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NATIONAL
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HEALTH OFFICIALS

Statement of

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On behalf of the

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**Before the Subcommittee on Energy Policy, Natural Resources and Regulatory
Affairs and the Subcommittee on National Security, Emerging Threats and
International Affairs**

House Committee on Government Reform

**Hearing on the Homeland Security Department's Plan to Consolidate and Co-locate
Regional and Field Offices: Improving Communication and Coordination**

March 24, 2004

It is my pleasure, Chairman Ose and Chairman Shays, to address you and your colleagues today concerning the public health perspective on Santa Clara County's experience in preparing for a terrorist attack. I am honored to represent the National Association of County and City Health Officials (NACCHO), the organization representing the nation's nearly 3000 local public health departments.

The inclusion of public health in this hearing constitutes a significant and crucial paradigm shift in the perception of who is a "first responder" in a terrorist event. The integral role of public health in readiness and response activities has only begun to be recognized relatively recently—and progress varies across different states and jurisdictions. In Santa Clara County, we are proud that our public health department is one of five CDC-funded Advanced Practice Centers, which develop cutting-edge resources and technology for public health preparedness. Today I will describe Santa Clara County's successful multidisciplinary approach to terrorism preparedness and recommend that the Department of Homeland Security (DHS) promote such approaches in all its work. DHS should coordinate program policy among its directorates to promote consistently the inclusion of public health officials as first responders in all terrorism preparedness work.

In Santa Clara County, California, our multidisciplinary approach in governing our preparedness activities has evolved over the last several years. The first monies that our jurisdiction received for terrorism preparedness came out of the 1996 Nunn-Lugar-Domenici legislation that provided funds for the country's largest 120 cities. San Jose, California, which is part of Santa Clara County, was among those cities. San Jose was the first city in the nation to complete an approved preparedness plan.

Much of the focus in that initial period was preparing for an incident of chemical terrorism. The resulting plans centered on a response at the scene by highly trained fire, law enforcement and hazardous materials personnel. Public health was at the table even then because it was recognized that there is a public health role in organizing a medical response and assessing the health consequences of a chemical release. In 1999, the

specter of bioterrorism drew increased attention. As we discussed how a bio-attack might unfold, I believe it became evident to almost everyone that public health provides more than just support and input. In fact, in any covert release of a biological agent, the public health and medical community will likely be the first to recognize victims. In a bioterrorism attack, public health IS a first responder and would take a lead role as part of a joint command structure.

While I know that message has not hit home with everyone, it is an established fact in Santa Clara County. There was a time when public health would rarely have been invited to a meeting with the fire or law enforcement communities. Now we are recognized as integral partners in terrorism preparedness. Traditional first responders are well aware of the potential for biological terrorism and that public health professionals will be the experts if such an event occurs.

What spurred this collaborative environment in large part was a requirement established by the State of California concerning how localities were to decide on expenditures of federal grant money from the DHS Office of Disaster Preparedness. The State mandated the creation of a five-member approval authority in each county: the County Fire Chief, the County Sheriff, a representative of all the municipal fire chiefs in the county, a representative of all the municipal law enforcement chiefs in the county and last, but by no means least, the County Public Health Officer. In our county, this authority has established and funded a task force to focus on deployment issues, standardization of equipment, training, exercises and the very critical area of interoperability during an event.

The result of bringing these parties together at one table, focused on the goal of terrorism preparedness, is a phenomenal collaboration. Knowing and respecting one another at a personal level is invaluable. We learn not only what our various agencies are doing, but we discover where we have strengths that can help other agencies achieve their missions and where they can help us.

Additional collaboration between public health and our partners in terrorism preparedness is coordinated through what we call our “Countywide Medical Response System

(CMRS)” This is similar to the Metropolitan Medical Response System (MMRS), but altered to fit California’s county-based approach. Financial support for this activity comes to us through the Centers for Disease Control and Prevention’s (CDC) Bioterrorism State Cooperative Agreements. The blueprint for this system is a 32-page document, available on our website, that outlines our efforts to prepare for response to a disaster that has a medical/health component. It involves 11 work groups addressing topics ranging from risk communications to decontamination and personal protective equipment, from mass prophylaxis to education, training and exercises. For each of these work groups, participating agencies are identified—including fire, law enforcement, hospitals, emergency management, schools, the medical examiner, mental health services, and many others. For each of those identified partners, the blueprint enumerates a list of their responsibilities to the CMRS, as well as a list of public health commitments through the CMRS that will assist those agencies.

The CMRS project supports and strengthens the overall efforts of the approval authority’s DHS-funded activities. The CMRS has a multidisciplinary steering committee that includes representatives from law enforcement, fire, and emergency management, as well as hospital, medical, and public health personnel. One CMRS workgroup addresses the critical activity of mass prophylaxis in a bioterrorism event. We are working out an operational methodology that will enable us to deliver critical vaccines or pharmaceuticals to a county population of 1.8 million in as little as 3 days. Law enforcement and fire personnel have been assured that they will be given top priority to receive vaccines or pharmaceuticals so that they can remain safe as they do their jobs. Law enforcement personnel will assist with the security issues that will arise if mass prophylaxis is necessary.

