would hope, based on your response here today, you would take our offer and come and meet with us.

Mr. DEAL. I'm not sure if the gentleman was aware, but we've already had a hearing on that issue in which CDC was present testifying.

Mr. STUPAK. Right. We had one hearing, it was the shortage of the vaccine that we're going to need, and that's why we want more on pandemic flu. Specifically we've asked, specifically in writing a couple of times, so I hope we can get this briefing for our staff and the members because this is a serious issue.

Mr. DEAL. Well, we will follow up with it from the committee level, I'm sure, and the full committee, too.

Mr. Engel.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

I have seen a series of articles which talked about the medical nightmare of people who were being treated in various New Orleans clinics, who needed a continuation of a treatment, who went to Texas and other places and didn't really know, for instance, if they had cancer, what stage the cancer was in. And I'm wondering if you could comment. I mean, one of the obvious ways to deal with this could be talking about the need for a national data base of electronic medical records. I know that it involves privacy issues and other things, but it would certainly seem to me that this is something we ought to work toward. I'm wondering if you could comment on that.

Ms. GERBERDING. I think Secretary Leavitt will be very happy you asked that question. One of our over-arching priorities in the

Department is the electronic health records. And we said—every shelter we visited, oh, if there was ever a case for an electronic medical record, this is it.

And one of the directions that we gave to our CDC team in New Orleans yesterday when we got a briefing on the redevelopment of the Health Department there is that your planning assumption should be e-public health, e-medical records. We have got to do this right. And now we have a chance to make it very visible why not only is it a convenience, or a patient safety issue, it's a life-saving issue in situations like this.

In most of the hospitals that were flooded, the medical records department was on the ground floor. Those medical records will never be recovered. I know that Dr. McClellan and his colleagues at CMS are trying to reconstruct chemotherapy regimens by going back through billing records because it's the only electronic resource available. That should never happen in an environment where we have the technologic capability that we have today.

I thank you for addressing that.

Mr. ENGEL. Thank you. And I really appreciate your answer because obviously you said it, it's not just simply a matter of patients not being able to get treatment, many medical records were washed away forever, and it's a real problem.

I was speaking with a friend of mine who happens to be a surgeon in the Miami area, and they're surrounded by water, and he was telling me also, not only with records, but the operating rooms in many of the hospitals are on the ground floor, so it's also a very big problem in terms of weather-related things. I suppose that new hospitals that are going to be built will change that.

The other question I had involves the same line of thinking, and I am told that an estimated 8,000 people with HIV/AIDS have been displaced by Katrina. And the Federal—the Department of Health and Human Services has not yet announced a comprehensive plan to guarantee HIV positive evacuees access to anti-retroviral medication and medical care. And I am wondering if you could tell me that because I am also—tell me if that's true because I've also been told that no provision has been made for emergency release of Ryan White Care Act funds to allow neighboring States to care for HIV positive Katrina survivors. That is obviously a problem, so I'm wondering if you can comment on that. And then I have two related questions.

Do you believe that HRSA or HHS should release these emergency funds to the States accepting the evacuees? We checked with HRSA this morning, and we were told there were no plans to. So I'm wondering if you could comment on that, and then I have another follow-up question.

Ms. GERBERDING. I very early after the hurricane personally received correspondence from the National Association of People with AIDS that outlined a number of concerns related to the disaster status of people with HIV/AIDS, and all very thoughtful and appropriate, including access to medications and relocation. And I don't know what decisions have been made at HRSA or within the Department, but I certainly will try to get that information back to you as quickly as we can.

Mr. ENGEL. Thank you, I appreciate it. And can you tell me if the CDC is supplying an adequate supply of rapid HIV testing kits to community organizations throughout the affected region and around the country to ensure that counseling and testing are available for evacuees near and far from the disaster, and educate providers about how to recognize infections in immune suppressed people? Because obviously if we are concerned with infections based on the water and whatever, people who have compromised immune systems are that much more at risk.

Ms. GERBERDING. Yeah. I think there are a lot of people with compromised immune systems for a number of reasons that are in the special needs population. And I'm sorry, I don't know if CDC is doing that, but I think it's a good idea and I will go back and check.

Mr. ENGEL. Thank you very much. I appreciate your testimony, thank you.

Mr. DEAL. I thank the gentleman.

Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Gerberding, on the issue of preparedness, as we look at Hurricane Rita poised just off the Texas coast, do you think there are things that we are likely to do better as Rita comes ashore as a consequence of having learned some things from Hurricane Katrina?

Ms. GERBERDING. I certainly hope so. I believe we see evidence of that already in terms of the comprehensive evacuation. I know from the people at CDC who are prepositioned, as well as what I'm seeing on television, that the vulnerable populations were among the first to be evacuated so that there was special planning for those individuals there.

I also anticipate that the coordination of the services for those people will have benefited from the fact that many of the materials and utilities are already in the State of Texas since that's been providing so much shelter and medical care to the survivors of the previous hurricane. So I would fully expect there to be some significant improvements in certain areas of response.

I hope that the biggest improvement is that people really do cooperate with the evacuation and leave because that is the single most life-saving thing that people can do.

Mr. BURGESS. Yes, I agree with you. Now many, many years ago I was in medical school in Houston, and I remember back in those days reading in the newspaper about the Houston-Galveston Area Council of Governments and their disaster preparedness and when the big one hits and what their plans were even back in the 1970's. Obviously all of this preparation is not something that's taken place in the last 3 weeks.

Do you feel that in any way that the Houston-Galveston area has been better prepared over the long term than perhaps the Louisiana Gulf Coast?

Ms. GERBERDING. I can't make that comparison directly. I have spoken with Dr. Eduardo Sanchez, who is the Health Director, and I am well aware of his perspective that the investments made in preparedness in the last few years have definitely paid off in mul-

multiple ways in helping to support the care and support for the evacuees that arrived in Texas spontaneously.

I also spoke to the Deputy Director of Health in Mississippi, who was adamant about how valuable the preparedness investments assessments had been made and his ability to support the public health functions and save lives in Mississippi. Whether one State is more or less down that path than another is a more complicated question.

What I will say from our perspective as an agency, as well as our responsibility for administering some of the preparedness dollars, all of our States can and will do more.

Mr. BURGESS. But surely going forward from these two historic storms, we'll develop some type of best practices, what worked in planning, what didn't work in planning, where were the weak spots, or at least I hope we do. That would be a real tragedy to not learn those lessons.

It seems to me from where I sat in Texas a week before Labor Day weekend—and I will reference most of my remarks about Louisiana since they were—that was the State closest to us—there are certainly some areas where there were pinch points, as far as getting people in, getting people out, getting aid in. I was very impressed with the private sector of the Dallas/Fort Worth area. If I put a call into American Airlines and said what are you doing, they said what do you need, they were ready to go. And then very quickly we would run into an obstacle that wouldn't let them participate. Same with DFW Airport. We heard the stories about Wal-Mart and Ray Pensley on the television on Meet the Press. What are we doing overall, particularly in the health care community, to keep those pinch points to a minimum and to make certain that, especially in delivery of needed care, that it becomes seamless rather than as rocky as it seemed in so many instances?

Ms. GERBERDING. Thank you. We are actually very actively looking at that as a department right now. And from a CDC perspective, we are going back to even looking at the grant programs and the expectations to see if we need to make fundamental changes in our expectations based on this.

But the coordination necessary to get the government agencies to work together is one piece of it. You're bringing in then how do we take advantage of the private sector opportunities, and that is a generic question that I believe all of us are going to have to look at from our own individual domain. It's a ying and a yang, because if you have an unstructured approach, then you have people running all over each other and you don't have that kind of command structure that we need. But a properly managed incident command structure should have allowances for inserts from the private sector to perform specific functions, and I think it's primarily a matter of communication more than it is of anything more complicated to solve.

Mr. BURGESS. But it is a problem that must be solved.

And finally, Mr. Ferguson brought up the flu epidemic. Have we weakened our public health infrastructure with these two storms or will we have weakened our infrastructure with these two storms such that we have increased our vulnerability to an outbreak or

just regular flu or avian flu or any other easily transmissible disease?

Ms. GERBERDING. It's always a challenge to have a surge in requirements in one domain, and you have to get that surge from someplace. It's difficult to sustain a surge for a long period of time without cutting into other needed programs.

At the moment, I feel, in part because CDC has exercised for many, many public health emergencies in the last couple of years, that we are able to sustain our mission and respond to these hurricanes in following our own strategy, which includes the concept of parsimony. We don't send everybody out. We try to be very thoughtful and rigorous about who we send—we are rotating people in and out. We're taking steps to try to support our workforce in mental health by including mental health counselors and resilience counselors on our teams to recognize when people are at risk for burnout or unable to work at their best.

So through a whole variety of personnel management issues, as well as organizational strategy, I believe at the moment we can continue our mission.

I mentioned earlier that there are specific capabilities we have as an agency that don't have as much surge as we would like to have, and we're going to have to go back as one of our after actions and understand how can we access that surge capability, those skills, those people when we need them, through volunteers or through relationships with external organizations, with academia, with the private sector in a formalized way so that they are there when we need them, they're trained and we can count on them. This is management, but it's challenging.

Mr. BURGESS. I will yield back, Mr. Chairman. Thank you.

Mr. DEAL. Thank you.

Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

Dr. Gerberding, I wanted to follow up on some of the questions my colleagues asked you. First of all, about just the regular flu. Here we are now in the fall season? Flu season is approaching, and you talked about how you feel about—you feel—I got the sense you are cautiously optimistic about the flu vaccine supply for this season; would that be accurate?

Ms. GERBERDING. I'm cautiously optimistic. I do remember sitting in the House hearing on October 4 last year when I learned that the supply had been cut in half. And so I have learned my lesson not to project strong optimism. But what I am optimistic about is that even if the worst case scenario occurs and we lose unexpectedly some component of our supply, we have what we need to get the high priority people vaccinated and we are starting out doing that first.

Ms. DEGETTE. And here's my question then; given the hurricane victims, and now it looks like we might have even more evacuees from this new hurricane, does the CDC have a specific plan for vaccinating evacuees? And just briefly, what kind of planning do we have for that?

Ms. GERBERDING. First of all, Santa Fe Pastore donated 200,000 doses of the first flu vaccine this year for evacuees, and it is included in the immunization programs going on throughout the

shelter system. So we put them in the priority group so they could—

Ms. DEGETTE. Because they're clearly a high priority.

Ms. GERBERDING. Absolutely. And they have gone through enough. They don't need to have the flu this year.

Ms. DEGETTE. Yes exactly. And, also, given some of the situations they're staying in, lots of people in one building, they're at a much higher risk.

Ms. GERBERDING. Absolutely.

Ms. DEGETTE. Okay. That makes me feel good.

Mr. Ferguson talked about the issue, as you know, that I have been concerned for a long time, and that is the Avian flu. I think it's more than just one or two people on this committee that are worried about the Avian flu because that, as you said, Doctor, this will make the hurricanes and all of the other disasters just pale in comparison.

Just today, in the Washington Post—I don't know if you saw this—there was an article about how now they have more cases in Indonesia, and they're thinking that some of those cases were human-to-human transmission, which, of course, is what we're worried, that the Avian flu will mutate and then spread around as a human-to-human pandemic.

But I wanted to follow up on Mr. Ferguson's questions, because we have had hearings in this subcommittee, but I think that we're really already so far behind the curve on Avian flu, even though this hadn't hit, and the potential devastation should be so great. You talked about how we're stockpiling drugs now for the possible Avian flu pandemic. But, first of all, I think the record needs to be clear. We don't have a vaccine for the Avian flu right now, correct?

Ms. GERBERDING. We have an H5N1 vaccine. We have less than a million courses of vaccine for it. It's a very small stockpile, but it was designed, first of all, to give us some H5 vaccine to test to make sure that we could get an antibody to; and, second, because the process of proving that you could do it speeds up our ability to do it with exactly the right strain should a new strain emerge that's easily transmissible.

Ms. DEGETTE. But since we don't know exactly what the strain will be once the virus mutates we don't have a vaccine that we know will be effective against a pandemic, correct?

Ms. GERBERDING. We have strong reason to believe this vaccine will be effective because we've seen it develop high antibody titers. The difference between this vaccine and the one that we used for regular flu is that it takes more of it to get an immunological response, so it's going to be harder to get an adequate number of doses.

Ms. DEGETTE. And that's my next question. A million doses stockpiled is not even a drop in the bucket. It's such a miniscule amount of what we would need. So what is the CDC doing in conjunction with its various partners and allies to increase that stockpile?

Ms. GERBERDING. We don't really want a stockpile of the vaccine because the virus is going to change. So, in other words, the vaccine we have right now we made from the H5N1 that was in Vietnam last year. Already this virus is evolving. When and if it be-

comes transmissible to people, we're going to need that virus to put that into the vaccine.

Ms. DEGETTE. Right. But we don't have the capacity to make that virus, that vaccine.

Ms. GERBERDING. That's why it would take about 6 months to be able to get the supply we need for the United States if we were starting from today.

Ms. DEGETTE. Right. So do you feel we have that capability to manufacture that amount of flu vaccine? Because I didn't have that sense after we had our last hearing.

Ms. GERBERDING. What we do is we would have to turn off the regular flu season vaccine and turn on the pandemic vaccine production, and part of the government strategy right now is to define exactly when would we make that decision. You know, if we see a small outbreak, is that an indication to switch or, you know, at what point do we say, yes, this is an imminent threat; we've got to change our factories over to making the new vaccine.

Ms. DEGETTE. The second question I have—I have more questions about that, but I have less time. The second question I have is there is an anti-retroviral drug that has proven—at least it gives people that get the Avian flu some hope of surviving, and that's the Tamiflu. And I understand that we are way down on the list for shipment from the Swiss company that's manufacturing this drug, is that correct?

Ms. GERBERDING. There is a manufacturing bottleneck. The company cannot make as much as people want right now, but they are looking at new opportunities to do that.

Our current plan, meaning, you know, fiscal year by fiscal year, is based on our understanding of what their bottleneck is. What we would like to achieve is what we refer to as a 20/20 approach for the first phase of our planning, and that means we would like to have enough vaccine available for 20 million people and enough antiviral for treatment of 20 million people, knowing that that's not the end, but that is a significant improvement over time.

Ms. DEGETTE. And, right now, how much Tamiflu do we have stockpiled?

Ms. GERBERDING. We have 2.3 million doses in our hands as we speak, and we have another 2.1 doses that are arriving.

Ms. DEGETTE. And that's out of 20 million needed doses, right?

Ms. GERBERDING. Right.

Ms. DEGETTE. And of the vaccine we have a million, and we would hope in 6 months to be able to ramp that up, is that what you're saying?

Ms. GERBERDING. We're not going to have a stockpile of 290 million doses of this.

Ms. DEGETTE. No. No. But what you're saying is we have a million stockpiled now and what we would need to have is 20 million.

Ms. GERBERDING. We'd like to have some additional doses. Even though the vaccine that we're creating right now is not likely to be a perfect match for what would emerge, it may give some partial protection. So it's just an extra margin of safety while we're waiting for the right vaccine to come out of the factory.

I do want to emphasize a couple of things, though, because there is such attention on the Tamiflu issues. There is kind of the im-

pression that this is the magic bullet solution, and we need all of these things just for the record.

Ms. DEGETTE. Right. Mr. Chairman, I just have one more question; and that question is, let's say we cut \$25 billion out of CDC over the next 10 years. How would that affect the agency's ability to do things like stockpile the vaccines and Tamiflu and to respond to possible issues like Avian flu that are out there but that are not immediate right now?

Ms. GERBERDING. My professional judgment, without constraints, is the agency could not accomplish its current mission with that level budget cut. But I also want to be clear that I believe that the people who put that dollar figure on the table were under the mistaken impression that it represented an increase this year in CDC's budget.

Ms. DEGETTE. I understand. If we cut that money out, that would really hurt your ability to plan for these future events.

Ms. GERBERDING. I would be very sober looking at how we would manage that cut.

Ms. DEGETTE. Thank you.

Mr. DEAL. Well, I would just simply point out that the likelihood of that is certainly not historically in the context of what Republicans have done. Since 1995 through this year you've actually had a 291 percent increase over the period of time that we have been in control. So I think that this suggestion by someone which has never been adopted is not in keeping with the historical precedent of Republican funding of your agency.

Ms. GERBERDING. I'm glad to hear that.

Mr. DEAL. Yes.

Mrs. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Dr. Gerberding, I think I'll change the subject from flu, because everybody starts coughing and sneezing as we are talking about it so we'll not spread that around. I do have a couple of questions on that, but I want to go back to some of the things that you have said regarding the response with Katrina. I found it interesting that you've used military analogy in saying that you all have some lessons learned from the way the military responded and that strategy and exercise are very important to an overall plan.

One of the things I would like to know from you is what you would say were the most significant nondisaster-caused barriers to your job. You've talked a little bit about workers without immunizations. You talked a little bit about having communications technology on the ground but somebody didn't have the fuel to power the generators readily available. And, as we all know, in that area, there was not fuel for a couple of days because there wasn't electricity to run pumps. So if you would elaborate on that for just a little bit. Or if you're not—if you don't have what were the most significant barriers in terms of like regulation, unnecessary regulation, poor communication or whatever, if you would like to respond to that later, as you look at your after actions, I would like to know that.

Ms. GERBERDING. Let me say, first, I mentioned the logistical command and control capabilities of the DOD as something that we learned from. But I think we also respect that there were four hur-

ricanes in Florida last year and that there was a very fine emergency response to those hurricanes. So we can learn from a lot of different places, not just the DOD.

Some of the other things that we're concentrating on right now are recognition that communication about medical supply needs was not streamlined and efficient. I resorted at times to calling the operations center directly and asking to speak to the health officials at the combined emergency operations center in Louisiana, and it was on one of those calls where a desperate person said if we don't get IV fluids to this facility within 2 hours, people will be dehydrated and die. You know, fortunately, we had the capacity to load up two planes full of IV materials and get them there within that timeframe. But that is not a system that's working, and so those are the kind of communication channels that we need to iron out.

Mrs. BLACKBURN. Okay. The responsibility for those supply lines, would that be something at a Federal level or a State level or do you see it as a shared responsibility?

Ms. GERBERDING. I can't answer that in a simple way. We were fortunate that the prime vendor of the medical supplies for the functional hospitals in the areas were operational. Most of the shelters that were providing medical services reached back to their prime vendor and were not experiencing supply disruptions, but, in some cases, such as pharmaceuticals or vaccines, those lines were not adequate, and we were there trying to augment and support them with materials.

I will also say that wasn't part of CDC's defined mission in disaster response because, as I said before, our stockpile was really designed to provide—

Mrs. BLACKBURN. But you stepped in.

Ms. GERBERDING. Yeah, we stepped in to do that.

Mrs. BLACKBURN. Okay. So, again, we have that private-sector/public-sector coordination that did not flow as smoothly as it should have.

Let me speak for just a moment about a couple of things relating to the evacuees that are in my State, and we have many. I have had the opportunity to visit some of the shelters and talk with some of the health care professionals, nurses and physicians both, who are delivering some of the health care.

On your Web site, you've got a piece that is titled, Medical Care of the Ill Evacuees: Additional Diagnoses to Consider. So this directs the physicians to look for some specific illnesses, and my question was this: With the evacuees being in 48 States, what kind of communication network do you have for those physicians that are working in those shelters? Is this something that you are taking a proactive lead with? Are you working with the medical associations? Do you expect the physicians to go into your materials and find out on your Web site? What's your interface?

Ms. GERBERDING. We have two main strategies. One is, just-in-case, you know, trying to provide materials before something happens, and then the just-in-time approach. Our just-in-time approach relies on our own distribution systems through the Web, through things called health alerts or dispatches where we fax or e-mail things directly to providers. We work through State health

agencies who are then sharing materials with the evacuation clinicians, for example.

