

Robert Mauskopf

Director of Emergency Operations, Logistics and Planning in the
Emergency Preparedness and Response Program of the Virginia
Department of Health (VDH)

Testimony

Before the

**United States Senate Homeland Security &
Government Affairs Subcommittee
on Oversight of Government Management, the
Federal Workforce and the District of Columbia**

Hearing on

**“Preparing the National Capital Region for a
Pandemic”**

October 2, 2007

Pandemic Flu Preparedness in Virginia and the National Capital Region

Good morning/afternoon. I am Robert Mausekapp, Director of Emergency Operations, Logistics and Planning in the Emergency Preparedness and Response Program of the Virginia Department of Health (VDH). I will be presenting the planning activities in Virginia for a possible pandemic of influenza, as well as discussing collaboration in the National Capital Region. The three points I want to be sure to emphasize are that: 1) Virginia has undertaken extensive planning efforts for a possible pandemic of influenza or other infectious disease, though much remains to be done; 2) the three jurisdictions in the National Capital Region work closely together on all aspects of emergency planning and response including pandemic influenza, through emergency response for each jurisdiction remains the responsibility of each Governor or the Mayor; and, 3) there needs to be closer collaboration and communication on NRC emergency planning between these three jurisdictions, federal agencies and the federal government since a high percentage of federal workers live in one of the three areas.

The Virginia Department of Health is a unified public health system, including 35 health districts that cover the entire state, as well as 5 planning regions that coordinate planning activities among the health districts in each region. The Northern Region has 5 health districts which comprise the Virginia component of public health in the National Capital Region. These 5 health districts – Alexandria, Arlington, Fairfax, Loudoun and Prince William – as well as the VDH Northern Region team, have been actively involved in all public health and healthcare planning efforts in the National Capital Region.

The Commonwealth of Virginia's planning for a possible pandemic of influenza dates back to 2002 with the development of the Virginia Department of Health's first Pandemic Influenza Response Plan. Virginia expanded this initiative in March, 2006 with a Statewide Summit co-hosted by the Secretary of Health and Human Services Michael Leavitt and Governor Timothy Kaine. This event brought together over one thousand public and private sector stakeholders from local, state, federal and volunteer organizations who identified many flu related issues during functional specific breakout sessions. Virginia formed a Pandemic Influenza Advisory Group in 2005 which has convened quarterly since that time. The Group consists of multi-discipline professionals and subject matter experts (public and private sector, governmental and non-governmental, health and non-health) who are engaged in the development, implementation and testing of the State Pandemic Influenza Plan designed to address the roles of all state agencies for Pandemic Influenza mitigation, preparedness, response and recovery.

In late 2005, VDH produced *PANDEMIC FLU: A Video Guide to Pandemic Flu Preparedness in Virginia*, introduced by Governor Kaine and a valuable resource to all Virginians. The production has English and Spanish versions and is available as DVD and VCR as well as streaming format on VDH's Pandemic Flu Web site, www.vdh.virginia.gov/pandemicflu. Over 12,000 copies have been widely distributed. This 15 minute video has aired on local cable TV access channels and been shown at formal and informal meetings of educators, faith leaders, community organizations and healthcare facilities statewide. It offers a brief overview of the major issues surrounding pandemic flu and can be used as a stand-alone tool or in conjunction with other pandemic

flu materials. VDH is in the process of updating the production in at least three additional target languages.

Weekly activity reports were provided to the Governor for the last 9 months of 2006 and were transitioned to monthly reports in January 2007. Reporting provides the Governor anecdotal descriptions of local, regional and state level preparations. The report enjoys a statewide distribution, with all reports available on the VDH web site. The September 2007 report is attached for your information. The VDH web site also provides timely and comprehensive information regarding all aspects of Virginia's government, business and individual Virginian's response to a flu pandemic, as well as presentations and other educational materials. VDH also monitors regional, national and international information related to Avian and Pandemic Influenza events and preparedness strategies available through numerous sources including the CDC and WHO, among others, and incorporates best practices into our planning efforts, where appropriate.

Emergency Preparedness in the National Capitol Region (NCR)

As with all Emergency Preparedness and Response Planning, Pandemic Influenza Plans are coordinated across the NCR at state and local levels as well as with our Department of Homeland Security Regional Coordinator and other Federal partners. School Systems, Private Sector / critical infrastructure partners also are active planning collaborators. Efforts are facilitated and supported by the Metropolitan Washington Council of Governments. Disease Surveillance, Regional Strategic National Stockpile Management, Medical Surge, Public Information and Fatality Management are among the focus areas addressed and coordinated. All planning is a collaborative effort involving Chief Administrative Officers, Emergency Management, Law Enforcement and Responder Communities, Public Health and Healthcare providers, and others. The NCR has a robust, coordinated exercise program which routinely tests plans, systems and other interoperability issues.

One important gap in our planning is in coordination with key federal agencies and, indeed, the entire Federal Government. NCR jurisdictions must be integrated into Federal Continuity of Operations / Continuity of Government (COOP / COG) planning. A thorough analysis of Federal support expectations of the NCR jurisdictions is an absolute requirement. Remember - Federal employees live in our neighborhoods and are dependent on our services; if there are any preferential expectations to assist in Continuity of Federal Operations, they have not been shared with us, their service providers.