A second workgroup is looking at isolation and quarantine, measures to prevent the spread of disease that might become necessary in an outbreak of a contagious disease such as smallpox. Law enforcement representatives have been closely involved in discussions regarding enforcement of the isolation or quarantine orders of the Health Officer and what level of force would be expected. We have begun educating leadership

in law enforcement and fire about the definitions of isolation and quarantine and under what circumstances we would be expected to invoke them.

How do we contribute to our partners' missions? One of our strengths in these collaborative efforts is serving as a resource. There are many examples I could provide, but I would like to highlight two. Even before September 11th, Santa Clara County Public Health had developed what we call our "Zebra Packet." The name comes from the old adage, "When you hear hoof beats, think horses, not zebras." Well, in light of the dangers posed by bioterrorism, we needed to draw physicians and other first responders back to the prospect of zebras in their midst. The Zebra Packets contain material on a set of identified possible bioterrorist agents, including a single laminated page that summarizes the clinical presentation of each disease and could be displayed in emergency rooms, clinics or offices. We held our first workshop in November 2000. While this resource was originally targeted for physicians, the audience was filled with other traditional first responders, including paramedics, firefighters and hazardous materials professionals. The Zebra Packet has become a model for other health departments that have developed similar materials of their own—right down to the black and white packaging—to share with their terrorism response partners.

Another resource that Santa Clara County Public Health provides is Disaster University, a learning venue designed to provide tools, knowledge, and practice in the field of public health emergencies and disaster response. While some courses offered are designed for public health staff, others are designed for the wider disaster response community including first responders, hospital staff, laboratorians, and mental health clinicians. Course work includes: HAM Radio Operations; Stress Management Strategies for Disaster Service Workers; Bio-agent Sampling and Laboratory Guidelines; Introduction to Standardized Emergency Management System (SEMS); and Psychological Implications of Weapons of Mass Destruction. Soon we will be adding a program in Forensic Epidemiology, which teaches public health and law enforcement professionals the basics of each other's fields and helps them work together in disease outbreak investigations where there may also a criminal law component, such as an anthrax outbreak.

Disaster University classes are offered in a variety of ways to reach our target audiences. In addition to classrooms, Disaster University uses satellite broadcasts and webcasts offered by our state and federal partners at the California Department of Health Services, CDC, and the Department of Homeland Security.

In recent years, and since September 11th in particular, needed money has been making its way to the state and local levels for terrorism preparedness and response activities. However, money and resources alone—although certainly necessary—will not bring a response together. Homeland security funding often focuses on the “stuff” agencies can buy: the equipment, the monitors, the vehicles, the gear. All of those items are only as good as the people that use them. Moreover, “stuff” does not buy such essential elements of preparedness as expertly staffed and coordinated surveillance systems that would detect a covert act of terrorism early, to enable a timely response.

It is imperative that funding for personnel not be restricted. People need to be hired when necessary and they need to be trained and exercised. These people—from all the different agencies to which they may belong—need to know how to work together. It isn’t an easy task—we all have our day-to-day work to tackle. But maintaining a strong commitment to ongoing preparedness is crucial. The next event will most likely not look anything like the first, but what is almost certain is that there will be another.

We believe that our progress in Santa Clara County provides important lessons for the entire nation. Terrorism preparedness requires coordination of all the first responders in a community so that they understand each other’s roles in a disaster. This is not a frill or something to think about later. It must happen now. The structures and requirements of federal homeland security grant programs should promote this, not impede it. One essential aspect of promoting coordination is always to consider public health departments first responders alongside fire, law enforcement, emergency medical personnel and emergency management, as we do in California, even though the funding streams come from different federal agencies.

We recommend that Congress and the Department of Homeland Security establish strong, clear, uniform requirements for the inclusion of local public health officials in all

federally funded terrorism preparedness planning, training and exercising. In Santa Clara County, public health is well involved in some DHS-funded programs, particularly those currently administered by the Office of Disaster Preparedness. By contrast, there is room for much greater engagement of public health in disaster planning and response programs of the Federal Emergency Management Agency (FEMA), the Transportation Security Administration (TSA), and immigration authorities. For instance, public health becomes an essential partner of airline security and border control when a threat such as Severe Acute Respiratory Syndrome (SARS) requires health screening of incoming airline passengers. Another example where public health involvement is crucial is the BioWatch program established by the DHS Science and Technology Directorate to detect airborne toxins in selected metropolitan areas. Public health agencies would be the lead responders in managing the consequences if a release of a biological or chemical agent harmful to human health is detected. Yet local public health agencies have not been consulted or fully informed, even as the BioWatch program grows.

To help achieve the full engagement of public health alongside other first responders in all homeland security work, we recommend that the Department of Homeland Security itself include public health officials among the first responder constituencies with whom it regularly consults. Collaboration among grant programs and consistent involvement of public health should start within DHS and be translated to localities through grant guidance. We have distinctive expertise that will help existing programs be more effective in protecting the health of people in local communities if a disaster occurs.

Thank you for holding this hearing and for your support of public health. I'll be happy to respond to any questions you may have.