But we also have an extraordinary network of medical associations, including the AMA that's on the next panel that have taken on the role of we give them what we think people are asking for and they use their extraordinary distribution systems to amplify beyond that. So we—yes, to all of those mechanisms. We, I think over the last 2 years, have greatly expanded our ability to get information out. Do we get it into the hands of every person who needs it when they need it? Probably not yet. But much progress and opportunity from the collaborations that we've established.

Mrs. BLACKBURN. One question on the flu, and I'll just hope that nobody coughs or sneezes, you know, that we're not spreading this around here. We've talked a good bit about that, and we're coming up on flu season, and we still have individuals that are living in shelters, and we know that with Rita we're probably going to see that. Do you all have a plan worked out, working with the State and local agencies, that will be providing flu vaccines for those residents that are in those shelters?

Ms. GERBERDING. Absolutely. And you're reminding me to emphasize that it's really the State health departments that have the responsibility for this. But we have immunization program staff in all of these centers, and our folks are there helping deliver vaccine and plan for the vaccine program. We made the decision not to do this in a crisis mentality of saying, okay, people need varicella vaccine, let's run and do that. Oh, no, it's flu. Let's do that. Rather, we are looking at the individual and saying, first of all, what does this individual need to catch up with? Often, we don't know. So, if we don't, we err on the side of reimmunizations.

Mrs. BLACKBURN. Another case for e-records.

Ms. GERBERDING. Well, that's right. And the second piece is to include the flu vaccine in this comprehensive approach.

One really great thing that happened with kids is that the State of New Orleans actually did have electronic immunization records for most of their children; and, as those children got redistributed across the shelters, special dispensation was made so that health officials in other States could query that electronic immunization record and would know, yes, this child has had the measles shot; no, this child hasn't. It was absolutely helpful for most of the children in that region. And I think, again, that's a lesson on the importance of these electronic records.

Mrs. BLACKBURN. Well, thank you for being here with us; and thank you for your leadership in addressing the issue. We appreciate that and appreciate your time.

Ms. GERBERDING. Thank you. I have to be very clear that I'm the spokesperson for CDC and all this, but I work for a wonderful agency full of really, really fantastic people.

Mrs. BLACKBURN. Thank you.

I yield back.

Mr. DEAL. I believe that completes our questioning; and, Dr. Gerberding, again I would repeat what you have heard from many of our members of the committee. We thank you for being here today. We thank you for your professionalism and your direction, and we also express our appreciation to those who work with you

and under your direction for the magnificent work that they have done in this time of crisis. Thank you for being here.

With that, I'll turn the gavel over to Mr. Whitfield, who will preside over the remainder of the hearing.

Mr. WHITFIELD. Those of you on the second panel, if you would come forward. You've been very patient, and we'd like to give you an opportunity to testify and have ample opportunity for questions. I do want to thank all of you for your patience, and we do look forward to your testimony.

As you heard earlier, this is a joint committee meeting of Health and Oversight and Investigation; and it is our practice to take testimony under oath. I would ask any of you, do any of you have any objection to testifying under oath this afternoon?

I would also advise you, as I did Dr. Gerberding, that under the rules of the House and the rules of the committee that you are certainly entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? Does anyone here?

Okay. In that case, if you would please rise and raise your right hand, I would like to swear you in.

[Witnesses sworn.]

Mr. WHITFIELD. You are now under oath.

Dr. Kirsch, we'll start with you. If you would give your 5-minute opening statement.

TESTIMONY OF THOMAS KIRSCH, AMERICAN RED CROSS; MARK PETERS, PRESIDENT AND CEO, EAST JEFFERSON MEMORIAL HOSPITAL, ON BEHALF OF AMERICAN HOSPITAL ASSOCIATION; ARDIS HOVEN, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; BERNARD SIMMONS, CHAIR, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, INC.; JOE CAPPIELLO, VICE PRESIDENT, ACCREDITATION FIELD OPERATIONS, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS; BOB DUFOUR, VICE PRESIDENT, PHARMACY SERVICES, WALMART, INC. ON BEHALF OF NATIONAL ASSOCIATION OF CHAIN DRUG STORES; AND BARBARA BLAKENEY, PRESIDENT, AMERICAN NURSES ASSOCIATION

Mr. KIRSCH. I'll try to keep my statement brief.

Chairman deal, Chairman Whitfield, Congressman Brown and Congressman Stupak, I'm Dr. Tom Kirsch. I serve as a voluntary physician advisor as the Medical Director for Disaster Health Services of the American Red Cross. My professional position, I work at Johns Hopkins Hospital as the Director of Operations at the School of Medicine Department of Emergency Medicine as well as in the School of Public Health as well as in some disaster preparedness centers. I appreciate the opportunity to appear before the subcommittees on behalf of the Red Cross and to share with you some of the activities in public health that we undertook following this extraordinary disaster of Katrina.

As an independent, nonprofit organization, the Red Cross is part of the first response community, working with police and fire personnel helping to move people out of harm's way and providing primarily shelter, first aid and food. When the National Response Plan is activated following a Federal disaster declaration, Red

Cross is the only nongovernmental organization with primary agency responsibilities for mass care such as feeding and sheltering, which is known as the ESF 6 of this plan.

The Red Cross has been instrumental in providing over 12 million meals so far in this disaster and more than 9 million snacks. We have provided services to more than 344,000 people with mental health problems; and more than 156,000 volunteers, including these trained public health professionals that we organized for this disaster, have responded.

This was different for the Red Cross in that in the past we have not ever really had a coordinated public health response. For years, particularly following 9/11, we recognized the need, that there were many issues in the shelters and within our services that were affected by public health questions. We, therefore, when this disaster struck, quickly assembled a team of public health experts from Johns Hopkins and from Harvard and began organizing a response.

The primary problems that we had identified in the past and we knew were going to be a major problem in this disaster was that many of the people who end up in our shelters have absolutely no access to health care. They've lost their records. They've lost their prescriptions. They've lost all ability to meet their basic health needs. So one of the main assessments that we were doing during our first preliminary assessment was to look to see what was available with regard to local health care access for the people in our shelters.

I'd like to just say that we went down there expecting that these people would be cutoff, and I was amazed by the local response by physicians and nurses in the areas. They had set up clinics in the shelters. They had set up mobile teams. They had really done wonderful things for the people in the shelters.

The second thing that we were concerned about was just the basic health care needs of the shelters. Often in major disasters the local, State and Federal agencies are really unable to respond immediately to look at the basic needs of our shelters, and there's some misunderstanding as to the functions of the shelters. So we did a preliminary assessment along those lines to see what we felt the major needs were.

Then, like everyone in this disaster, there were concerns from the first day of the potential for outbreak and epidemics; and so our primary mission was to look into that, also. We deployed two teams, one to Mississippi, one to Louisiana, did these preliminary assessments and, based on the findings and recommendations, came up with a strategy.

The first strategy was that there is an obvious need for a high-level coordination in public health and health response; and we assigned team members to the EOCs in both of the States to interact with FEMA, the Department of Public Health in the State, the U.S. Public Health with CDC, et cetera.

Then we also began a surveillance-type system in our shelters which were based more on symptoms than disease specific. Because most of the people in shelters, those that are directing the shelters, have little medical training; and it's difficult for them to report disease-specific systems, like they cannot diagnose dysentery. They are retired nurses or even managers.

We have managed in even in the State of Mississippi, working with the State, to set up a toll-free number so that our shelter members can call into this number, speak to either a State epidemiologist or one of our professional volunteers to get information on cases and then have an investigation conducted, if necessary.

The other things that we accomplished were developing educational tools for the shelters. We developed posters on hand washing, sanitation and recognition of symptoms that could be transmissible; and we continue to have teams in the field and, in fact, have deployed another team to—I guess they're going to Austin now in preparation for Rita.

So, based on this experience, there were some specific recommendations that we came up with that we feel are important. And I think many of the Members, including Ms. Eshoo, Dr. Burgess, Ms. Baldwin, Mr. Stern, had brought up the issue of local volunteers or volunteers in general. This is a huge issue. I think Dr. Gerberding touched on this.

Like I said, I was amazed—I was down there 4 days after the event, and I was amazed at the ability of the local health care system to absorb some of the blow, particularly in the shelters. There were doctors and nurses in pretty much every shelter I visited, and I visited some of the most remote ones in the State of Louisiana. The team in Mississippi found the same thing.

So I think that, based on that, there clearly needs to be—the trouble with these people responding to shelters is that they weren't credentialed. No one knew exactly who they were. No one knew what their training was. No one had any formal control or credentialing process over them. That is clearly a need that needs to be addressed going forward.

The Medical Reserve Corps in the U.S. has been somewhat tasked with that mission but has not been given the structure of funding, in my understanding, to really conduct that mission. I think that there needs to be work with the Medical Reserve Corps to formalize that.

Another possible thing that I have found was the remarkable response of particularly the LSU and the Tulane Schools of Medicine. What they accomplished having their hospitals destroyed and then setting up secondary hospitals in field houses was truly amazing. I think there would be a significant role for academic medical centers or medical schools to act as a focal point for organizing local physicians and health care response pretty much in every State in the Nation. Johns Hopkins itself was tasked with forming one of these 40 medical teams to respond to the disaster; and we had more than 250 volunteers ready to be deployed, physicians, nurses and other support staff. So I thought that the coordination of the local response is truly important both for the Red Cross as well as, in general, the response.

It is not the role of the Red Cross to credential health professionals. We don't have the ability to do that. So that has to be looked at seriously.

Interestingly enough, people had commented on the laws regarding volunteer health practitioners. There was a review done by the Center for Public Health Law which is available at www.publichealthlaw.net that specifically reviews the legal issues.

They were tasked by HRSA to do this, and the law is called the ESAR-BHP. Many of the States have already signed on to cross-credentialing capabilities for outside providers to come into States.

The other issue that was tremendously important to the people we found immediately and for weeks going on was the access to medications, and I'm glad to see that there are representatives here from pharmacy because that is a problem with almost every disaster that we've encountered in the Red Cross for decades now. People do not have their medications, don't know what their medications are, don't have any access to their medications, and so that is an issue that clearly there needs to be some coordination moving forward.

Mr. WHITFIELD. Dr. Kirsch, if you could summarize. We appreciate your testimony, but you're about 3 minutes over.

Mr. KIRSCH. Okay.

Other thing would be that there needs to be, like Dr. Gerberding said, further strengthening of the local public health response. The public health in many of the States were overwhelmed and didn't have the personnel to respond.

Finally, there needs to be a little bit more operational control, I believe, at the ESC level in the States to coordinate public health response between the different agencies.

[The prepared statement of Thomas Kirsch follows:]

PREPARED STATEMENT OF THOMAS KIRSCH, MEDICAL DIRECTOR, DISASTER HEALTH SERVICES, AMERICAN RED CROSS

Chairman Deal, Chairman Whitfield, Congressman Brown, and Congressman Stupak, I am Dr. Tom Kirsch, and I serve in a volunteer capacity as the American Red Cross Medical Director for Disaster Health Services. My professional position is Director of Operations, Department of Emergency Medicine at the Johns Hopkins School of Medicine. I appreciate the opportunity to appear before the Subcommittee on behalf of Red Cross and to share with you the public health efforts that have been undertaken following Hurricane Katrina.

As an independent, not for profit organization, the Red Cross is part of the first response community, working with police and fire personnel by helping move people out of harm's way and providing shelter, first aid and food. When the National Response Plan is activated following a federal disaster declaration, Red Cross is the only nongovernmental organization with Primary Agency responsibilities for Mass Care (feeding and sheltering), known as Emergency Support Function #6.

In addition to being a primary agency for Mass Care, we serve as support agency to the Department of Health and Human Services in the provision of Public Health and Medical Services, as outlined under Emergency Support Function #8 (ESF 8).

Our major responsibilities Under ESF #8 include:

- Provision of emergency first aid;
- Assistance for community health personnel;
- Mental health counseling for individuals affected by the disaster;
- Coordination with the American Association of Blood Banks Interorganizational Task Force on Domestic Disasters and Acts of Terrorism to provide blood products and services as needed through regional blood centers;

As we focused on the public health issues that could arise in the many congregate shelters needed as a result of the massive evacuation following Hurricane Katrina, we assembled a team of public health experts at Red Cross National Headquarters in Washington, D.C. on Wednesday, August 31, 2005. Within 48 hours, we had two assessment teams already deployed to Louisiana and Mississippi to assess our sheltering operations in order to conduct an emergency assessment of our shelters. As a Red Cross volunteer, I led the efforts with my colleague, Dr. Courtland Robinson from the Johns Hopkins Bloomberg School of Public Health. The purpose of the visit was to:

- Assess the health and public health needs of the shelters;
- Establish relationships with local hospitals and health care practitioners; and

- Begin liaising with other governmental and non-governmental agencies providing aid.

Our teams visited the regional Red Cross headquarters in Baton Rouge, Louisiana and Montgomery, Alabama as well as local chapter headquarters and individual shelters throughout the two states. We also coordinated activities and established relationships with local, state and governmental officials through each state's Emergency Operations Center (EOC) and by direct visits to these agencies. Based on these preliminary assessments, an emergency public health response was developed for each of the states.

We also developed a public health command center in the Red Cross Disaster Operations Center in Washington, D.C. Along with two of my colleagues, Dr. Gregg Greenough of Johns Hopkins and Harvard Universities, and Dr. Ed Hsu of Johns Hopkins, the command center is manned effectively. Not only have we been able to better coordinate our public health efforts, but we have also developed assessment tools and educational materials for use in the field.

To date, we have accomplished a great deal, including:

1. Emergency health and public health assessments in more than 35 shelters in Louisiana, Mississippi and Texas;
2. Medical and public health expert advice for the Red Cross at the national and regional levels.
3. Ongoing engagement with FEMA, the CDC, Public Health Service, state health departments, DMAT teams and local health facilities in three states.
4. Deployment of 27 public health trained physicians, including the Dean of the Johns Hopkins Bloomberg School of Public Health.
5. State-wide survey of all shelters in Louisiana in conjunction with the CDC and U.S. Public Health Service.
6. Completed a state-wide shelter assessment in Mississippi and implemented surveillance system using a toll-free number for all shelters.
7. Developing and adapting health education handouts and brochures for distribution to ARC shelters.

I am proud of the work that we are doing to ensure that shelters remain safe for evacuees and survivors. I am also proud of the medical community for their immediate support to these shelters. There was some concern that an organization like the Red Cross would have to assume responsibilities for coordinating local medical needs and medical personnel. I am happy to report to you that this is not the case. There was tremendous response from local physicians and nurses with providing direct medical care throughout the state including in shelters. However, there needs to be better coordination of these local doctors, nurses, and other medical professionals so that credentials and skills can be verified to ensure the highest possible care for those affected by disaster. This type of oversight could be conducted by academic medical schools, the Medical Reserve Corps, or other state agencies.

CONCLUSION

As the hurricane season continues, and the need for shelters is still prevalent, it is imperative for the American Red Cross to continue having a public health presence for the next 2-4 weeks or until local, state and federal authorities can complete the infrastructure needed to ensure public health safety.

My hope is that as we continue to assess the sheltering operations that we will continue to work to mitigate any potential public health crises. This will require long term public health expertise and advice as the sheltering of these displaced peoples continues.

Thank you for the opportunity to appear before you today.

APPENDIX

Louisiana

In Louisiana, our team¹ initially met with the leadership of the regional Red Cross response and reported through the Disaster Health Services manager. Over the next four days we assessed 19 Red Cross shelters and three very large state shelters, established relationships with the local emergency health facilities such as the Pete Marovich Center in Baton Rouge, and met with multiple agencies through the state EOC. Reports of possible infections at two shelters were also directly investigated.

Major initial findings:

¹ Thomas Kirsch, MD, MPH (Johns Hopkins), Hilarie Cranmer, MD, MPH (Harvard), Alex Vu, MD, MPH, (Johns Hopkins), Joyce Sople, MD (private).

1. Initially there remained many logistic, communication and supply problems but these rapidly improved.
2. There were no infectious disease issues identified at any shelter.
3. Every shelter had good access to medical care either through local physicians providing care in the shelter, visiting medical teams, DMAT teams or relationships with local hospitals.
4. There were no outside resources rapidly available to access public health issues in Red Cross shelters or to begin surveillance for infectious diseases.

Based on the preliminary findings plans were made to:

- Create a full-time health liaison position to coordinate activities with other agencies providing aid; and
- Create four teams of public health experts to visit each ARC shelter and assess public health needs, begin a passive surveillance system and provide health education to shelter nurses.

Surveys and educational tools were drafted and more public health experts were sent to the field. However, soon thereafter the Red Cross health liaison found that the state, in association with the U.S. Public Health Service and the Centers for Disease Control, was interested in a similar survey and our efforts were combined. There are now 24 teams conducting surveys of every shelter in Louisiana. Urgent findings will be available immediately for operation purposes. Thus far there are no reports of problems with infectious disease outbreaks.

Mississippi

In Mississippi, the team² initially met with the leadership of the regional Red Cross response center in Montgomery, Alabama. We then conducted assessments along with a regional physician in 12 shelters in the Biloxi-Gulfport area. After these visits a health liaison was sent to the state EOC in Jackson, Mississippi to begin coordinating with other agencies.

Major initial findings:

1. There continued to be severe disruption in basic logistical support and communications.
2. There were difficulties in staff availability.
3. There was reasonable availability of health care for the clients of Red Cross shelters.
4. There were no infectious disease problems identified, although some shelters were continuing to improve shelter services and sanitation.
5. There was a need to begin disease surveillance and health education.

During meetings in Jackson, the Mississippi Health Department requested that the Red Cross begin shelter assessments and disease surveillance. The means chosen for this was to develop four health intelligence teams, whose goals are similar to those in Louisiana but will focus more on establishing a "passive-active" surveillance system with county public health authorities and health education of ARC staff and clients through the use of educational tools. These teams will begin work on September 12.

Texas

A team³ was sent to Houston on September 8 primarily to liaise with other health and public health agencies to ensure the safety of the shelters. Thus far they have been conducting planning with the CDC and state public health officials to finalize surveillance and education systems. They have also conducted assessments in more than 10 shelters in conjunction with a team of epidemiologists from the CDC.

Mr. WHITFIELD. Okay. Thank you. Dr. Kirsch, thank you.

Our next witness is Dr. Mark Peters, who is the President and the CEO, East Jefferson Memorial Hospital in Metairie, Louisiana.

Dr. Peters, we welcome you and look forward to your testimony.

TESTIMONY OF MARK PETERS

Mr. PETERS. Thank you.

Good afternoon, Mr. Chairman. My name is Dr. Mark Peters. I'm president and CEO of East Jefferson General Hospital; and, as you

²Courtland Robinson, PhD, Margurite Kearney RN, PhD and Kellog Schwab, PhD (Johns Hopkins), and Jonathan Spector, MD, MPH (Harvard).

³Michael Klag, MD, MPH (Dean of the Johns Hopkins School of Public Health), Alex Vu, MD, MPH (Hopkins) and Sarah Tunebrtg, BSW (Tulane).

mentioned, I am in Metairie, Louisiana, which is a suburb of New Orleans. I'm also a family physician by training.

I'm here on behalf of the American Hospital Association and its 4,800 hospitals and health system members. We all appreciate the opportunity to tell the committee about the impact of the hurricane on our hospital and the hospitals in the gulf region.

We are a 450-bed acute care hospital in Jefferson Parish, which is adjacent to Orleans Parish. We employ more than 3,000 team members, and we have more than 900 medical staff members on our staff. I think it is very important to point out that the great majority of our medical staff are independent practitioners with their own private practice. We are a full-service, not-for-profit hospital that provides the full gamut of services for our community.

Throughout the onslaught of Hurricane Katrina and its aftermath, our hospital remained open all during the time of the storm and remains open today. We are one of four hospitals currently open in the New Orleans area, one of which is North Shore, which is on the north side of lake Ponchartrain which is a different area of the New Orleans region. The three of us on the south side are—the area you're most familiar with—are ourselves, the Oschner Clinic and West Jefferson Medical Center.

I'd like to take a moment and tell you about our experience at our hospital during the storm and also tell you what we're doing right now to ensure that the continuity of care continues in the greater New Orleans area.

Two days prior to the storm, we activated our disaster plan. The medical staff members and employees came together, followed the plan, decided who was going to be in the hospital, made plans for continued stay in the hospital and really geared up for what was coming. Our medical staff, who is independent, did not have any financial obligation to stay. They chose to volunteer their services, serve our patients and have continued during these 3 to 4 weeks to work side by side with our employees to assure that our patients receive care.

As the storm started, we made some decisions about our patients. We made a decision to transfer all our babies out of the neonatal unit. We felt that the risk to those babies staying in our hospital was greater than the risk of transfer. We were able to send them to a hospital in Baton Rouge. We sent some other patients away. We also made some decisions to keep some of our sick patients because we felt the risk of transfer was greater than the risk of staying.

Quickly after the storm we lost power and ran on generators. Our generators continued through the storm at times were not at full strength.

We had to make decisions to minimize the use of power. We had no air conditioning. We continued the power to run ventilators and key medical equipment.

We did not have flooding in our hospital. The floodwaters stopped about 30 yards prior in front of the front door. We did have multiple leaks in our facility, and a few windows were blown out.

Also, other factors that we dealt with were security, communication and restaffing. I think everyone saw some of the security issues as it related to the storm. We were fortunate not to have a

direct impact on our facility, but the fear and the perception on our patients and our staff was very significant. Fortunately for us, the Jefferson Sheriff's Department and the National Guard responded to our needs and helped secure our facility.

Communication was very difficult. Cell phones, as you've all heard, were very, very difficult to get them to work. Our own in-house phone system went down, and we had 2 or 3 days of minimal communication with the outside. That was another factor of how we had to assess the situation from our perspective, make our best decisions with patient care No. 1, our No. 1 priority.

We also ran low on food. There were several days where the staff and physicians ate once. We were able to maintain, though, the food on a regular basis to our patients. We had very, very fortunate cooperation with our vendors throughout the southern region.

Patient safety and employee safety were our top priorities through these 2 weeks. It was very difficult and challenging, but I have to very much applaud the efforts of our staff in very difficult times. You have to think about people who either knew that they lost their home, did not have an idea of how their home was, or their family relocated that stayed there, provided health care when they were tired, when they were fatigued, when they were stressed. And I think us, along with the other two hospitals, are very proud of the fact that we were able to continue through the storm and to be able to continue our services as we provided care for the community.

We have some issues, though, now that I need to get out in front of this committee. Three hospitals are left standing out of many hospitals in the New Orleans area—we are it—to provide hospital care for our region.

There are other hospitals in the future that are going to look to get restarted. That will be challenging. Some have facility issues. Some have lost their staff, and reopening and getting back to where they were is going to be a process.

We will have health care needs in our community of people coming back. You all have talked about the flu. You talked about that a lot with the CDC. We anticipate this winter to have extensive health care needs within our community.

Our issue right now is we're all at about a third capacity. We're losing money on a daily basis. I can speak for East Jefferson. We've lost \$12 to \$14 million through the storm, through 2 weeks of the storm, and we are currently losing approximately a half a million dollars a day. Why that's happening is we have committed to being fully staffed, to being prepared, to have that capacity that we feel is needed. That being said, we have a financial responsibility to our hospital, and we are running into some difficult decisions in the very near future.

I'm also speaking on behalf of the Oschner Clinic in West Jefferson. We three have been here this week talking to many different officials, making certain that everyone is aware of our current financial plight as we continue to try to serve the community. It's a real issue. It's an immediate issue within the next 7 to 10 days.

Can you imagine sitting in my chair, talking to somebody who's worked through this storm, worked hard, worked double shifts, worried about their home, and I may have to tell them we don't

have enough business, I need to send you home. We might be able to use you later, but we can't use you now. How would that make all of you feel? And what does that say to the rest of hospitals that are going to face this issue and are facing this issue today and tomorrow?

We also have housing issues for our staff, for our medical staff. The other hospitals face this issue, also. That will allow us to continue to provide the services that are needed.

I also would like to take a minute and point out issues with our medical staff. A lot of times physicians get lumped in with hospitals. In our case, in West Jefferson, that is not the case. They run their own practices. It's their own business. There have been no patients, no money coming in. They're facing issues of survival, and we have a great risk of losing physician manpower in our community. People can only tolerate no income for a period of time. That will be a great strain on the New Orleans area if we lose health care workers, and any sign of instability in our systems can prompt that.

We also need economic support of our private practice physicians, and we need some regulatory relief in what hospitals can do with physicians. There are appropriate regulations in place. These are unusual times that require some interim relaxation of those regulations of what hospitals can do for physician practices. It's imperative that we look at that as we continue to support the health care needs of our community.

I've also included in my written testimony a document compiled by the American Hospital Association that identifies critical legislative and regulatory issues that need immediate attention to ensure that health care needs are met in the wake of this storm. It is very unfortunate, with what is happening with Hurricane Rita, and I've also been informed that that's ticked a little bit to the north which does not bode well potentially for Louisiana. Regardless of where it goes, it heightens the three hospitals' need for financial relief.

Appropriately, some of the agencies that have helped us have to direct their attention now to Texas or wherever this storm hits. We need to be able to stand up to care for our community and provide really the beachheads for the future health care needs of our community. Rita has even accentuated that further.

Mr. Chairman, I appreciate the opportunity to tell you of the tremendous care that was given by all the individuals of East Jefferson, Oschner and West Jefferson. Ours, we realize, is just one of many stories throughout the gulf coast region and throughout the U.S. We also appreciate everyone's help from the outside, and we appreciate the opportunity of being able to share our story.

Thank you.

[The prepared statement of Mark Peters follows:]

PREPARED STATEMENT OF MARK PETERS, PRESIDENT AND CHIEF EXECUTIVE OFFICER, EAST JEFFERSON GENERAL HOSPITAL, ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Good morning, Mr. Chairman. I am Mark Peters, M.D., president and chief executive officer of East Jefferson General Hospital in Metairie, Louisiana. On behalf of the American Hospital Association's 4,800 hospital, health system and other health care organization members, and our 33,000 individual members, I appreciate the opportunity to speak to you and your colleagues about the impact that Hurricane Katrina had on hospitals in the Gulf Coast region.

I have been with East Jefferson since December 2000. Prior to that I practiced family medicine and served in various medical leadership roles with health care facilities in Ohio, where I earned my medical degree from The Ohio State University.

East Jefferson General Hospital is located in Metairie, on the east bank of Jefferson Parish, adjacent to Orleans Parish. We are a 450-bed tertiary care facility with more than 900 professionals on our medical staff. We employ more than 3,000 people, and are one of the largest employers in the parish. Our publicly owned, not-for-profit hospital offers the clinical expertise and cutting-edge technology that our community expects and deserves. We offer a range of outpatient services as well as numerous primary care services including cardiovascular, rehabilitative, oncology, and women and child services.

Throughout the onslaught of Hurricane Katrina and in its aftermath, East Jefferson General Hospital has remained open, caring for patients. In fact, we are one of four hospitals open in the New Orleans area; the others are West Jefferson Medical Center in Marrero, Oschner Clinic Foundation in New Orleans and North Shore Regional Medical Center in Slidell.

When Hurricane Katrina hit the Gulf Coast, no one could have prepared for the intense devastation it left in its wake. The wind and the rain wreaked havoc across Alabama, Mississippi and Louisiana. Knowing that the huge storm was headed their way, hospitals began sending home ambulatory patients. Those in critical condition or requiring special assistance, such as ventilator-assisted breathing, remained in the hospital. When hospital staff reported to work on Monday, they knew it might be a few days before they were able to return home. When the levees in New Orleans broke, however, the situation changed dramatically.

This morning, I'd like to tell you how my hospital prepared for and operated during the storm, what we are doing to ensure the continuity of health care delivery in the Gulf Coast region, what our facility as well as the rest of the New Orleans medical community needs to ensure that our doors remain open to provide critical health care services to our community, and answer any questions you and your colleagues might have.

Hospitals routinely plan and train to deal with disaster, whether it's the derailment of a train carrying hazardous substances, a multiple-vehicle accident on a nearby interstate, a plane crash, or a natural disaster such as a hurricane or earthquake, depending upon the region of the country. As they prepare for natural disasters and the prospect of going without public services such as electricity and water, they plan on being "on their own" for at least 72 hours, in case it takes that long for assistance to arrive from the state or federal government.

East Jefferson is no exception. The weekend of August 27, we activated our disaster plan, which includes being self-sufficient for 72-96 hours following a disaster event; met with our hospital and medical staff to ensure that we were able to care for patients currently in our hospital as well as those who might come with injuries as a result of the storm; and began moving our less-critical patients. The physicians who comprise our medical staff are part of independent practices, not employees of the hospital, and thus had no obligation to remain with us in what looked to be a dangerous weather situation. They did stay, however, and were tremendous in caring not only for our patients, but also for our staff and others in the community who sought shelter at our facility.

Before the storm hit and roads were closed, we moved our neonatal unit to Woman's Hospital in Baton Rouge; many other patients were transferred to facilities both in and out of state, though we did not move patients that required ventilator-assisted breathing. We felt the risk to their health during a transfer was too great.

While we quickly lost power and ran on generators, our building weathered the storm fairly well. We reduced our electrical consumption by shutting off the air conditioning and reserving our power for ventilators and other key medical equipment. Our damage included quite a bit of leaking throughout the building, but that did not hinder our ability to care for patients. A few windows were blown out. Once the levees broke, the flood waters came within 30 to 50 yards of our front door. At that point, we evacuated the first floor, which is not used for patient care.

Security, communication and restaffing became critical concerns as we moved past the initial storm and began to look toward recovery. We heard reports of looting and other unfortunate events in Orleans Parish and were concerned for the safety of our patients and staff; the National Guard quickly responded and provided us with armed security. All phone service of course went down as well as cable connections, and cell phone service was infrequent at best. This made it almost impossible to ask other employees to come in and assist those who had been working 12-hour shifts for days. It also made it impossible to speak with other hospitals in our area and the public officials trying to provide assistance. I was able to get to a Baton Rouge television station, however, and announce that East Jefferson was still open and op-

erating, and that hospital staff were desperately needed. Help began to arrive soon after.

A day or two after the storm, we ran low on food. We always were able to feed our patients, and there were only two days when the staff had to eat once a day, and in small amounts. After that, we were able to contact various businesses and vendors to replenish our supplies and food.

Throughout the storm, our first priority was patient safety, and second—though only by a hair—was staff safety. Throughout the ordeal, we received tremendous support from the men and women who work in our hospital as well as from the independent private physicians who provide care. In addition to caring for our patients, the physicians set up a quasi-pharmacy with samples from their offices so that hospital staff had access to needed prescriptions such as blood pressure medication. It provided one little bit of comfort for staff who went above and beyond their call of duty.

This is our story of how we maintained our commitment to serving the residents of Jefferson Parish. Obviously, other hospitals in the Gulf Coast region went much longer before relief arrived. They relied on generators until fuel ran out, all the while trying to arrange the means to evacuate patients and hospital staff. In New Orleans, of course, the situation was exacerbated by the rising flood waters, as patients were carried up flights of stairs to dryer floors, and authorities tried to arrange air and water evacuations.

RESPONSE FROM AMERICA'S HOSPITALS

When the levees broke and the city of New Orleans flooded, the immediate assumption was that all the hospitals would be inoperable in the wake of a significant need for surgical and trauma care from the many injured anticipated.

The AHA received countless calls from hospitals across the country asking how they could help their colleagues in the south, with most ready to send resources and health care teams at a moment's notice. The AHA developed www.hospitalreliefforts.org, a Web site through which hospitals could sign up and volunteer for deployment by the government. The response was swift and generous. By September 3, three days after the Web site went live, more than 500 hospitals volunteered for duty, and today that pool of hospital and health care facility volunteers is over 800. This information was forwarded on a daily basis to the Department of Health and Human services.

Very quickly, through conversations with our member hospitals, it became apparent that the need was not primarily immediate trauma and emergency care, but rather the facilities and ability to assist patients and evacuees suffering from chronic conditions. It was finding a way for the cancer patient to continue chemotherapy treatment, for someone suffering from kidney disease to continue dialysis, and for someone with hypertension to obtain the right medication. At the same time, we needed to care for those who suffered minor injuries as a result of the storm. In the hurricane-stricken areas, as well as other areas where evacuees have been taken, we're seeing an increased demand for mental health and substance abuse services, chronic care, and public health services.

The AHA also has been working to help locate patients who—in the initial evacuations from Louisiana's storm-battered hospitals—had been taken to other hospitals, possibly without patient ID records. This information will help ensure that these patients get the care they need no matter where they are.

IMMEDIATE NEEDS

Currently, we have several critical needs in the disaster area—restarting the cash flow to these facilities, relieving staff, obtaining temporary housing, and accessing fuel. As we assess the damage and attempt to rebuild our facilities it is critical that we find a way to improve our cash flow. If we have no patients, we have no income. If we have no income, we have no way to pay our workers, to obtain services such as food and water, and to continue providing health care services to areas that already have lost so much of their infrastructure. During the first two weeks of the storm and its aftermath, East Jefferson General Hospital lost approximately \$12 to 14 million. Now we're losing about \$500,000 a day. West Jefferson Medical Center, the Oschner Clinic Foundation and my hospital each are caring for about 150 patients a day. At East Jefferson, our average daily patient population is 350.

Our situations are urgent. Unless we find financial relief within the next seven to 10 days, we will be forced to make some very tough decisions. We are committed to our patients, our hospital staff and our community. However, we can't continue to care for our patients and community—many of whom hopefully will return soon from the evacuation—unless we have immediate financial assistance.

Hospitals, including ours, have caregivers who are reaching “burnout” and need relief from personnel from other hospitals, for two-week rotations. These caregivers can help us by relieving staff who are trying to rebuild their own lives after losing everything to the hurricane, and, for facilities outside the immediate New Orleans area, providing health care services to an influx of evacuees who have settled, at least temporarily, in other communities. We also need temporary housing—both for our personnel as well as for the temporary health care workers who come down to assist us. And in order to get our staff, as well as our emergency first responders, to the hospital, we need fuel.

GOVERNMENT ASSISTANCE

More than a quarter of a million people fled New Orleans. They ended up homeless, in evacuation shelters, or took up residence with relatives in other states. Some of these victims—for certainly they are victims of one of the worst natural disasters in our country’s history—may have had jobs, benefits that included health insurance, a roof over their heads, plenty to eat and all of the basic necessities. But, many may not have been as lucky and already relied on the government to assist with their health care needs. Regardless of their financial situation previous to this disaster, all now need help.

The AHA has identified several areas that require immediate attention to ensure that patients continue to have access to health care services and that hospitals continue to be able to provide them. The Centers for Medicare & Medicaid Services already has eased some of its regulations governing Medicare and Medicaid. There are, however, additional measures that can be taken. The AHA suggests immediate federal coverage for the uninsured people affected by the hurricane. So that access can be granted as quickly as possible, additional relief from Medicare and Medicaid red tape is needed. In order to facilitate providing relief health care workers to the Gulf Coast region, the AHA suggests granting broader liability protection to providers serving in disaster areas. The AHA also asks that Federal Emergency Management Agency funds be available for all types of community hospitals affected by the storm. Additional priorities include reconstructing the hospital and health care infrastructure in states battered by Hurricane Katrina; aiding stressed health care personnel; and addressing the growing caregiver shortages in affected states. I’ve included a full list and more details on these issues in the attached document, “Ensuring Health Care for Individuals Affected by Hurricane Katrina.”

LESSONS LEARNED

Every tragedy and disaster provides lessons to either avert the next one, or, if that is not possible, mitigate the consequences. This disaster is no exception. During the last few weeks, we’ve learned a number of valuable lessons and gained some insights on how best to work together. We realize that response to disasters is always ad hoc at the start, when it is best to rely on good judgment rather than policies and procedures.

We learned this time, as we did with the events of September 11, 2001, that communication systems are the first thing to go. From our experience at East Jefferson, it is obvious that an alternative, reliable communication service must be in place, so that public officials, first responders and the health care community can efficiently communicate their needs, situations and availability to assist.

Mr. Chairman, I appreciate the opportunity to tell you about the situation in my community, and offer suggestions for improving disaster response in the future. In closing, I’d also like to add that I am here representing the many people who work at East Jefferson and live in our community, who are dealing with loss and tragedy, but have remained steadfast in their mission of caring for the illnesses and injuries of their neighbors.

Mr. WHITFIELD. Dr. Peters, thank you very much. We certainly appreciate the valiant effort that you all put forward, and your testimony is quite important to us.

Our next witness is Dr. Ardis Hoven, who is a member of the Board of Trustees of the American Medical Association.

Welcome, Dr. Hoven, and you may give your opening statement.

TESTIMONY OF ARDIS HOVEN

Ms. HOVEN. Mr. Chairman and members of the subcommittees, good afternoon. I am Dr. Ardis Hoven. I am a practicing internist

and specialist in infectious diseases and the Medical Director of the Bluegrass Care Clinic in Lexington, Kentucky. I am also a member of the Board of Trustees for the American Medical Association and thank you for inviting me to speak with you today.

It is now clear that Katrina is the worst national disaster to affect our country. Our thoughts and prayers are with all of the survivors. It is also now clear that the gulf region has experienced an unprecedented public health disaster. Parts of the public health and health care delivery infrastructures are wiped out or severely damaged. Many physician offices, hospitals and clinics are simply gone. The local drugstores do not exist. Funding is needed so that this can be rebuilt and restored.

The health care needs of Katrina's victims were and continue to be significant. Physicians on the front lines faced major challenges in treating patients.

We must plan so patients in hospitals, nursing homes and those living at home are evacuated before disasters occur. The AMA is prepared to play a leading role to meet these challenges. However, we cannot do it alone. We need the support of Congress and the Federal Government as well as other private organizations like those that are on the panel with me here today.

Our testimony today focuses on three key issues: First, what were the health care needs of evacuees and what problems did physicians have in treating and saving their patients? Second, what must be done to rebuild physician practices and the rest of the public health and health care delivery infrastructures so that patients' needs are met? And, finally, how can we make sure that the medical and emergency response communities are better prepared for future disasters?

Physicians were on the front lines of the response to this disaster. Physicians tried to save and evacuate their patients from hospitals and nursing homes that were flooded and had lost power and communication systems. Physicians in the disaster areas and across the country volunteered by the thousands to help rescue and treat patients and evacuees. Physicians set up emergency medical facilities overnight.

What problems did they face? Patients arrived with no medical records and often could not remember what drugs they were on or what the dosages were. Physicians treated many patients with heart disease, high blood pressure, diabetes and serious mental illnesses who had been without their drugs for many days. Physicians needed to determine how to reconstruct treatment for patients with special health needs such as those with cancer and those needing dialysis and find facilities that could take them long term. For example, the oncology community acted quickly to help patients find physicians' help across the country in treating them.

Physicians also had to contend with many legal issues, such as consent to treat, licensing waivers, protection from liability and privacy issues. Another significant problem was the lack of coordination and delays in accepting and placing volunteers where they were most needed.

These displaced patients will continue to have major health care needs that require ongoing medical management. We must make sure that those with chronic conditions have access to medication.

We can expect more injuries as people return home and attempt to clean and rebuild.

The AMA is doing everything we can to make sure that patients can be reunited with their physicians and that physicians can get back to treating their patients, but we need Congress' help. To make sure patients have access to care, we call on Congress to enact legislation to help physicians rebuild their practices or relocate, help ensure that patients have health insurance, rebuild laboratories to detect and track infections, ensure adequate vaccine supplies, provide long-term mental health services for both displaced persons and first responders, conduct research on disasters to develop best practices and lessons learned.

The AMA, through its Center for Public Health Preparedness and Disaster Response, is ready to help lead and provide guidance and the tools necessary to ensure effective response in disasters. And, of course, we must learn from what happened after Katrina. Effective response is a system. That system is greater than the sum of its individual parts. We must train more physicians with the skills to respond to future disasters. As we have just learned, a disaster scene is not a classroom.

Thank you very much, Mr. Chair.

Mr. WHITFIELD. Dr. Hoven, thank you.

Our next witness is Dr. Bernard Simmons, who is the Chair of the National Association of Community Health Centers.

Dr. Simmons, welcome. We look forward to your testimony.

TESTIMONY OF BERNARD SIMMONS

Mr. SIMMONS. Thank you, Mr. Chairman.

I have submitted written testimony to the committee, and I request that the written testimony be entered into the record. I will use the remainder of my time to present highlights in oral testimony of the condition on the ground affecting community health centers.

Mr. Chairman, thank you and the committee for the hearing. I am Bernard Simmons, and I'm the Chief Executive Officer of Southwest Health Agency for rural people in Tylertown, Walthall County, Mississippi. I'm currently serving as Chair of the Board of the National Association of Community Health Centers. On behalf of America's health centers and the 15 million people we serve, I thank you for the opportunity to speak to you today about the Federal health center program and the vital role and response they have played in Hurricane Katrina and the aftermath.

Health centers across the country, but especially those along the gulf coast, have been first responders, though often not recognized as first responders and victims of this disaster. I know that there has been a devastating impact on many health centers, for I alone operate a community health center, and I will be dealing with areas and issues that affect rural community health centers especially, for they are different animals and treated differently somewhat in the emergency response scene.

I am in an affected State, I'm in an affected county, and my health center also was affected. However, due to a 9-day lack of power and electricity to my area, water not being supplied to the area, our major sites were affected where we could not provide care

for 10 days in our primary site, and one of our sites is also inoperable at this time.

I want you to know that, based upon a discussion with emergency response persons in my county, 6,500 evacuees are in the County of Walthall and are expected to receive care and services in that locale. The hospital—we are located in the hospital circle, and the hospital did have generators but no power to other physicians' offices or community health centers. There are many things, not only power, but water, because most of the rural communities has been encouraged to become part of a rural community water system that relies upon electricity. Also, the advances of technology, also with the emergency medical records and other things also need electricity to operate. I know that many health centers are being affected.

But I want to share with you the fact that a community health center is a community health center that responds specifically to the needs and the desires and requirements of that local community. As we look at the situation, America has at its disposal a system of health care infrastructure that can be expanded, can be also strengthened to be first responders in the first zero to 72 hours. They are in the affected areas.

I am in a rural county and oftentimes, and even before I left coming to our national meeting last week, some areas of the county did not have power at that particular time. Telephone service is sporadic. Electronic—not only electronic but cell phone service is very sporadic in those areas.

Residents of my county are traveling 75—60 to 75 miles just to try to access where possibly they can get Red Cross and some FEMA assistance of immediate response. They will be coming to our area, but as rural people hear of assistance and services they are responding to where they heard it was available, many without gasoline, to travel that distance but to get in a line and then wait there for hours to be told we're not serving your county today.

In the State of Louisiana, our health centers in New Orleans are assumed 100 percent destroyed, with more than \$43 million in facility damage, facilities that often served some 18,000 homeless individuals—health centers in other areas of the State are saying the same—or more evacuees. They have extended hours, hired temporary clinicians to handle the growing number of new patients.

Health centers in Mississippi, Alabama, Louisiana also have been hard hit by Hurricane Katrina. We believe that there are 54 health center grantees in 302 communities that have been affected by the hurricane and the aftermath thereof. These centers provide basic primary care as well as urgent medical care, mental health and enabling services to thousands of persons.

In Mississippi, along the gulf coast, the coastal family health centers, which served more than 30,000 patients last year, have been severely damaged and completely destroyed and have only managed to open one of their sites in north Biloxi.

Several health centers in Alabama were severely damaged both by wind and flooding, and the Bayou Labatte area health development board, which served 17,000 patients experienced structure damage but was able to provide care through a recent generator that had been placed in the center.

As a result of this disaster, health centers across the region are seeing an increased number of gulf coast evacuees. They are being seen in Texas. They are being seen in Georgia. They are being seen across the region.

Health centers always assume or are accustomed to confronting adversity head on and providing health and enabling services to communities; and, therefore, in the wake of this storm, it's nothing new for health centers. We need to request of Congress the ability to get funding, to have the ability to rebuild, repair and restore health center facilities. We estimate about \$65 million in facility requirements—\$45 million for Louisiana, \$10 million for Mississippi and approximately \$10 million in Alabama—to enable existing health centers to serve as many displaced individuals as possible. Because we do it at a rate of about \$500 per year. Therefore, we will be able to serve approximately 400,000 people.

The extension of the Federal Torts Claim Act liability coverage. We would like to certainly request that physicians and clinical personnel have the right to travel offsite and across State lines and that that access be provided them or that coverage, follow them wherever they go, and remain in effect at the existing centers where they work.

We also need to encourage this panel, as you look at Medicaid, that you enact emergency Medicaid spending to provide Medicaid and SCHIP coverage for evacuees and that 100 percent of that reimbursement be covered by the Federal Government rather than by the States, provide emergency Medicaid coverage for all evacuees, regardless of categorical eligibility and expanded income and asset eligibility thresholds, streamline the Medicaid process so that the eligibility requirement—and ease documentation requirements in an effort to overcome administrative problems.

America's health centers who specialize in providing care in low-income communities throughout our Nation are bringing their unique skills to this emergency relief effort now, as ever. We are committed to being a shelter in the storm and a health care home for the individuals and families in medically underserved communities across this country.

Thank you, Mr. Chairman, for this time; and I will be glad to entertain questions at the appropriate time.

Mr. WHITFIELD. Thank you, Dr. Simmons.

At this time, Mr. Joe Cappiello, who is the Vice President of Accreditation Field Operations for the Joint Commission on Accreditation of Healthcare Organizations.

We look forward to your testimony, Dr. Cappiello.

TESTIMONY OF JOE CAPPIELLO

Mr. CAPPIELLO. Thank you so much and good afternoon, Mr. Chairman.

I am Joe Cappiello, Vice President of Accreditation Field Operations for the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify before you today on the health care delivery situation in the wake of Hurricane Katrina.

The Joint Commission, by background, is a private-sector, not-for-profit entity dedicated to improving the safety and quality of

health care provided to the public. We accredit over 15,000 healthcare organizations in the United States along the full continuum of care, including the preponderance of the U.S. hospitals.

Now emergency management has been a priority for the Joint Commission for over 30 years. Following the terrorist attack on 9/11, however, our efforts took on a new sense of urgency and our standards began to focus heavily on issues of community-wide planning. Among the many tools and resources that we have developed is the document that you have before you entitled, *Standing Together: An Emergency Planning Guide for America's Communities*.

In continuing efforts to understand communities' response and recovery of their health care systems following a large-scale disaster, the Joint Commission sent a team to the region devastated by Hurricane Katrina. Our charge was to make initial observations and establish contacts for a more deliberate debriefing in the future. Our mission was to develop a set of lessons learned and openly share these with America. As a member of that team, I'm here today to discuss our observations and to highlight for you the immediate challenges for restoring health care infrastructure to the gulf region.

In New Orleans, we witnessed a health care system attempting to recover from a staggering blow. Major parts of the infrastructure that support medical care—water supply, sewage, electricity—have been significantly damaged. At the time of our visit, only three of New Orleans 16 acute care hospitals were fully operational. Other hospitals are trying to open their doors as quickly as possible.

While New Orleans has been the focus of much of the press reports, we visited areas in Mississippi where the destruction was as severe and whose recovery will be just as difficult.

I would like to highlight from my written testimony a few activities essential to the restoration of health care services in the affected States. They are not listed in any specific order of significance.

First, disseminate information at a national level to advise returning residents and workers of certain responsibilities, dangers and available services. Incoming residents and workers should be apprised of the need for immunizations and where to get them, specific hazards they may encounter, the ways to access emergency help and the limitations of the current health care system, what is open, what is not, what services are available and where.

Second, provide this information to people again as they enter the city in order to reinforce and update the information as needed. I believe the Federal Government could be helpful in such information dissemination.

Third, re-establish the post-acute care infrastructure, such as home health, rehabilitation, and nursing home care, quickly to ensure that hospital beds, which will be at a premium as citizens return, are not unnecessarily tied up with those who can be helped at lower levels of care.

Fourth, institute a process that insures that patients receiving services in temporary care sites are provided with their medical information so that it is portable to other sites of care and to primary care providers who may treat them in the future.

Fifth, focus on insuring that a number of critical physical plant and environmental care concerns are addressed, especially mold abatement. Engineers with mold abatement training should be identified and brought in to support these facilities as quickly as possible.

Sixth, implement and expand upon HHS's Critical Infrastructure Data System to capture real time, accessible data needed for recovery purposes.

Seventh, ensure that returning health care workers have adequate access to housing, food and other supportive services, including payroll. Because, without such services, they will be less likely to return to those affected areas.

Last, integrate mental health and clinical services. There needs to be a strong focus on appropriate mental health in order to deal with increased risk of behavioral health issues such as suicide, lack of or access to psychotropic medications and post-traumatic stress disorder.

The Joint Commission will participate and collaborate with appropriate oversight officials in developing a strategy for ramping up hospitals and other healthcare organizations to full-service institutions. For example, we are working with representatives from the State and Federal Governments to help get systems back up and running by establishing a minimal, consensus-driven checklist of physical plant safety that will provide organizations with guidance on what they must do to meet oversight requirements for reopening their facilities. That checklist will add increasing granularity as levels of care increase.

In conclusion, there remains much work to be done in the gulf States, but there is also an opportunity here so rare and unusual that it cannot be overlooked. The opportunity presents itself to be innovative in the reconstruction of the health care infrastructure of a major city to make New Orleans a model health care delivery city that will do more than just bring back the professionals and citizens that fled that city due to the storm but a model that will attract the best and the brightest of every profession. God willing, we will never have this opportunity again.

Thank you, Mr. Chairman.

[The prepared statement of Joseph Cappiello follows:]

PREPARED STATEMENT OF JOSEPH CAPIELLO, VICE PRESIDENT, ACCREDITATION
FIELD OPERATIONS, JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS

I am Joe Cappiello, Vice President of Accreditation Field Operations for the Joint Commission on Accreditation of Healthcare Organizations. I appreciate the opportunity to testify before the subcommittees on Health and Oversight and Investigations on the health care delivery situation in the wake of hurricane Katrina.

Founded in 1951, the Joint Commission is a private sector, not-for-profit entity dedicated to improving the safety and quality of health care provided to the public. Our member organizations are the American College of Surgeons; the American Medical Association; the American Hospital Association; the American College of Physicians; and the American Dental Association. In addition to these organizations, the 29-member Board of Commissioners includes representation from the field of nursing as well as public members whose expertise spans such diverse areas as ethics, public policy, insurance, and academia.

The Joint Commission currently accredits over 15,000 organizations in the United States. These include hospitals (both general acute care and specialty), critical access hospitals, laboratories, health care networks (including integrated delivery systems, HMOs and PPOs), ambulatory care, office-based surgery, assisted living, be-

havioral health care, home care, hospice, and long term care organizations. About one-third of accredited organizations are hospitals, comprising the nearly 85% of hospitals that contain 96% of U.S. hospital beds.

Emergency Management has been a priority for the Joint Commission for over 30 years. In 1999 with the help of emergency management experts and 2 years before the disaster of 9/11, our emergency management standards were revamped to reflect the most current thinking in the field. At that time, the Joint Commission started the process of assessing and modifying our accreditation standards to better reflect the need for health care organizations to be involved in community-wide planning, as opposed to only focusing on their institution. Following the terrorist attacks on September 11, 2001 and the subsequent anthrax exposure, our efforts took on a new sense of urgency.

In 2003, the Joint Commission published *Health Care at the Crossroads: Strategies for Creating and Sustaining Community-wide Emergency Preparedness Systems*, a report that reflected the work of a roundtable of experts. These experts were assembled under the Joint Commission's Public Policy Initiative to frame the issues associated with (and to recommend strategies for) developing community-wide preparedness.

More recently, the Joint Commission partnered with the Illinois Department of Public Health, the Maryland Institute of Emergency Medical Services Systems, and the National Center for Emergency Preparedness at Columbia University to convene two expert roundtable meetings. In addition, over the past four years, Joint Commission has conducted site visits to communities impacted by a disaster, such as New York City and Washington, DC (following the terrorist attacks and anthrax exposure), Houston (massive flooding during 2001 Tropical Storm Allison), Southern California (wildfires), Florida (the 2004 Hurricanes) and the North East (power outage in August, 2003). Information gleaned from the roundtable meetings and site visits to communities impacted by a disaster was used to develop *Standing Together: An Emergency Planning Guide for America's Communities*.

In continuing effort to understand communities' response and recovery of their healthcare system following a large scale disaster, the Joint Commission sent a team of disaster experts to the region devastated by Hurricane Katrina. The charge of that team was to make initial observations and establish contacts for a more deliberate debriefing in the future. I was part of that team and I am here today to discuss our observations and to highlight for you efforts that are underway to restore the health care infrastructure in the Gulf Region.

WHAT OUR TEAM SAW LAST WEEK

In New Orleans, we witnessed a health care delivery system attempting to recover from a staggering blow. In recent history, a major city in the United States has never experienced the destruction wrought by Hurricane Katrina. Major parts of the infrastructure that support medical care—water supply, sewage system, and electricity—have been significantly damaged. At the time of our visit, only three of New Orleans' 16 acute care hospitals were fully operational. Other hospitals are trying to open their doors as quickly as possible. When we departed New Orleans on September 16, there was no 911 system (although a call center was being established), no ambulance transport system, no Level 1 trauma center, no burn center, no home health care, no long term care nor any dialysis centers. That is part of the challenge this city faces.

In New Orleans, we visited Ochsner Medical Center where we took part in the "virtual" daily briefing, which brought together a broad array of federal, state and local healthcare leaders to discuss daily status reports and coordinate their efforts. We also visited several other facilities that were in the process of recovery. While New Orleans has been the focus of much of the press reports, we visited areas in Mississippi where the destruction was as severe and whose recovery will be just as difficult. For example, Hancock Medical Center in Bay St. Louis will face the same challenges to restore service to its community as any hospital in New Orleans. For a period of time, they were being supported by federal Disaster Medical Assistance Team (DMAT) teams in their parking lot and coping with extensive water damage.

In Mississippi, we had the opportunity to visit several deployable medical units designed to accommodate surge control for an existing functioning hospital. **Nevada 1** is an air transportable, expandable Federal Management Shelter capable of treating a wide range of health care conditions and a large number of patients. It has a capacity of 100 beds and can be set up for both primary and ICU care, as well as labor and delivery. **Carolina 1** is an air transportable facility that has at its core, an 8 bed fully equipped ICU and a fully functioning Operating Room. These deployable units are clearly life saving entities that can supplement existing medical

infrastructure. These health care assets can bring much needed supplies and emergency systems with them, and can be helpful for staging, surge control, and providing special medical services.

Furthermore, we learned of many acts of heroism and caring that medical professionals rendered throughout this disaster and I can say with certainty that there were a thousand other acts of compassion that will go unrecorded and unnoticed. Such is the nature of health care professionals.

I would remind the members that the Joint Commission is interested in and accredits the full spectrum of care. My remarks are directed with equal importance to the care provided outside of the hospitals, as well as hospital-based care. Hospitals in every community rely on and need the support of community-based structures to effectively accomplish their mission. My comments are directed toward the restoration of the synergistic interplay of all health care resources that comprise the fabric of care.

RESUMING THE DELIVERY OF HEALTH CARE SERVICES IN THE GULF STATES

The following is a list of activities that are essential to restoring health care services to the affected states in the next few weeks to months. They are not listed in order of significance.

- Disseminate information at a national level to advise returning residents and workers of certain responsibilities, dangers, and available services. Incoming residents and workers should be apprised of—
 - the need for vaccinations, especially Tetanus and Hepatitis A;
 - locations of facilities providing free vaccinations;
 - specific hazards, such as water, mud, debris;
 - the ways to access emergency help; and
 - limitations of the health care system, e.g., what is open and closed, what services are available and not available, where services are located, and how to contact service providers.
- Provide the information noted above to people a second time as they enter the city in order to reinforce and update the information as needed.
- Resume the traditional 911 services as soon as possible because alternative call centers are not as effective—i.e., people will not remember the number or find it quickly during a crisis.
- Begin Level 1 trauma services in the New Orleans area.
- Restore supportive medical services as quickly as possible and commensurate with the re-population plan. These services include, but are not limited to pharmacies, laboratories, diagnostic imaging centers, ambulance services, and dialysis centers.
- Develop a plan for the delivery of healthcare to the chronically ill, but ambulatory low-income and uninsured populations, whose normal health care providers are not operable. The affected states had high rates of both low income and uninsured people. In New Orleans, for example, the majority of those uninsured or in poverty relied upon Charity Hospital for primary care and other services, but it is unlikely that this hospital will reopen any time soon.
- Establish services for disabled and special needs populations, such as medical transport and rehab facilities, as soon as possible.
- Re-establish the post-acute care infrastructure, such as home health, rehabilitation, and nursing home care, quickly to ensure that hospital beds—which will be at a premium—are not unnecessarily tied up with those who could be helped at lower levels of care.
- Ensure that providers have broad scale access to the Department of Health and Human Services (DHHS) network of pharmaceutical records in order that the pharmaceutical history of residents can be known by those providing treatment.
- Institute a process that ensures that patients receiving services in temporary care sites are provided with their medical information so that it is portable to other sites of care and to primary care providers who may treat them in the future.
- Focus on ensuring that a number of critical physical plant and environment of care concerns are addressed, especially mold abatement. Engineers with mold abatement training should be identified and brought in as soon as possible. Environment of care issues are paramount to resuming patient care. Other concerns involve air quality, sanitation, and contamination.
- Monitor on a daily basis the number and geographic location of individuals with rashes, fevers, and diarrhea to ensure that any trends indicating a public health concern are identified early. Disseminate this information to all relevant health care and public health entities.

- Establish mechanisms to communicate across health care facilities so that care delivery can be coordinated and made efficient and effective. A common communication system will help to leverage health care assets and disseminate essential information that is necessary for recovery.
- Implement and expand upon the Department of Health and Human Services' Critical Infrastructure Data System (CIDS) to capture real time, accessible data needed for recovery purposes.
- Make available safe water and restore sewage capabilities, so that health care organizations can resume operations.
- Ensure that returning health care workers have adequate access to housing, food, and other supportive services (including payroll) because without such services, they will be less likely to return to affected areas.
- Assist health care facilities to establish laundry services and sterilization capabilities.
- Establish telemedicine services, to provide access to specialists from unaffected areas.
- Integrate mental health and clinical care services. There needs to be a strong focus on appropriate mental health care in order to deal with increased risks of behavioral health issues, such as suicide, lack of access to psychotropic medications, and post traumatic stress disorder.

EFFORTS UNDERWAY

The Joint Commission is commonly recognized as an entity with the unique capability of bringing disparate groups together to focus on a common goal. We are engaged in that activity today. The Joint Commission is working collaboratively with federal, state and local officials to ensure that health care organizations in the affected areas can obtain a sufficient level of functioning to provide safe health care services. There has been significant study on the graceful degradation of care but few studies or experiences with the reestablishment of care. The Joint Commission will participate and collaborate with these officials in developing a strategy for ramping up hospitals and other health care organizations to full service institutions.

For example, we are working with a wide spectrum of organizations to help get systems back up and running by establishing a minimal, consensus-driven checklist that will provide organizations with guidance on what they must do to meet state and federal requirements for reopening their facilities. That checklist will add increasing granularity as levels of care increase. For example, there will be a basic set of criteria for re-opening the doors of closed facilities so that they are safe for occupancy by staff and patients. The criteria will become more specific as particular types of services are brought on line, such as surgery.

The Joint Commission is also an active participant in the "Emergency System for Advanced Registration of Voluntary Health Personnel (ESAR VHP)." This Health Resources and Services Administration (DHHS) project brings public and private sector groups together to identify and address issues and formulate responses associated with credentialing and privileging volunteer health care personnel. Hurricane Katrina was the first real test of those states who have been funded to put this system into practice. We were pleased that this system could be activated to help.

CONCLUDING REMARKS

In conclusion, there remains much work to be done in the Gulf states, but there is also an opportunity so rare and unusual that it cannot be overlooked. The opportunity presents itself to be innovative in the reconstruction of the healthcare infrastructure of a major city, to make New Orleans a model health delivery city that will do more than just bring back the professionals and citizens that fled the city but a model that will attract the best and the brightest of every profession. God willing, we will never have this opportunity again.

Mr. WHITFIELD. Thank you, Mr. Cappiello.

Our next witness is Mr. Bob Dufour, who is Vice President of Pharmacy Services with Wal-Mart Corporation.

TESTIMONY OF BOB DUFOUR

Mr. DUFOUR. Thank you. And I'm a Director, not a Vice President.

I'm here today testifying on behalf of the NACDS. I was asked because of my involvement in helping to organize chain pharmacies

to respond with emergency medications to the shelters and to evacuees.

My testimony today is really a success story. We have a lot of successes. I know that many of you, as you visited the area or you saw in the media the different shelters going up, these shelters were provided with prescription medications, many of those from chain pharmacies.

In total, we contacted over 400 shelters; and we served hundreds of thousands of evacuees who were in these shelters, in hotels, staying with relatives and staying with friends. We did this without any formal Federal contract, without any State contracts. It was an ad hoc response by community pharmacy because we recognized need of these evacuees to have their medicines. This was possible because of the cooperation we had with several different groups, first of all, with the pharmaceutical manufacturers; and I think the congressman from Florida this morning mentioned the contribution they made.

Starting on Tuesday after Hurricane Katrina hit, I approached six different manufacturers with the notion that the company I work for, Wal-Mart, wanted to provide a 7-day supply of emergency medications to anyone who was affected by Hurricane Katrina. I asked them for their support by asking if they would provide replacement products for those prescriptions that were donated. Four of those companies immediately said yes. Two other ones said they would have to get back with us after they checked with other folks in their company. Later on, we had our pharmaceutical buyers contact other manufactures.

I also contacted Mr. Billy Tauzin, who is now with the Pharmaceutical Manufacturers Association, explained what we were trying to do and sent him a letter that he distributed out to the PHARMA companies. So we really appreciate his support.

There was also great cooperation with the government at the State and Federal level.

On Wednesday, I contacted folks at the emergency operations centers in Louisiana and in Mississippi to offer help to find out what they needed. We also worked with boards of pharmacy. The boards of pharmacy in Mississippi, Louisiana and Texas recognized the urgency of the situation and provided a means for pharmacists to dispense medicines to patients where they may not have a prescription with them, could not get ahold of the doctor or the pharmacies and they may be in shelters where there were no physicians yet, so pharmacists were using their good professional judgment in dispensing these.

We also had cooperation from the DEA, where they allowed us to dispense controlled substances under these emergency guidelines.

I would also say we had good government cooperation with the Medicaid departments in Mississippi and Louisiana and also Texas. They worked very hard to allow out-of-State pharmacies to quickly enroll and provide services because many of the evacuees had gone out of their home States. We had real good cooperation which provided a lot of help there.

We started this retail network. It started on the Wednesday evening after Hurricane Katrina hit.

I was speaking with Fred Mills, who was in Baton Rouge working for the Louisiana emergency operations center. As shelters were starting to pop up, they were trying to figure out how do we get medicines to all of these different shelters. They did consider at one point a scenario of maybe having some type of government pharmacy and how would they get people, how would they get the drugs from the Federal supply down to these pharmacies; and we brought up the fact that there were a lot of Wal-Marts in a lot of the locations where the shelters were going. I offered the support of Wal-Mart, saying we would provide a 7-day supply of medicines to each of these shelters that were close to us.

I then asked them to prepare a list of the shelters and fax it over to me, which they did. When I saw how extensive the list was, we enrolled the help of the other chain pharmacies. The following day we held a conference call with chain pharmacies.

We also invited Larry Kolcot from CMS, who was a very big help in this process. What we did was we would e-mail out the list of shelters and how many evacuees were in these shelters and we would ask chains to adopt a shelter. And what adoption means is that the pharmacy chain that adopted the shelter would take responsibility for sending pharmacists over to the shelter and making sure prescription medicine were given to these people who needed it. We did this each day.

As more shelters were opened in Texas and Mississippi, with these shelters, what we would do—if you've got a shelter typically of less than, say, 2,500 people, the most efficient way to provide medicine in the large shelters like the Houston Astrodome and George Brown Convention Center, places like that, mobile pharmacies were dispatched.

I think this was a real good example of the value of community pharmacy and what we can do. You did not hear a lot in media about the independent pharmacists, but I'll tell you the independent pharmacists also participated in this to the extent they could.

The recommendations that I would have for this panel as we're looking at Hurricane Rita and we know that other catastrophes will happen, one way we could organize the need for prescription medicines is for the Federal Government to create a Federal Government disaster prescription drug program very similar to what employers have for their employees, or with the Federal Government you have a little plastic card that's in your wallet you use to purchase prescriptions. Under this Federal disaster, the Federal Government would get a VIN number and they would set up the parameters of what drugs would be covered, what days supply and, very simply, the Federal Government could turn on this plan electronically whenever a disaster hit.

By doing that, there's some distinct advantages. You could have every community pharmacy in the Nation participate. If you think about emergency response and how do you get drugs to where they're needed, 95 percent of Americans live within 5 miles of a community pharmacy. So wherever the disaster is you're going to have community pharmacies with personnel and drugs already on hand.

This prescription drug program would also give the Federal Government real-time access to what prescriptions are being dispensed, the names of people and what shelters they're at.

The second thing I'd recommend is, when we talked earlier about the national data base, and I think Mr. Engle and also Dr. Hoven mentioned the importance of having medical information. Dr. David Braylor with the Health Information Technology Group in HHS has been working for the last couple of weeks with three different pharmacy technology companies as well as chain pharmacy and independent pharmacies to create a data base. I believe today they are announcing that. They have over a million health care records of people in the path of Hurricane Katrina. I would recommend the committee take a closer look at that and say, how can this be applied to other areas when a disaster is coming.

Overall, besides working the prescription network, I was also involved with responding in Mississippi and in Louisiana with other health care needs, supplies to hospitals, nursing homes. And I would say, in general, the biggest thing I saw was, if we were going to focus on something to make this better, is to look at fuel, look at communications and look at coordination. One piece of coordination I'd like the committee to consider is if emergency responders had a phone number they could call in and their needs could be posted on to a website that was monitored by FEMA or the emergency operations center of a State, they could—the State could see all the needs that were coming in, determining if they were valid needs. And then if they wanted to respond, they could do it with a FEMA response, a Federal response, or they could post that over to another website that was open to authenticated suppliers who could look at what those needs were, and those suppliers could respond. So, for instance, if there was a need for water or if there was a need for medicine you could go to a web page and you could see that being posted by FEMA and a supplier could come back and say we can respond back in 1 hour, we could respond back in 2 hours. Thank you.

[The prepared statement of Bob Dufour follows:]

PREPARED STATEMENT OF BOB DUFOUR, DIRECTOR, PHARMACY PROFESSIONAL SERVICES AND GOVERNMENT RELATIONS, WAL-MART, INC. ON BEHALF OF NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. Chairman and Members of the Subcommittees on Health and Oversight and Investigations. My name is Bob Dufour and I am Director of Pharmacy Professional Services with Wal-Mart.

I am here on behalf of the National Association of Chain Drug Stores (NACDS). NACDS asked me to testify because of my involvement in helping to coordinate the chain pharmacy industry's response following Hurricane Katrina.

The purpose of my statement today is to help the Committee better understand the response of the community retail pharmacy infrastructure to the Hurricane Katrina disaster. We would also like to provide some recommendations that would help facilitate the role of community retail pharmacies in responding to future public health emergencies.

RETAIL PHARMACY SUPPLY CHAIN ROLE IN PUBLIC HEALTH EMERGENCIES

There are about 56,000 community-based retail pharmacies in the United States. There is a community retail pharmacy within 5 miles of 95 percent of the population in the United States. Therefore, retail pharmacies are an important point of entry into the health care system for most Americans.

Hurricane Katrina showed us that the existing community pharmacy infrastructure plays a vital role in providing medications and other health care products and

services to individuals in their communities during public health emergencies as well as daily activity. Obviously, in many communities located within the Gulf Region, much of the health care infrastructure was devastated and will have to be rebuilt. We look forward to working with the Committee to ensure that this vital infrastructure is restored as more and more people return to their homes.

As evacuees from the Gulf Region were relocated to various places across the United States, pharmacists and pharmacies helped to respond in many different ways to meet the health care needs of these individuals. First, many pharmacy chains established mobile pharmacies in evacuee centers and other areas along the Gulf Coast so that they could provide prescription drug services and other health care items to these individuals. We all heard news and press reports about individuals who had been evacuated without vital health care supplies such as insulin and other prescription drugs, which are needed to sustain life and health. Pharmacies worked with physicians at these evacuee sites to assess each patient's health care status—given that they had little or no medical history with them—and get them started back on their prescription therapy.

Many community retail pharmacies also filled tens of thousands of prescriptions for evacuees that were relocated to smaller shelters or temporary housing. Many of the evacuees were low-income individuals who are Medicaid recipients in their home state, and obviously they did not have their Medicaid cards with them when they came to the pharmacy. Others had lost their insurance information, or had no insurance at all. We have been working with the Centers for Medicare and Medicaid Services (CMS) and host state Medicaid agencies to ensure coordination with their efforts.

Thus, as policymakers consider what might be changed in the future to make those responses to public health emergencies more effective, it is equally important to ensure that we maintain and strengthen infrastructures that are already in place that can respond quickly to emergencies within the communities in which people live. One of these infrastructures is the neighborhood retail pharmacy.

We all agree that the nation needs certain stockpiles of medications and other supplies readily available to ship to emergency centers or disaster zones. However, when it comes right down to it, there are many more community pharmacies and other types of local health care centers that are accessible and convenient to people in their communities. The retail pharmacy is at the heart of this distribution system, and each part of this system—from the drug manufacturers to the wholesalers to the pharmacies—responded in such a way to keep the flow of prescription medications moving to shelters and the pharmacies and ultimately to the evacuees.

The success of the prescription drug distribution infrastructure in serving the needs of evacuees is best demonstrated by the fact that, in a survey of evacuees in Houston shelters, 67 percent reported that there was not a time since they were evacuated that they did not have their prescription medications. States have been reassuring the pharmacy industry that they will do everything they can to see that pharmacies will be compensated at some point in the future for providing these services to their residents. We appreciate the efforts of the Bush Administration in granting a Medicaid 1115 waiver to the state of Texas to establish an uncompensated care pool to help pay providers like pharmacies for the care that they provided to evacuees with and without any form of prescription coverage. NACDS is hopeful that other states will adopt similar measures. In addition, it is important that the federal government consider developing a clear policy to address the reimbursement of health care providers for uncompensated care.

ORGANIZING THE RETAIL COMMUNITY PHARMACY RESPONSE

To facilitate the response of community pharmacy to the Hurricane Katrina crisis, NACDS and other pharmacy-related associations and interests were in daily communication. These daily calls allowed us to ensure that we were quickly deploying resources where they were needed, without duplicating efforts. For example, pharmacies were adopting shelters, meaning that a chain pharmacy would take responsibility for providing pharmacy services to that shelter. This method allowed a quick coordinated response and prevented duplication of efforts to service the prescription needs of those housed at the shelters in Louisiana, Texas, and Mississippi.

A large number of chain pharmacies and members of the supply chain contributed as well.

- Wal-Mart helped to contact and organize contributions from brand and generic pharmaceutical companies to provide replacement medications for some of the products being dispensed by pharmacies to evacuees.
- Wal-Mart adopted 99 shelters to provide emergency medications.

- Wal-Mart worked to help supply oxygen to health care entities in the region that were running low on these vital supplies. Finally, some of our stores in the area helped to supply medications to nursing homes that were running out of these supplies.
- CVS/pharmacy said last Friday that it has completed its emergency pharmacy operations at the Astrodome in Houston, where it has been filling prescriptions for Hurricane Katrina victims, now that all evacuees have been relocated out of the stadium to other facilities. Utilizing delivery service from area CVS stores and two mobile pharmacy units on-site at the Astrodome, CVS reported that it filled more than 20,000 prescriptions for 7,000 people who took shelter in the Astrodome. CVS/pharmacy also deployed mobile pharmacy units to the Convention Center in Austin, Texas, and Kelly Air Force Base in San Antonio, Texas. It will continue to serve the prescription needs of Gulf Coast evacuees at local CVS locations.
- Walgreens offered to deploy as many mobile pharmacies as needed and provided hundreds of pharmacists to dispense prescriptions to evacuees.
- Rite Aid is continuing to fill emergency prescriptions for evacuees. The chain also set up temporary pharmacies at evacuee shelters.
- Many other pharmacy chains, such as HEB and Kroger, sent additional pharmacists to these shelters and the pharmacies that are located in the Texas and Louisiana areas. This was important, given that the demand for prescription services increased significantly in the areas where evacuees were relocated.
- Pharmaceutical wholesalers worked to ensure that needed products would remain in-stock for dispensing, and helped to transfer them to the shelters and the pharmacies.
- Groups representing health plans helped to provide specialty drugs to AIDS and cancer patients in the shelters.
- Individual pharmacists and technicians at a large number of chain pharmacies, as well as many independently-operated pharmacies, should be recognized for their efforts. Many worked day after day putting in long hours providing services to people in these shelters.

WORKING WITH STATE PUBLIC HEALTH AGENCIES

NACDS and community retail pharmacy also worked with state government agencies to help ensure that the response to the crisis was as organized as possible. Boards of Pharmacy from affected and host states worked with us to approve the use of emergency policies and procedures to provide needed prescription drugs to evacuees.

For example, the combined efforts of the Louisiana Board of Pharmacy, Louisiana Medicaid Department, and Louisiana Department of Health and Hospitals were particularly instructive in coordinating a response to a crisis of this nature. These agencies immediately recognized a need to have a system that would provide timely access to medical supplies and pharmaceuticals. They recognized that the existing statewide network of community pharmacies and wholesalers could respond immediately and serve many of those in need.

A state-based wholesaler provided the majority of bulk shipments needed to shelters, hospitals, and other areas identified by this group. Wal-Mart also responded with two shipments from its pharmacy warehouse. Many independent community pharmacists responded to the local needs of their community by providing emergency prescription medications.

The efforts of the state of Mississippi in helping to ensure that their evacuees could continue to obtain Medicaid services should also be noted. The Department asked out of state pharmacies to provide prescription services to Mississippi Medicaid recipients during this emergency. The Medicaid program would reimburse these pharmacies at the prevailing Medicaid rate. Mississippi Medicaid did allow out of state pharmacies to use an existing "in state" Medicaid provider number if the pharmacies were under common ownership.

ELECTRONIC DATABASE OF EVACUEES' MEDICAL HISTORY AND PRESCRIPTION NEEDS

One lesson that this unfortunate event has taught us is that electronic medical records are valuable in providing continuous patient care to displaced individuals, especially in cases where important medical and prescription information is lost, possibly forever. Our industry coordinated efforts with federal, state, and local government, as well as other industry partners through daily conference calls and work groups. This constant communication allowed us to collect and integrate as much medical information as possible about the evacuees' from various sources, including

prescription files, and provide it to the health care professionals caring for those displaced by Hurricane Katrina.

For example, in response to this need to create a better database of information about evacuees' prescription drug therapy, our industry has been working with HHS and the HHS' Office of Health Information Technology, headed by Dr. David Brailer, to create a single database of close to 1,000,000 names from the region affected by Hurricane Katrina. By working together over about an eight-day period, several chain pharmacies, *SureScripts* and Florida-based *Gold Standard* built the database and designed the interface that all participating health care professionals could use. The database lets a pharmacist, physician, or other health care professional treating patients know what medications an individual had been taking over the past ninety days. This system has been established just for people in the areas affected by the hurricane.

A program that was initially piloted to a few chain pharmacies is now becoming available to growing numbers of pharmacies, doctors and other health professionals. With these records, the first question a physician asks—"What prescription medications are you taking?"—can be answered accurately.

NACDS believes that this event has reinforced the need for a single national patient identifier number to help access those records. If the national patient identifier had been in use, then it is likely that it would have been easier and faster to match evacuees' medical information with their prescription information. This would have helped deliver care to these evacuees, who in most cases did not have any of their medical information with them.

RECOMMENDATIONS TO ENHANCE THE PUBLIC HEALTH RESPONSE TO EMERGENCIES

We have already made some recommendations about how we might improve the ability of community retail pharmacies to respond to public health emergencies. We believe that community retail pharmacy worked well with various state and federal agencies, although there are always ways that the efficiencies of these interactions can be increased. Here are some ideas:

Consider Federal Emergency Rx Claims System: The Federal government should consider establishing a system that would allow retail pharmacies to process prescription claims for evacuees through a special Federal prescription drug plan that would be used only in emergency situations. Many evacuees that filled prescriptions in our pharmacies were uninsured, or had prescription drug coverage, such as Medicaid and third party coverage, but did not have their identification cards, so pharmacies were not able to process their claims to the correct payers. While pharmacies filled prescriptions for these individuals, a Federal emergency system would help keep track of prescriptions that are being filled for evacuees, as well track the expenditures incurred by individuals for prescription drugs and other medical supplies.

In the event of an emergency, the plan could be activated via its Bank Identification Number (BIN) or routing number. This would allow emergency prescriptions to be filled at any pharmacy in the nation. The adjudication of these claims in real time would provide the government valuable information on the medications being dispensed, to whom, and in what volumes. Parameters could be preset for reimbursement, eligibility, and other important factors. We would be interested in working with HHS, FEMA and other relevant agencies on this issue.

Encourage Development of EMR Technology: Continue to encourage the development of electronic medical records, the use of the national patient identifier, and integrated databases that can be used both in delivery of medical care in ordinary times and extraordinary circumstances. We have a long way to go in developing the infrastructure necessary to support this system, but the disaster in the Gulf Region reinforces how important it is that the health care system maintains the ability for providers to deliver care to individuals wherever they might be.

Strengthen Retail Pharmacy Infrastructure: Please do everything you can to strengthen and maintain the existing community retail pharmacy infrastructure. The disaster in the Gulf Region reinforces the importance of community pharmacies, particularly since many of them are located in rural areas, are often the "first responders" to the health care needs of many individuals, both in emergencies and in normal times.

Post Specific Needs on Web: Fourth, the government may also want to consider a web-enabled program on which emergency responders could post specific needs. FEMA or state emergency response agencies could review these request, and respond with government resources, or determine how fast the private sector could respond to this request.

Mr. Chairman, again on behalf of Wal-Mart and the entire chain pharmacy industry, we appreciate the opportunity today to provide the Committee this testimony. Thank you.

Mr. WHITFIELD. Mr. Dufour, thank you.

The next witness is Ms. Barbara Blakeney, President of the American Nurses Association. We welcome you and look forward to your testimony.

TESTIMONY OF BARBARA BLAKENEY

Ms. BLAKENEY. Thank you, Mr. Chairman.

It's a pleasure to be here today to be able to address the committee. Not only am I the president of the American Nurses Association, but I have been a nurse practitioner for over 30 years with experience in public health, including 18 years working as a director of Health Services for the Homeless for the city of Boston. I have spent 18 years in shelters, Mr. Chairman, and I consider myself an expert in what happens in those shelters and what the needs are long term.

ANA has been very, very actively involved in the work. Our State nurses associations have been very, very involved. Through our communications network, we have been able to trigger a response of over 20,000 nurses available and ready to respond to this disaster and, unfortunately, the disaster that's about to hit in Texas. We have board members currently in Gulfport, Mississippi, directly providing care, and I'd like to acknowledge today that Ms. Ricky Garrett, the executive director of the Mississippi Nurses Association, is here today and leaned over to me a half hour ago and said to me, it is an unusual experience to sit here and listen to us all talking at a systems level about the people that I know who have been harmed and killed. And so I'd like to try to put a face on who it is that we're talking about, Mr. Chairman.

In the Gulf Coast, prior to Katrina, one out of every three children were dependent on Medicaid for their health coverage. Prior to Katrina, 22 percent of the Louisiana residents and 19 percent of Mississippians lacked any health insurance, which is compared to a 15.7 percent ratio percentage nationally. Prior to Katrina, a family of three could not earn more than \$174 per month in order to qualify for Medicaid in Louisiana. This is only 17 percent of the national poverty threshold, Mr. Chairman. Prior to Katrina, almost 24 percent of all Mississippians lived in poverty. It is very, very well known that poverty and ill health go hand in hand. These are the people who have been displaced, these are the people who currently sit in shelters, on broken porches, environments that are unhealthy and unsafe.

And as we think about what they need in the short term, we must understand that long after this event goes below the fold on the front page of our local newspapers and long after the fact that this event goes to the back page of the newspapers and long after we have moved on to other events in this country, these people will still not be home. They will still not be healthy. They will still be in need of major, major support from an infrastructure that has been destroyed, an infrastructure that will take months to years to recover, hospital records lost, patients in the middle of chemotherapy without treatment, patients needing dialysis. The city of

New Orleans has the highest rate of dialysis needed for people in the entire country. That infrastructure is gone. That infrastructure prior to the storm was not effective to manage the basic day-to-day needs, and now we're asking that infrastructure to manage the surge capacity that is not only short term but will go on for years.

The American Nurses Association participates in a program called the National Nurse Response Team, which was originally designed and created in partnership with Health and Human Services in 2002. The goal of that program was to create 2,000 nurses ready to go to be able to be Federalized in case of bioterrorism. To the best of my understanding today, we have 700 nurses in that program. Many thousands of more are interested, but because there is a bottleneck in the paperwork, have not been able to sign on.

That team has not been activated. It cannot be activated because this storm is outside of the scope of its mission. Recommendation No. 1, Mr. Chairman, is that we readdress that mission. Our ability to respond to a crisis is highly dependent on the strength of the infrastructure to respond to the daily needs of the people in this country. It is no secret that the health care infrastructure is in disarray. People waiting 8, 10, 12, 24 hours in emergency rooms to receive care. If that system cannot respond to those people, Mr. Chairman, that system is no way able to respond to the overwhelming demands of the crisis that we have in front of us.

We cannot afford to stop paying attention to the needs of the infrastructure. One of the things about public health is that public health is viewed as successful when things do not happen, when an outbreak doesn't occur, when an illness doesn't spread, when we have enough vaccine for flu. It's hard to measure how successful you are when something doesn't happen. It's the bane of all of us in public health.

The bottom line, Mr. Chairman, is that we cannot respond to the daily needs of our citizens today, never mind a disaster. I could tell you what we have done as nurses and the heroic things of our nurses in Louisiana and in Gulfport, Mississippi and Biloxi and all the little towns we seem not to be thinking too hard about right now. But you already know those stories. We need to address the issues of the infrastructure that prevent us from being able to respond well. We can talk about all the things that the doctor talked about this morning, but if we cannot base those responses on an existing system that is efficient, effective, and functional on a daily basis, no matter how hard she tries, no matter how hard the rest of us try, it will not work.

Our recommendations today are to expand the NNRT mission to allow appropriate advanced practice nurses to serve as primary case managers—it is amazing to me that that is not permitted under Federal requirements—to create a mechanism for seamless transfer of licensing authority during times of crisis. In some States, we've managed to do it very well, and in other States, we have a backlog of nurses, physicians and other licensed clinicians who cannot be authorized to practice because of cumbersome bottlenecks. We need to strengthen the health care infrastructure and increase access to care.

The people I'm describing to you, sir, are among the poorest in the country. Their health care was poor to begin with. If we think that basic emergency responses are going to get them on their feet, it's not the case, and we delude ourselves if we think otherwise.

I know that this hearing is not supposed to be about Medicaid, but I would be remiss, sir, if I did not say to all of you that that is the safety net. How big do we want to create the holes in our safety net? Big enough to drive a tank through or small enough to catch these people? Mr. Chairman, the challenge is to catch these people long after they drop below the fold on the first page of our newspapers. Thank you, sir.

[The prepared statement of Barbara Blakeney follows:]



Nurses Respond to Hurricane Katrina

Presented to:

**Subcommittee on Health, and
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives**

For the Hearing:

Assessing Public Health and the Delivery of Care in the Wake of Katrina

On:

September 22, 2005

Presented By:
**Barbara Blakeney, MS, RN
President,
American Nurses Association**

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Good Morning. I am Barbara Blakeney, President of the American Nurses Association. I am also a nurse practitioner with nearly 30 years of experience in public health. I am here today to speak to you about the lessons learned from Hurricane Katrina and the immediate need to invest in our health system.

ANA is fully supportive of this Committee's efforts to provide for the immediate needs of the Americans hardest hit by this natural disaster. We look forward to working with you to ensure that these efforts are swift and effective. Nurses from across the nation have been at the forefront of efforts to rescue and provide care to countless patients and residents of Gulf Coast communities hard hit by Hurricane Katrina, and ANA is prepared to assist in any way possible.

Throughout our history, nurses have always answered the "call to care" during times of need and crisis, in times of war, epidemics and natural disasters. During the hurricane, nurses risked life and limb to provide for their patients. Nurses with very little food and less sleep worked heroically to care for the sick and to protect the vulnerable. We are continuing to respond to this disaster.

ANA has been working with nurses associations in the affected states, the federal government, the American Red Cross, and Project Hope. We have used our website - NursingWorld.org - to spread the message about how nurses can help with relief efforts. Thanks to these efforts, more than 20,000 nurses have volunteered to assist — exceeding the immediate need for help. ANA's board members have also personally joined the efforts in the Gulf area.

Additionally, in response to a request from the Substance Abuse and Mental Health Services Administration, ANA and the American Nurses Credentialing Center are recruiting approximately 100 certified psychiatric/mental health and gerontology nurses to work in Louisiana, Mississippi, and other Gulf Coast states. These nurses will be assigned to two week deployments, and there will be four deployment cycles starting on September 18, with the last two-week deployment cycle starting on November 1, 2005.

As a nurse practitioner who has worked with the homeless, I know that people from the Gulf Coast will require many months of medical and mental health services to deal with the consequences of this horrific storm. Their needs are not temporary, and neither should the response be. That is why I am here today asking this Committee to abandon plans to reduce funding for Medicaid in the reconciliation process. Now is not the time to further unravel the health care safety net.

Hurricane Katrina has shed light on many issues. One of these being the long-standing inadequate access to health care services in the Gulf Coast. Here are a few quick facts;

- Prior to Katrina, one out of every three children in the Gulf Coast were dependent on Medicaid for their health coverage.
- Prior to Katrina, 22% of Louisiana residents and 19% of Mississippians lacked any health insurance (compared to 15.7% nationally).

- Prior to Katrina, a family of three could earn no more than \$174 per month to qualify for Medicaid in Louisiana (this is 14% of the national poverty threshold).
- Prior to Katrina, 23.5% of all Mississippians were living in poverty.

These people would have been hard hit by cuts to Medicaid before Katrina hit. Their needs are even greater now. And their plight is shared by many other Americans.

In August, the U.S. Census Bureau reported that:

- Last year, the number of uninsured in America had increased by more than 800,000. In 2004, the number of Americans without access to health insurance reached 45.8 million. This does not include the thousands upon thousands of Americans who have lost everything, including health care coverage, as a result of this disaster.
- More than 150,000 people lost employment-based health insurance in 2004 (60.4% of Americans had this coverage in 2003; 59.8% has it in 2004). Since 2000, more than 3.6 million Americans have lost this coverage.
- The number of Americans relying upon Medicaid increased by 1.8 million in 2004 (the percentage of Americans covered by Medicaid increased from 12.4% in 2003 to 12.9% in 2004). Since 2000, nearly 8 million have been added to the Medicaid rolls.
- In 2004, the number of Americans living in poverty increased by 1.1 million. Since 2000, the number of Americans living below the poverty level has increased by more than 5.4 million.

So, we are facing a situation where hundreds of thousands of Gulf Coast residents have joined the tens of millions of Americans without access to health insurance. Nurses understand the terrible choices that people face when struggling to afford basic health care services. No one should have to choose between paying the rent and getting their child immunized, or between purchasing food and buying much needed medicine to manage conditions like diabetes, high blood pressure and asthma. The simple truth is that those who don't have health insurance live sicker and die younger. In fact, the Institute of Medicine has reported that the lack of health insurance causes 18,000 working-age Americans to die unnecessarily each year.

I would like to leave you with one simple message - compassion and common sense should prevail. Our nation should provide basic health services to those who require them. The first step in this direction is to abandon plans to cut funding for health care for the medically needy and indigent. Now is not the time to reduce access to needed health care services. Now is not the time to cut Medicaid funding.

Mr. WHITFIELD. Thank you.

And thank you for the testimony that all of you have given. We appreciate it very much, on a very serious issue. And at this time, we will go to questions. I will begin the question period. We'll each have the appropriate time, 5 minutes.

Dr. Peters, thank you for being with us today. When you talked about the evacuation of your hospital, you mentioned that you moved the neonatal care up to Baton Rouge. Did you evacuate anyone else in the hospital in preparation for Katrina?

Mr. PETERS. We evacuated a few other patients due to some special needs that they had, but the great majority we did keep at our hospital.

Mr. WHITFIELD. And the ventilator patients were kept there as well?

Mr. PETERS. Correct. We had a discussion of the pros and cons of transferring, moving those patients out. That was actually a day after the storm, when we were having power difficulties and looking at what were the risks associated with further power outages. We made the determination that we felt that we were best at that point, due to the myriad of communication issues on the outside and also some of the saturation of the spots where we would normally send patients, to keep them there.

Mr. WHITFIELD. Were your hospital records destroyed or damaged?

Mr. PETERS. No, they were not.

Mr. WHITFIELD. So they're in tact.

Mr. PETERS. They're all in tact.

Mr. WHITFIELD. How would you describe your dialog with emergency officials and emergency responders during this period. Did you have to obtain any approval to move patients, or do you have the authority to do that on your own?

Mr. PETERS. I think we used various approaches. Because of all the circumstances and some of the challenges that we have all talked about, I think the communication piece or the difficulty with that caused us to look for multiple solutions, multiple different carriers to transport those patients. All of them were very responsive to us, but it was a matter of getting them lined up with us.

One of the things that, into this, that we decided was that we really were going to have to make some decisions and take the ball and run with it. In choosing to transfer our patients, we lined up the transport and got them out.

Mr. WHITFIELD. Now, did I understand you to say that, if you do not receive financial assistance within 7 to 10 days, that you will have to close the hospital?

Mr. PETERS. I didn't say that. What I did was say that each day us and the other two hospitals are losing significant dollars. There's a point that we all reach in the near time where we have to reassess services and how fully staffed we're going to be. To give you an example, we have a 450-bed hospital. Usually, we'll have about 400 patients in beds. Since the storm—we started the storm at 300—we dropped to about 150. So we're running, if I do my math correctly, about a third capacity.

We will be forced to quickly, as the other hospitals look at overhead, look at all the things that go into make our facility what it

is and maybe have to make some hard choices. The problem with this is that once we start doing that, those health care workers that have other alternatives will leave the area. When the anticipated and almost certain influx of needs occur, then we're all going to find ourselves to be short-staffed, to not have capacity. And what really, frankly, is at risk is we'll then have the second evacuation of patients from the greater New Orleans area.

Mr. WHITFIELD. Congress has passed two supplemental appropriation bills in the amount of about \$62 billion to FEMA to assist. Have you all been in discussions with FEMA about interim funding or assistance in funding?

Mr. PETERS. We've spent this week discussing this issue because it's so important to the three hospitals. We have talked directly with FEMA, and first off, I would say it is very complicated for us to understand, but our understanding is that there are certain regulations where FEMA can spend its money on the housing issue and for any damages done to our facilities, building damages, of which we all have, but those are not the issues at hand for us. We're talking about operational funds.

Mr. WHITFIELD. You need payroll.

Mr. PETERS. We need payroll. There have been some suggestions of maybe there are ways to quickly alter some of the regulations of what FEMA can be supportive of.

Mr. WHITFIELD. Is that what you were referring to in your testimony this morning when you said we need some regulations changed?

Mr. PETERS. Those regulations that I was talking about have to do with the support of the private practice of medicine. Today, as a hospital, I can do very little for a practicing physician because there is a suspicion that I'm going to induce him to send patients to me. What we're asking in these unusual times is a relaxation of things such as helping with their staffing, helping with rent and with areas of need, especially in primary care, direct financial assistance for a period of time to allow recovery. Also selected specialties, which are very important, because everyone has issues with recruiting.

New Orleans especially is not an easy place to recruit people to. The cost to all of us to try to replace rather than to retain what we have is markedly different. That goes for hospitals also.

Mr. WHITFIELD. Thank you, Dr. Peters.

My time has expired. At this time, I'll recognize the gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Dr. Peters, you have heard us talk today about the Baucus-Grassley bill, which would make Louisiana people immediately eligible for Medicaid, and therefore, you'd have a flow of dollars coming in. Would that be of help to you, or is that too slow, too late? I understand what you mean about if you don't get geared, you're going to lose your hospital and doctors are going to be gone. You're never going to come back.

Mr. PETERS. I separate it into both short-term and long-term issues. I think there have been a lot of very positive funding issues, whether it be Medicaid, whether looking at Medicare for a while with something like a critical access designation that gets hospitals, more temporarily, to a cost base reimbursement.

All of those help us, but also, right now, today, even if the 150 patients that we have in the hospital were Medicaid, we still don't have the revenue coming in that support the operation, and that is true of our hospital and the other two. We're in this trough, and it's hard to judge when the trough ends because of the influx of patients coming back. We anticipate by wintertime part of that trough is going to be gone. So we're looking at a window of support to get us through that time.

Mr. STUPAK. Any suggestions you'd have? You mentioned a couple of them, some of the waivers. We'd like to see it. I've been on health care for, what, 12 years now. Some of us are very interested in that area.

With Hurricane Katrina, we saw—I want to ask about the first responder communication, because I've been on this issue for years, ever since September 11. Being a police officer, I've seen it for decades. After every major event like this occurs, the President and everyone says, we're going to get all this communication stuff for first responders. That will last for about 1 year, never address it, even though we've had legislation for years and can never seem to get a hearing on it. Maybe one of these days we will.

But the frustration in the faces of medical professionals who did not have communications, couldn't save lives, they certainly deserve our gratitude, but you also deserve our help and a better communication system. And I was listening to your testimony, and in there, you say that an alternative reliable communications service must be in place so that public officials, first responders and the health care community can firstly communicate their need situations and availability to assist.

Can you please expand on this based upon your most recent experience? And do you have some specific recommendations about equipment and planning? Just explain the need for communications for us and then why it's so critical when you lose it.

Mr. PETERS. It's critical because, as we all dealt with this storm and any other disaster, any time you become isolated, you don't have all the facts to make your decisions. All of the planning for disasters involve a team approach. It's not just East Jefferson, not Charity Hospital; it's everybody being involved. And there is a plan in place. Along with that, there are always curve balls that happen, things that you do not anticipate. The security issue, which became a huge issue in this subject, the lack of communication, lack of awareness of what was going on, and just the unknown fear created apprehension within our hospital.

I think the most difficult day we had at East Jefferson was the Thursday after the storm when there was a lot of stories about what was going on, that our hospital was at risk for violence, and our staff and both physicians and nurses were very appropriately scared. I think that was the most difficult to hold it together. If we would have had more information, been able to communicate more effectively, I think it would have made that markedly diminished.

I'm not a communications expert. I don't have the solutions, but it also is very amazing how we all have become dependent on cell phones, and the cell phones were gone. I've heard people talk about ways to put up temporary towers. Again, this is way beyond my ex-

expertise, but the lack of that creates some significant holes; it really does. It allows for, I think, the lack of coordination of effort.

Mr. STUPAK. Had there been any effort to put an alternative communications system in New Orleans prior to Katrina?

Mr. PETERS. Not that I'm aware of.

Mr. STUPAK. Mr. Cappiello, hopefully, I said that right. I'd like to ask you about your accreditation standards for emergency communications. You said in your statement that the organization went through a 5-year process to update the emergency preparedness standards in 2003. I'd like to know if the emergency telecommunications infrastructure is a criteria for hospital and other health facility infrastructure accreditation today.

Mr. CAPPIELLO. Thank you for that question. One of the things that our standards does address, it says that communication is a key component to planning and recovery from disasters. The standard, because the standard must apply to every hospital and every community in the United States, it is not specific. So the standard does not say that the standard must have—to meet the standard for communication, you must have 800 megahertz radios, for instance. We don't go that far. What we do say is, you need to look at your community, plan with the community and develop communications networks within the community that will stand up and be viable at the time of disaster.

The reality is that some communities are simply not there. They just don't have the capacity and the ability to do that.

Mr. STUPAK. When you do your accreditation of hospitals, do you score them on that?

Mr. CAPPIELLO. What we ask is that—the standard looks for an emergency management plan that is robust, that is exercised, that is planned for, that engages not just that particular facility but sister facilities; that there's planning within the community and that there is contact between the hospitals and their community as they develop their emergency management plans.

One of the requirements of that plan is certainly the ability to communicate. So we say that in your emergency preparedness planning, there must be thought given to and dialog with the community about how to communicate.

Mr. WHITFIELD. The gentleman's time has expired.

When you all were giving your testimony, I was pretty lenient, and I allowed everyone to go 2 and even 3 minutes over the 5 minutes. I'm going to try to get through a 5-minute opening, 5-minute questions from every member because we're going to be voting soon. And then those who are interested, I hope you would have time that, if we want a second round, we have an opportunity to do that.

At this time, I recognize the gentleman from Georgia, Mr. Deal.

Mr. DEAL. Thank you.

First of all, Mr. Dufour, I want to thank you for your efforts, your cooperation efforts, the efforts of the chain drug stores, of the private pharmacy community druggists and so forth and the pharmaceutical industry for the cooperation that you have outlined. I think it is truly one of the nongovernmental participatory efforts that have been a true success in this emergency. I just simply wanted to say thank you for that.

Let me hit a couple of other topics right quickly. Mr. Simmons, you indicated that currently the Federal Tort Claims Act, as I understood your testimony, would not provide protection under it for your providers if they provided services off the site. That is my understanding.

Mr. SIMMONS. Off site and across State lines where it's not my facility doing it, it is facility specific. The facility is deemed and the provider is contracted with the facility. Therefore, the coverage goes with the provider and the facility. In an emergency, if a facility in Ohio wanted to send a provider team, mobile van or just providers down to the Gulf Coast of Mississippi, there were questions and roadblocks as to whether or not they were covered under Federal Torts Claims.

Mr. DEAL. A community health center employee from one State could not go to a community health center in another State and still have that Federal Tort Claims protection. That is what I'm understanding, or it's questionable.

Mr. SIMMONS. It is questionable.

Mr. DEAL. We need to straighten that out.

Mr. SIMMONS. The main issue is: Is it going to a shelter or—

Mr. DEAL. I got you. Off-site from a community facility itself. I got you. Let me explore, because I think we've had two other witnesses, Ms. Blakeney, you alluded to it, and I think you called it the need for a seamless transfer of licensure or words to that effect. Let me ask you and Dr. Hoven in that regard, from your two professional points of view, we've heard the doctor talk about the Federal certification process. That seemed a little bit slow and cumbersome to me, quite frankly, and we do need, if that's the route we're going, we need to ramp that up in terms of the numbers of individuals pre-licensure, pre-certification so that we don't have to do it after the emergency and then cope with everything else that's going on.

With regard to transfer and recognition of licensure, normally licensure is something that is a State prerogative through your State medical boards, et cetera. Are there reciprocity agreements among certain States to allow that? And if not, is that an area that your associations could explore, even if it were not a carte blanche recognition, to allow, through a reciprocity agreement, through the States, in a time of crisis, that this could be done? Both of you or either of you.

Ms. BLAKENEY. Thank you, Congressman. It is a State authorization for licensure. What happens when a professional whose license is Federalized, as long as they have a valid license in one State, because they've been Federalized, they can move freely to provide services as long as they're working within that construct of Federalization. Where we get into difficulty is with people who have not gone through that process prior to the event occurring, so there's not a data base that people have not already submitted their paperwork and had all of that done.

With the National Nurse Response Team, the 700 nurses who participated in that have completed that process and are available to be activated by the Federal Government. Volunteers going through the Red Cross, volunteers going through church groups or through individual activities have to go through their individual—

move from their State, the affected State, and be approved in that affected State. Even though we all take the same licensing examination, the accreditation process within that State varies enough so that the State board has to individually look at each one of those candidates.

Mr. DEAL. So that's still a problem then.

Ms. BLAKENEY. It is.

Mr. DEAL. Dr. Hoven?

Mr. HOVEN. Thank you. The AMA has particularly been concerned about this and has been working with the States that have been involved to do credential verification to expedite that in order to enable these physicians to participate in care. The AMA's master file, for example, has track of all the physicians since 1906 and can do primary source credentialing on all training, practice, et cetera, so it provides a very useful tool to be used in this particular setting.

Mr. DEAL. Thank you. My time is about out. Thank you. I would encourage everyone to work in that regard.

Very quickly, Mr. Cappiello, I would wonder when you made the statement in response to the earlier question about communications that your standards have to be basically one size fits all, everybody has to have the same standards. I would simply ask, in your accreditation, it would seem to me that we all ought to say that there needs to be specialized criteria for those who are in harms' way or known harms' way, previous hurricanes, previous flooding; it would seem to me not only in the communications arena but also in the construction of the facility itself. We've heard about, why is the operating room not on the second floor rather than the first floor?

I know I don't have time for a response, but I would tell you that I would be concerned that certification organizations ought to be looking at differentiating and not just have a one-size-fits-all.

Thank you, Mr. Chairman.

Mr. WHITFIELD. At this time, we recognize Mrs. Capps.

Mrs. CAPPS. Thank you, Mr. Chairman.

Ms. Blakeney, there are over 2 million registered nurses in this country. You are the president of the American Nurses Association, by far the largest organization of the nurses, and I'm one of your proud members. So, today, in your testimony, you're really speaking on behalf of a profession deeply engaged in the delivery of health care services in this country. In fact, when we think about federally funded health programs, which Medicaid is one, and we think of who provides care for all of the people enrolled in Federal programs, it's the nurses across the land. And so you have credentials to speak on the topics that we're addressing today.

And I know you also mentioned that you carry in your heart the stories of the nurses who are serving as we speak in difficult situations responding to this disaster, those that are Federalized and those that are frustrated because they're not, and the myriad of ways that nurses are engaged in addressing this situation that we have and also the underlying needs of those who do not have access to health care.

Now, I want to focus if I could on a bill that Senators Baucus and Grassley have introduced, Senate Bill 1716, that would provide

immediate federally funded medical assistance through Medicaid for Katrina survivors. States hosting Katrina survivors could cover all low-income individuals, not just those who would ordinarily be eligible for Medicaid, like pregnant women or children. This bill would ensure that the sick could quickly access, no matter where they are, health care treatments and wouldn't be delayed due to lack of insurance coverage. I know that several of the organizations represented on this panel have supported that bill, and you have indicated the American Nurses Association also supports it and supports full Federal funding for it.

I wonder if you would expand on the reasons for that and if you would also like to further—at the end of your testimony, you mentioned your deep concern in your organization about proposed cuts to Medicaid. And if you'd like to have that be part of your answer as well.

Ms. BLAKENEY. Thank you, Congresswoman, for the question.

It is important that we be able to move quickly to provide care regardless of where the victims of the hurricane end up, both in the short term and in the long term. That needs to occur as seamlessly as we can possibly make it happen, and obviously, there has to be financing to support that. So anything we can do to relieve States of the additional burden that they carry because they have been hosts for these individuals, needs to occur. So in the short term, it's an important step to take. In the long term, I think we have to acknowledge and recognize that the people who have been displaced, the providers who have been displaced, the infrastructure that has been destroyed is going to take a very, very long time to reestablish. Some of it can happen very quickly, and it will look as though, fine, we're okay, we can move on. But the bottom line is, medical records are gone forever. Rebuilding peoples' health care histories, rebuilding their pharmacy histories, understanding what their needs are, are going to take a very, very long time.

The bottom line is that it's going to take the region years to recover from this both economically and from every other component of societal thought and concern. So the long term investment needs to be there. We cannot afford to expect an infrastructure to respond effectively to a crisis and a surge capacity if it can't respond to its day-to-day needs. The bottom line is, as a provider of health care, as an individual who represents nurses who are so frustrated, they're leaving, that they're crying at the end of their shifts because they can't provide the kind of care that they need, to say to them, okay, now on a faulty infrastructure that's barely standing, we want you to surge to a new capacity, and yet they manage to do it for the short term. We've heard the stories. We know that.

So the question is, how long can we ask a system that's crippled to be able to surge? We can't. It's not realistic. It's not possible. And to then turn around and blame the system for not being able to respond when the system has been terribly under-supported is just not fair.

Mrs. CAPPS. So we need to do, and I heard this in your presentation, we need to do several things at the same time. That's not easy to do.

Do you want to, just a few seconds left, go No. 1, No. 2, No. 3 in prioritizing, the triaging, if you will?

Ms. BLAKENEY. We have to fund the surge capacity that's needed right now. We need to make sure the people who have dispersed all over the south and other parts of the country seamlessly can access care, No. 1. No. 2, we need to look to rebuild a structure that has been harmed and the locations that it's been harmed in. And No. 3, we need to take a very, very hard look at the harm that's been done to the health care system over these last couple of decades, and we need to fix it. We need to re-prioritize where health care goes. We need to focus on primary prevention and secondary prevention. We need take a look at preventing the things causing harm.

In this country today, almost 50 percent of the health care burden is carried by chronic diseases, chronic diseases that are preventable or delayable. If we could delay the onset of diabetes for 5 years, billions of dollars would be saved. Those are the kinds of things we need to think about simultaneously. And you're right, it will not be easy. But if we don't do it now, it will be later. We have children with hypertension—children with hypertension. We have children developing type 2 diabetes. The cost of that alone is huge. We've got to turn our focus as much on prevention as we do on acute care because it will be expensive. It'll be a whole lot more expensive later on. We're going to have people dying young, not old.

Mr. WHITFIELD. The gentleman from Illinois.

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

This has been a great panel, and I want to appreciate all your testimony. There's really so much there that you just can't get a handle on. It's a big disaster in so many different arenas. I'll try to run through a couple of things.

First of all, one of the most frustrating things about health care is the payment scheme or the lack thereof and the cost shifting, and I think that's talking to part of the preliminary problem. I wouldn't totally just disregard reform because, in the debate, Ms. Blakeney, as you just mentioned, that if we reform our entitlement health care programs that are designed primarily to do the amputations from diabetes instead of initial diabetes screening and care—that's our current system right now. So reform would be, let's do preventive care.

In the Medicare reform bill, the Welcome to Medicare screening, which was never done before, is an attempt to start caring for people and managing their health instead of just doing the catastrophic emergency operations. People still flock to the United States because it has the best health care system in the world. We have a funding issue, and it's really tied to this, though, because if we talk about—with my military background, the military has been trying to go digital with dog tags. Now this would address records, the medical records for our soldiers. Because this is the same issue, what happens on the battlefield, what if there's a catastrophe, the guy can't talk, you can't get his papers out in the mountains of Afghanistan? So you put him on a digital dog tag. And with a catastrophe this size, that's kind of what we're talking about, or having a stockpile of digital records somewhere or dispersed in different areas so when the individuals comes in, if they can speak and give you some identification, maybe it's biometric. I mean, we will have constitutional debates over who keeps digital

records, how they're stored, who can access, but that's kind of one of the major hurdles that we're facing. When people are displaced to the Superdome, and they say, I need a drug, I'm taking a drug, I don't know what it is though, it's a little green pill, I've been taking it for 3 years, I don't really remember the name anymore.

So I don't know how to solve that. But these are the debates that we have to have and start thinking outside the box. I live in Illinois, along the Mississippi River, the New Madrid fault has been a concern forever until it breaks again, and then we're going to have a catastrophe like this.

I've been talking to my community about this sister city relationship that they ought to develop more extensive, not, hi, I'm your mayor, you're the mayor, let's shake hands and here's the key to the city, but also go across State lines to do mutual supporting operations.

And I'm wondering if the hospital association is now looking at sister hospital relationships out of region, like Louisiana hospital marrying up with a hospital in Virginia or one in Illinois, or maybe for Illinois, we would have to look at, if my communities wanted a sister city relationship that would do mutual support, maybe fire-fighters, policing and stuff if the New Madrid fault broke, they'd have to go to Indiana, they may do one with a city in Missouri, but if the bridges are all down, it doesn't help.

So I think we have to also think in that vein. I also wanted to mention, on the communications issue, because the telecom subcommittee has been working on this, what the first responders need is, we need the 7 megahertz band. That's what our digital transition bill is all about. This will just add fuel to the fire to make sure that that's moved so that it's not—they need more space to be able to communicate across the lines.

We have—I'm going to finish on this. I think that this country, because of the health funding issue—I'm not a one-payer guy, I don't believe in national health care delivered by the Federal Government, because we know how well the government provides services. I'm not sold on it. But I do think it's time for us to debate—like other industrialized nations making sure that everyone has access to some type of health insurance policy. I think that addresses a lot of the crises of portability of records. It may be a critical care model, but even the industrialized nations that have national health care, many of their models are insurance projects. They'll give their citizens three or four choices of different insurance products that would be portable based upon the event if there were truly a national policy. So we're working on it.

Thank you. Although I didn't ask any questions, you spurred a lot of, obviously, thoughts in my mind, and I appreciate it. I yield back, Mr. Chairman.

Mr. WHITFIELD. Thank you.

At this time, the gentleman from Illinois, Mr. Rush, is recognized for 5 minutes.

Mr. RUSH. Thank you, Mr. Chairman.

Mr. Chairman, I really want to congratulate the chairman of the committee for—and I want to thank him for bringing Dr. Simmons in as a part of this hearing because I know that, in my district and other similar districts throughout the nation, community health

clinics are really indeed on the front line, in the trenches along with hospitals, but I think that there is a place, a vital role that community health clinics play in the delivery of health care. And if there is one thing that we all can agree on as a result of what happened in Louisiana with Hurricane Katrina, that is that there is a segment of our society that is invisible, that just is very much in need but because they don't have a particular voice as a group. They are not heard by many of policymakers, including Members of Congress, and so their needs are mostly unmet.

First of all, I have a couple of questions, and before I return to this theme, I want to ask I think Dr. Kirsch, if I'm not mistaken, Dr. Kirsch, I want to ask, at a meeting, a breakfast meeting that the Congressional Black Caucus had with the president of the American Red Cross, specifically in the aftermath of Katrina and days immediately following, the question was put to her, why did the Red Cross hesitate to go into New Orleans? They were out on the outskirts for a couple of days, 2 or 3 days, but they didn't go in. And she said that they didn't go in because of the Governor's refusal to allow them to go in.

I just wanted to concur, is that a statement that you would make for the record?

Mr. KIRSCH. She knows better than I do, but I can tell you that the primary mission of us is to create shelters in safe environments. That was my mission, to make sure the environments were safe. And if there is any question of environmental or any other type of safety, the Red Cross will not establish shelters in those areas. We usually defer to the State or local officials to make that determination, in fact, now working with the State public health department in Louisiana to look for sites to go back into just prior to the evacuation.

Mr. RUSH. So was the appearance of the unsafeness of the area, was that instability caused by the flood or was that the threat of so-called—so-called threat of violence? Which one?

Mr. KIRSCH. There are many factors that go into safety from my point of view. Being a public health official, my concerns were always based on the multiple warnings coming out from State officials about contamination and don't get people in there and let's get everyone out. So the directive was to move as many people out. And I believe, I'm not privy to the ultimate decisions made by the Red Cross leadership, but I believe that was the primary reason.

Mr. RUSH. Mr. Chairman, I believe, and witnesses, I believe that our public health system in this country was stretched almost too thin anyway prior to Katrina as it relates to poor people. And I just would like to ask, Mr. Simmons, in these few seconds that I have left, can you express your opinion about the health care delivery system as it relates to poor people now and how that played into New Orleans and the catastrophe at New Orleans?

Mr. SIMMONS. If I may speak personally as a health care provider and not necessarily speaking for the national association as its chair, I know it is our job to try to assure that patients don't fall through the cracks, so they depend on community health centers to maneuver the waters and all the bureaucratic red tape to assure they get care. One of the reasons we indicated our concern that health centers be involved as part of first responders is be-

cause the population is used to going to that location, asking those people to help them, assist them with whatever. I am also convinced that a large majority of the population that was in the Superdome and the Convention Center were patients of the community health care system in the city of New Orleans. It is stretched, and it is frayed, and there has been tons of money—well, not tons, lots of money placed into the community health center appropriation line, and we need that, but we have to look at what is happening to the existing infrastructure and demands placed on health centers.

Mr. WHITFIELD. The gentleman's time has expired.

Recognize the gentleman from Texas, Dr. Burgess, for 5 minutes.

Mr. BURGESS. Dr. Simmons, let's continue along the line that Mr. Rush was just asking about. If the health care delivery system for disadvantaged individuals, presumably your community health care center is the model for the sort of the provider of last resort, how many people across the country are cared for in community health centers as their only source of care?

Mr. SIMMONS. I can't tell you the exact number of how many as their only source of care. I can tell you, as of the UDS reports as of 2004, about 15 million people were served across the country.

Mr. BURGESS. Fifty or fifteen?

Mr. SIMMONS. Fifteen million.

Mr. BURGESS. I know when Secretary Levitt was down in Dallas visiting one of the shelters, he maintained that one of his visions was to—I don't think he used the word, the adverb, maybe I wish he had, but to expand the community health centers in areas that previously may not have had them in order to provide ongoing care because we have a number of individuals, the Mayor of Fort Worth calls them guests, but I believe they're going to be residents of our city, that previously received their care at a community health care center and may well need to—we have parts of the city that historically are poor but don't have a community health center available to them. We do have the Tarrant County Hospital District not too far away, but one of the things that's impressed upon me in my few years in this job is: Access is one thing; utilization is another. And the community health center has an advantage in that it is in the neighborhood and visible, and hence, utilization tends to go up.

Do you have any thoughts on that? Do you think that was a genuine expression that Secretary Levitt made that we're perhaps going to see the expansion of community health care centers as a consequence of Project Katrina?

Mr. SIMMONS. I'm not going to try to speak for the Secretary, but I will tell you, the National Association of Community Health Centers supports the President's expansion for community health senior centers across the country. One of the reasons is because we're sure, to the best extent of our ability, that no one falls through the cracks.

Mr. BURGESS. This is one member who will work with you to see that the President is true to his word, and the Secretary as well.

Our representative from the Joint Commission of Hospitals, Mr. Cappiello, you heard, if you were here during the early part of the day, the anxiety and angst in my voice about hospital generators being located in the basement. We learned that lesson with Trop-

ical Storm Allison in Houston and those very dramatic stories of residents carrying patients on a ventilator down a staircase to get to an ambulance. I know it's not the Joint Commission's job to site those generators when the hospital is built, but surely it's your job when you come in and inspect the hospital and certify it as functional and safe, that its emergency equipment, i.e. A generator, is it going to be one of the first casualties of a hard rain? Would I be wrong?

Mr. CAPPIELLO. You would be correct. I think the issue of generators is a complex one. And here is a place that perhaps the Federal Government can help. Even if you remove generators out of the basement of many of our facilities, a lot of the switching gear for that power and the power panel still resides in the basement or in susceptible floors. Now my background is not that of an engineer, but I understand that even if you move the generator but the sources of going from the generator into the hospital still flow through those bottom floors, you still have the same problem. So the generator is dry, but it shorts out for other reasons.

Mr. BURGESS. I'm a simple country doctor, but surely someone is smart enough to pick that out, particularly in hospitals that live in coastal areas where flooding is a way of life. It's happened in Houston before. I pray that it doesn't happen Saturday morning, that we hear the same stories all over again in the hospitals in Houston. Again, I pledge to work with you. I'm not trying to be antagonistic about this, but we can't keep learning this same lesson over and over again.

Mr. CAPPIELLO. I could not agree more. I guess I started out just giving that as a little explanation that the problem is not just generators alone, but it's a bigger problem. So you have to look at this problem in its whole, not just in its exponent part. The problem is, if you go back and you look at many of these facilities that may be as old as old Hill-Burton facilities and the generators were built down there in those basements, the replacement, the capital expenditure to move generators and replace generators is quite enormous. And many of the hospitals in the United States are sort of on the financial edge. And to layer on a requirement to do a fairly significant, for some of these facilities, project at great expense, I think that if you're going to ask that—and I think it's the right thing to do—I think there needs to be some support to do that.

Mr. BURGESS. I wouldn't completely rule that out, but you hold a lot of power in your hands. I know from my days that I spent in the hospitals that if you give someone, I forget whether it's a 1 or 5 or whatever, I mean, they respond. And I've seen private for-profit hospitals pay a great deal of money to overcome those deficiencies.

Mr. WHITFIELD. The gentleman's time has expired.

The gentleman from Pennsylvania is recognize for 5 minutes.

Mr. PITTS. Mr. Chairman, I yield my time to Dr. Burgess.

Mr. BURGESS. I thank the gentleman.

Dr. Peters, I apologize, I wasn't here when you gave your testimony. Dr. McLennan, I was chairing a meeting he was speaking at along the lines of preventive care. He was telling a good story from the perspective of one person at the table.

Dr. Peters, I know you had a week that you would hope to soon not ever replicate. Can you tell us a little bit about what happened to you and your group at the East Jefferson Hospital during Katrina?

Mr. PETERS. Sure. We geared up for the storm per our plan, brought staff in, both medical staff and our hospital staff. Issues that we dealt with were the communication issues, a sense of isolation of not being able to effectively communicate with the outside world. We dealt with power issues. Our generators fortunately are 12 feet up, and we were able to keep going, although even with that, we had to conserve energy; no air conditioning, which put some demands on patients, and we had to be very careful with that.

Security was probably the third component that caused a lot of issues. As I mentioned before, I think that that was probably the biggest difficulty that we had, the perception that we were at risk. Fortunately, we never really had violence on our campus or close to us, but our employees heard about that, our medical staff heard about that, and fortunately for us, the National Guard, the local police responded when we were able to get in contact with them and provided good security.

So those were the three variables that I think placed a lot of demands on all the people providing the care. Fortunately for us, I'm able to say we did not lose a patient; a patient did not die that we would attribute to the storm, and I think that that's a lot of good work that people did.

Mr. BURGESS. I would agree very much with that statement. Did you ever feel that it was hard for help to get in to you? Clearly, you have got a generator that's not going to go out, but it's only designed to get you through a period of power outage, not meant to be your main source of power from then on. So the evacuation, were there impediments to the evacuation that were encountered afterwards?

Mr. PETERS. As far as the generator goes, we did have concerns. And there were a few days there that just getting the diesel fuel to continue the generators got to be a little bit dicey. We had to search in multiple different directions. Some of our Jefferson Parish officials helped us with that. I think that it makes you look at things differently, and constantly it caused us to reassess, and like a lot of things in life, you weigh the risks of whether something is going to happen or not going to happen.

And just the balance of that with trying to decide whether to transfer patients or not 2 or 3 days into it, you know, what are the odds of that generator going down and what is going to happen to those patients that are there? And I personally think there are no right or wrong answers, it's a matter of judgment and leadership and making the calls and moving on. Mr. BURGESS. Well, I just have to tell you from my perspective, probably some 400 miles west, I got a call in the middle of a night from a mayor who said, you're a Congressman but you're also a doctor, and I've got have a friend of a friend of a friend who is having trouble getting a patient out of the hospital. And I said, come on, it's midnight, there's nothing I can do. The next morning I thought, well, maybe I should at least call this friend of a friend of a friend, and I did.

And as the story unfolded, what he reported to me was actually accurate, that there was a hospital, a specialty hospital that maintained patients on a ventilator, and they couldn't get their patients out; the ambulances had been stopped at the gate—I don't know where the gate was. And indeed when I talked to this person I said, well, where are the patients now if they're not in the hospital; and she said they're at the corner of I-10 and the causeway. And I said what building is that? And she said, well, it's just the corner of I-10 and the causeway. And I said, ma'am, you mean to tell me you've got patients on the medium? And she said, no, they're on the side of the road. Well, it turns out that was actually true, and through some phone calls we did get the ambulances in later that day.

And of course I had gotten my call at midnight, so we were easily 12 or 14 hours into that ordeal for those poor people. And then I saw the news that that they was exactly right, there were people on the side of the road on gurneys being hand ventilated. I've got to tell you, that just left me with a terrible feeling that—how poorly we were prepared, State, Federal, local. I guess this was a private hospital, so certainly they weren't prepared, though they did have the facilities to evacuate the patients, they had new facilities for them to go to, obviously it became much harder as you got 2 or 3 days into the time post hurricane than if they had transported them the Friday night before. These are just things that we've got to work on for the future.

Thank you, Mr. Chairman, for your indulgence.

Mr. WHITFIELD. Thank you, Dr. Burgess. And there's no one else to yield time to you, so—

All of us have completed one round of questions. You all have been very patient and your testimony is vitally important. And we're going to have a series of about 7 votes probably within about 10 minutes or so, so if you would remain with us, we would like to just give everybody an opportunity to ask another couple of questions, if that's okay with you all. And I will go first.

First of all, Dr. Hoven, you had mentioned in your testimony I think that the physicians and other healthcare professionals must be better trained in how to respond to disasters. Would you mind elaborating on that a little bit?

Ms. HOVEN. I would be very glad to.

Physicians are trained in the daily care of their profession in delivering healthcare, but disaster preparedness and public health preparedness are special issues; some of us are trained more than others in that area. In that light, the AMA has actually undertaken an education and training program which has been extremely well recognized and accepted, now training up to about 14,000 physicians in public health preparedness and disaster response. There are special issues. And we learned anecdotally after Katrina that, in fact, those physicians who had been trained this way, when they went in to do the work that needed to be done, actually were much more efficient. So this is something that we would encourage and continue dialog with our colleagues throughout the country on.

Mr. WHITFIELD. Thank you.

Dr. Peters, you had talked about you're losing \$500,000 a day, your hospital, and certainly fixed costs are so much, and are you

losing this money because of the lack of patient load right now?
Or—

Mr. PETERS. Yes, it's a patient load, both on an in-patient standpoint and out-patient. If you think about all the things that people access hospitals for.

We're very optimistic that that's going to return, and that's why we feel it is worthwhile in asking for those short-term assistance so we can maintain the capacity that we currently have.

Mr. WHITFIELD. Okay. And three hospitals are still in operation, or 4?

Mr. PETERS. Four; one of which is on the north shore, which received less damage.

Mr. WHITFIELD. And how many are closed, do you know?

Mr. PETERS. Eight are closed.

Mr. WHITFIELD. Okay. And Dr. Simmons, on the community health center, I know that there are some very stringent rules about using community health center money for capital projects, and I guess there's a prohibition on that. So how do you go about rebuilding this community health center?

Mr. SIMMONS. We are requesting Congress to reconsider that line or that regulation in terms of allowing 330 funds to be used for capital such that an increase in funding for that purpose, but right now we're doing the best we can. Hopefully the health center had insurance and it will pay some portion.

We also have access to file a claim with FEMA, but that's going to be after insurance does what it's going to do, if it does anything. So the facility will be down unless there is some direct grant fund or authority granted to health centers.

Mr. WHITFIELD. Thank you.

Dr. Kirsch, how would you briefly describe the medical condition of the people at the centers that you are responsible for?

Mr. KIRSCH. I think from both my indirect observations in dozens of shelters, as well as from interactions at the major emergency hospitals and the D-MAT teams, the major issues are, like everyone has mentioned, the chronic underserved population and their health needs, and the lack of prescriptions, the lack of access to medications, et cetera, was just an overwhelming program earlier. One of the D-MAT team guys complained to me that, you know, I came down here to do surgery in the field and all I've been doing is writing prescriptions for people for their blood pressure medication. But that's truly the need that we identify in the field and that's what has to be addressed.

Mr. WHITFIELD. Thank you.

Mr. Stupak.

Mr. STUPAK. Thank you.

Mr. Simmons, you mentioned, in earlier questions, that you and Dr. Peters were talking about how to keep the hospital going if you're down to one-third of your clientele, yet Secretary Leavitt and the President are saying we should have more community health centers being built, and that's going to take about 6 months. So if we don't have a population base that's strong enough to support the hospital, why put a layer of community health services on top of it, presuming you don't have enough people to support the community health centers then either at this point in time. So aren't

we really just duplicating and further driving the health delivery system further into bankruptcy in the New Orleans area? Sure, Dr. Peterson.

Mr. PETERS. I think one of the things that has happened—which is very unfortunate, obviously, of this storm—but it is an opportunity to really ask the questions, what does the system and the region need to move forward. And I think a knee jerk replace everything that was there before, at least the questions should be asked. You know, we're talking about three facilities that are currently in operation. We anticipate, with the influx of people coming in, that on the in-patient hospital side there will probably be capacity issues, not enough beds 6 months out. So the question has to be, well, should all hospitals that were damaged have a lot of dollars put into them to rebuild? And how is the general population best served?

Our Governor, when she was elected, had a healthcare task force 2 years ago, had a lot of experts come in and really were very, very supportive of everything that has been mentioned there, preventative care, community clinics, to move away from just sick care. A combination of that with using existing facilities, looking at where the holes are graphically I think is what needs to be done at this point without just repeating the past.

Mr. STUPAK. It reminds me a little bit like those debit cards, we gave everyone \$2,000 and everybody was just standing in line changing. We needed more and more debit cards, not even knowing if the people who were supposed to get them were getting them. And I don't want to see that continue to happen, especially in healthcare, it's an issue near and dear to my heart. And community health centers I have in my district, I support them, I will do everything I can to help the qualified clinics, but I just don't think we start throwing more stuff into New Orleans without really understanding what's going on.

So in the meantime, in the 6-month period then what do we do? I asked about the Baucus bill and the Grassley-Baucus bill, how do you get those services back, keep you afloat, but provide service to the constituency that's there until we get that built up, it's going to take at least another 6 months?

Mr. PETERS. When I talked about the other facilities that are currently not open, I think there's efforts for them to gradually reopen, but probably not to the same scope that they were before. So if we have several out-patient facilities and an emergency room in Orleans Parish, that's a start, it's a start providing those initial care for those patients.

The three hospitals have made a commitment that we're going to step up for the hospitalization of those patients in Orleans Parish. I think working with some of the existing physicians, some of the academic centers, I think some unique things could be put together to serve that ambulatory population.

Mr. STUPAK. Mr. Simmons, do you care to comment at all on this?

Mr. SIMMONS. Thank you, sir. Most of the population that has been evacuated from New Orleans, that burden has become on now other community health centers because it is a natural thing for a person to look for the system of care that they've been usually get-

ting their care. One of the reasons we're talking about now providers and the funds being available to health centers for the increased burden.

It is also a need for health centers in the area to be able to be—if the population is underserved, I'm not sure where the underserved population is going now in the city of New Orleans, with the health center service, in our opinion, totally destroyed. And most of the care probably is at the Charity and Tulane and some of the academic health centers in the area. There is a need for mobile or some type of medical service that will address the returning evacuees that are going back there to take those jobs in the service industry and other places.

We do want to commend Secretary Leavitt, they have moved up funding for the December 1 round of 330 health centers that was going to receive funding, and in the affected States they can begin to expand and do some things, but it doesn't address the issue, Chairman Whitfield, in regards to capital and facilitator issues.

Mr. STUPAK. Thank you, Doctor.

Mr. WHITFIELD. The gentlelady from Tennessee, Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I want to thank all of you for your patience today. And I want to thank you for continuing to serve constituencies. We have gone through Katrina and look at Rita. And I had had some questions for Dr. Gerberding when we did panel No. 1, and I want to continue in that vein.

We talked a little bit about CDC and the strategy that they felt was necessary, going through exercises, that they had learned a lot from the way the military approached this, and in the same vein I—and Dr. Kirsch and Dr. Peters, I think I'm going to address this to the two of you if I may. If I you were to look at the three things that really hampered you from doing your job after the storm hit, I would love to hear those. Now I'm not talking about disaster-related, I'm talking about the rules and regulations, the poor communication, the lack of coordination, all of those things that we heard either through many of your opening statements or through the questioning that has taken place in this committee today.

And Dr. Kirsch, if you will go first.

Mr. KIRSCH. I'm betting we're going to agree without prearranging.

I think the No. 1 problem that everyone faced in this disaster, from Red Cross to the hospitals to providers is the communication was essentially gone. I was there 4 days after the event and remained there for a week after that, and the cell phones in the more distant areas were not available, and the land lines were not available, and there were no radios and no SAT phones. And so I think by far and away the No. 1 issue is communications.

The second one that was an early problem, which I think was relatively rapidly resolved, was logistics. I have to compliment Wal-Mart because I was fascinated to go to these small towns and find the Wal-Mart stores open, and Red Cross volunteers going to Wal-Marts and getting baskets full of supplies for their shelters and stuff. So logistics is another tremendous issue that has to be addressed, and I think coordinating with private industry is an excellent way to address that.

The third issue is, I do believe, interagency coordination, although it was pretty good at the EOC level and the two States, I don't think it was perfect. And there was this tremendous lack of coordination of actual health delivery. And like I said, they had all these voluntary doctors wandering around with limited direction, and I think they need to have a better handle on that.

Mrs. BLACKBURN. Okay, thank you.

Dr. Peters, do you have anything to add to that?

Mr. PETERS. Two things that I would say. I would put security on my list because I think that, both for the facilities and the people out in the field, it created issues. Our ambulances didn't run at night for a while because of concerns and fear. And I would guess and almost certain that has had some impact on healthcare in our community. I think coordination of efforts.

And I just did want to say that about 5 or 6 days into this, HHS organized a daily working group of which—the three hospitals, and then started with gradually pulled in CDC multiple other people so now that group is very big and continues to meet every morning at nine o'clock. And the first 4 or 5 days there were a lot of issues with lack of coordination of efforts, well-meaning people that were crossing paths. And I think that effort, although everything is not perfect, has given us all a great benefit that at least the people are talking to each other, we are understanding in, I think, a more teamwork approach to things.

Mrs. BLACKBURN. Okay. Thank you.

Mr. WHITFIELD. The gentlelady's time is expired.

We recognize the gentlelady from California, Ms. Capps.

Mrs. CAPPS. Thank you again, Mr. Chairman.

During my first round, I used the bill in the Senate introduced by Senator Grassley and Baucus and focused on one witness to expand on support or not support for it, and now I want to use this time, at least part of it, to get a quick answer from some of the others of you whose organizations have made some statements so that we can have that for the record.

Dr. Mark Peters, the American Hospital Association letter that I have here States AHA's support for this legislation, stating in the letter that AHA believes it is critical that any healthcare coverage provided to survivors in Katrina must follow them wherever their journey for temporary or permanent housing and work may take them. Do you also support 100 percent Federal funding for low-income hurricane evacuees through Medicaid in the devastated States as this bill does?

Mr. PETERS. Yes.

Mrs. CAPPS. All right. Thank you. I think, Dr. Kirsch, the same, the American Red Cross is on board in support of the Grassley-Baucus bill. The letter from your organization States that, quote, as our Nation faces the challenging task of ensuring that the victims of Hurricane Katrina receive care and compassion and support needed to reconstruct their lives, legislation such as this Senate bill helps to ensure that their healthcare needs will be met. And this is something that you also support?

Mr. KIRSCH. If my president supports it, I certainly support it.

Mrs. CAPPS. A true team player.

Also, Dr. Simmons, the national Association of Community Health Centers supports Senate bill 1716, and I won't read the quote from your letter, it's a similar kind of quote. Do you—maybe I'll ask you a more targeted question, can you elaborate on what 100 percent Federal funding would mean for getting community healthcare centers back on their feet?

Mr. SIMMONS. We do support strongly the Grassley-Baucus bill. One of the things that 100 percent Federal match would do, it would eliminate things States from shying away from serving the Medicaid population because of a State matching their own individual dollars.

And in consideration also waivers; we are concerned, as community health centers, that if this bill does not provide 100 percent financing or reimbursement for Medicaid, that waivers or other means that are used—there are two services that health centers provide that will probably be eliminated, one of them is EPSDT, and the other one is the deferred—

Mrs. CAPPS. Mm-hmm.

Mr. SIMMONS [continuing]. Payment, which will severely strain or cripple the health center system.

Mrs. CAPPS. Mr. Chairman, I also want to get on record that Dr. Hoven, the AMA endorses this legislation.

Ms. HOVEN. Yes, it does. And if I might make a point here, I think we recognize strongly that the safety net is a Medicaid-driven safety net right now. And it is what you're hearing today are stories about the safety net not working, and so for that reason we speak very much in support of this.

Mrs. CAPPS. And finally, I know I'm over now, but this will make it unanimous. Mr. Dufour—I'm sorry, I don't want to interrupt you. You don't represent necessarily a service—well, yes, you do, but you are also part of the private sector. And you nodded, however, when somebody else said yes. Do you want to commit on this issue, on the Senate bill?

Mr. DUFOUR. Well, I haven't read the bill. I will agree with the fact that a lot of State budgets are stretched, they're trying to find ways to save money; and by the Federal Government stepping up and doing this it is going to help provide needed relief for the States.

Mrs. CAPPS. Makes it unanimous. Thank you very much.

Mr. WHITFIELD. Thank you.

Dr. BURGESS, you are recognized.

Mr. BURGESS. Okay. Well, since we're talking about the Grassley bill, now I am from Texas, and we took in a lot of people who were displaced, and now we've got some problems of our own coming our way. Last Friday, Secretary Leavitt created a special temporary category for Medicaid eligibility for hurricane evacuees, and these individuals do receive a full Federal match. They are not going to be burdens upon the State's match. But even more, it goes a little further, it creates an uncompensated care pool for many of those services that don't fit into traditional Medicaid or you would have to ask for a waiver to get them to fit into Medicaid.

So this seems to me—this administrative fix seems to me to be a much more logical approach rather than depending upon us to write legislation, get it through the House and the Senate, con-

ference committee, over to the President to get signed—good luck if you expect to see it before Christmas, it's probably going to hit sometime around Valentine's Day. The reality is we're already doing that, the Secretary is already doing that for Texas. And if that needs to be expanded to other places, I would encourage perhaps the Department of HHS to consider that. But the whole purpose was not to recreate a Medicaid system that may at its very core be dysfunctional, but to prevent the very costly complications of disease, many of which are absolutely preventable.

We saw the situation with the buses when they arrived in Dallas, it was simply a question of getting somebody back on their blood pressure meds who had been off for 4 days, someone who was up against probably a hospitalization or disability because of not treating their disease, folks, as they came off the bus were, are you on medication, even if they didn't know what it was, triaged over to a desk where they could be interviewed, their prescriptions written.

As the gentleman pointed out, people went down there to do surgery, but were writing prescriptions. But I've got to tell you the doctors in Dallas, Paul Peppy and Ray Fowler, did a tremendous job. Here it is Labor Day weekend, they send out a blast fax to all the doctors of the Dallas County Medical Society, 3,600 members, 800 showed up on a holiday weekend.

And we've got to figure that a quarter of them are on call anyway at other hospitals and couldn't respond. So that is tremendous response from the private sector. Stepped up, did what was necessary. Out of 17,000 patients brought to Reunion Arena, 200 were hospitalized at Parkland Hospital. 200 patients out of a pool of people who had been in the Superdome, many of them on chronic medications and hadn't taken them for 4 or 5 days, let alone all of the other horrors that they had to live with while they were inside there.

So actually, there's a situation that worked well because people were given the freedom and the flexibility to do the right thing.

And I know I haven't asked a question, Mr. Chairman, but I appreciate the extra time, I just wanted to make that point. You know, we'll do legislative fixes if we need to. Dr. Peters, if we need to roll back the star clause, I'm with you, I'll help you, but Grassley-Baucus, it's months away before you get that help. Secretary Leavitt has provided that help this week. Thank you.

Mr. WHITFIELD. Thank you, Dr. Burgess.

Mr. Rush, do you have any questions?

Mr. RUSH. Thank you, Mr. Chairman.

Ms. Blakeney, according to the Joint Commission, the affected areas in Louisiana will suffer from a shortage of doctors and nurses because they have left or are leaving for other communities. This is a segue into what I consider one of the most serious problems our public health system is confronted with across the Nation. And I think that what happened with the Katrina really kind of focuses the attention on the shortage of doctors and nurses in the underserved communities.

Could you expand upon the thought that maybe this is an opportunity for us to have some incentive programs to get doctors and nurses trained and serving in inner city areas?

Mrs. BLACKBURN. Thank you for your question, Congressman.

The fact of the matter is that if we do nothing to address the nursing shortage, we will have a shortage of about 30 percent shortage of nurses in this country by the year 2020. Funding for nursing education, funding to support nursing education, while Congress has been very kind to us and has gradually increased that line item in Title VIII for the last few years, as much as we are appreciative of that, you need to understand that it only touches the tip of the iceberg. The bottom line is to get nurses and physicians into those areas, we must first have them in the first place.

Loan forgiveness programs, the ability to support, both financially and with access to continuing education in universities in those areas, would be a great incentive to bring nurses and other clinicians back into that area. The bottom line is that it's—many of our nurses who have relocated to other areas can easily find jobs in those areas. There are shortages of nurses in Texas, Arkansas, Tennessee, all of the surrounding States. So those nurses can easily, once they have the identification and their licenses, can find those jobs. Bringing them back is going to require specific attention.

Mr. RUSH. Thank you very much.

Mr. Dufour, the remaining seconds of my time. I was reading a story in the Wall Street Journal a couple weeks ago, and it was fascinating, about Wal-Mart and how Wal-Mart was able to communicate, organize and mobilize with the divisions of the military really. Can you expound upon that briefly, what you all were able to do and why were you able to do it.

Mr. DUFOUR. Wal-Mart has an emergency operations center where someone is dedicated to that, just like as of now, folks who are in the emergency operation center are preparing for Hurricane Rita. We use our data to determine what products customers need and want in these disasters and start staging those products. Once the disaster hits, we have a lot of folks manning the phone and just a lot of coordination within the company of what the needs are. Regional vice-presidents and other folks go out to the field, assess the situation of the stores and what the needs are and communicate that back to our corporate office.

Mr. RUSH. Well, I want to just congratulate you all.

Mr. WHITFIELD. Well, I want to thank all of you for your patience; I know many of you have been here since nine o'clock this morning. Your testimony was invaluable as we look at ways to be more responsive to this disaster. I want to thank you for your dedication and commitment. And for those of you who've made specific recommendations, I want to assure you that we are going to examine that, explore that, and we my have some jurisdictional issues that will have to be addressed, but without your assistance we would be not as far along as we are now. So thank you very much, and this hearing is adjourned.

[Whereupon, at 3:26 p.m., the subcommittee was adjourned.]