Virginia's Emergency Response

The Commonwealth of Virginia Emergency Operations Plan describes how the Governor leads response efforts through the NIMS compliant Virginia Emergency Operations Center (VEOC). As mandated by a Governor's Executive Order, certain state agencies are directed to provide members for the Virginia Emergency Response Team who will manage their agencies' representation at the VEOC in times of emergencies. (Example: VDH is assigned as lead agency for the Health and Medical Emergency Support Function (ESF-8.)) Certain state agencies maintain an in-house reach back coordination center so that agency heads manage their resources statewide. Most state

agencies maintain intra state regional presence. However the VEOC coordinates jurisdictional emergency response directly with county / city level Emergency Operations Centers. VDH coordinates hospital response through Regional Hospital Coordination Centers (RHCCs, all Level 1 Trauma Centers) in the state's six (6) hospital regions. RHCCs serve as communications links to hospitals in their regions in times of emergency.

Continuity of Operations (COOP)

Governor Kaine issued an executive order directing state agencies to create or update Continuity of Operation Plans to conform to a template produced by the Virginia Department of Emergency Management. State agencies have updated COOPs with Pandemic Flu related / specific elements. Addressed issues include:

Workforce Reduction

- Absenteeism Policy
- Telecommuting Policy
- Development of an adjunct emergency workforce
- Communicating with employees via an "employees only" section on the public website

Staffing Support/Coordination

- Compensation Policy
- Data Privacy Policies
- Management Expectations and potential alternative duties.
- Limiting points of entry into VDH buildings and providing regular health screening

Identification of key positions, skills, and personnel

Back-Up personnel

Delegation of authority

Leadership Succession

System Redundancies

Alternate Worksites

Primary and secondary individuals for core functional roles for Incident Command

Prioritization of Agency Functions

Augmentation Support Personnel: Twenty-six Medical Reserve Corps (MRC Volunteer Management System (VMS) Currently over 7,200 MRC volunteers including over 5,400 with medical skills are identified and available for response.

Pre-positioned Equipment Caches

Anti-Viral Caches: State and regional caches of 5-day anti-viral treatment courses are in place in quantity to provide treatment courses to over 37,000 hospital staff, approximately 30% of the Commonwealth's hospital workers. This is in addition to the state purchased cache of anti-viral medication to treat members of the public who develop influenza.

Communication and Coordination Efforts

Virginia's Community Outreach partners include (but are not limited to) the Virginia Municipal League, Virginia Association of Counties, Emergency Managers, Local / Regional Summits, schools, colleges and universities, healthcare entities, private

sector partners including businesses and other local contacts. Communications efforts focus on pre-scripted Public Service / Public Health Announcements, keeping media engaged, developing public education opportunities and materials, developing Message Maps and establishing a Public Inquiry Center.

VDH Communications has developed a series of print communications tools to support the work of health districts to reach Virginians with important pandemic and seasonal flu messages. The content is based on recommendations from the Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services. Pandemic flu print materials include:

- English and Spanish language brochure on washing hands and sneeze and cough etiquette
- English and Spanish language brochure on pandemic flu, seasonal flu and personal hygiene
- English and Spanish language stickers for elementary school-aged children on personal hygiene
- Adult English and Spanish language bookmarks on preventing colds and flu
- Teen English and Spanish language bookmarks on preventing colds and flu.

VDH also developed technical assistance tool kits to support public outreach and manage media relations statewide during National Influenza Awareness Week and throughout flu season. Health district directors were provided electronic copies of these tool kits so they could be easily reproduced and customized for their district.

Based on the need to communicate with low literacy and other special populations, the communications team is developing a series of “talking posters” based on fables and folklore from a variety of cultural traditions. These will be disseminated to health departments and other public and private sector partners. The posters are an important social marketing tool as they can be downloaded and reproduced cost-effectively; tailored to meet the needs of a range of populations; and visually reinforce other existing communications tools. Culturally appropriate and literacy tested posters are currently in development to target the following populations in Virginia: English low-literacy, Spanish, Native American, Farsi, Russian, Tagalog, Korean, and Afro-Caribbean. These will be tested in local communities through local health departments.

As mentioned already, the pan flu video has been widely distributed statewide to a broad range of audiences. Nationally respected risk communications expert Vincent Covello, Ph.D., addressed health district and central office VDH leadership on best practices to manage the delivery of information to protect people, their families and communities during a public health emergency. His recommendations have been incorporated into Virginia-specific pandemic flu message maps.

Treatment Plans

All treatment planning has been collaborative with the healthcare community and specifically with the Commonwealth’s 90 Acute Care Hospitals and the Virginia Hospital and Healthcare Association. Discussion of healthcare efforts is found in the following section addressing Medical Surge.

Mass vaccination plans have been developed and exercised at state and local levels. In the event of a pandemic, influenza vaccine in Virginia will be distributed in

accordance with provisions of the Commonwealth's Strategic National Stockpile Plan once normal vaccine distribution mechanisms are unable to accommodate the situation. Vaccine will be administered in accordance with priority groups determined by the Commissioner of Health based upon USPHS/DHHS and Pandemic Influenza Advisory Group recommendations. Local communities have the responsibility to plan for and implement Mass Vaccination Plans for the receipt, storage, re-distribution, monitoring and administration of influenza vaccine in their jurisdictions. Each health district maintains a Mass Vaccination Plan Annex that includes provisions for identification / designation of vaccination clinics, staffing, security, transportation alternatives and other logistics including the use of volunteer staff. VDH maintains a database of statewide Dispensing Site locations and points of contact. The goal of the Vaccine Delivery and Distribution Plan is to move available vaccine to targeted locations throughout the state. The vaccine must be moved quickly and the product integrity maintained. Movement of the vaccine to the primary SNS Receipt, Stage and Store location and subsequently to Health Districts, local health departments and associated community partners has been included in the planning effort. The input and counsel of stakeholders with expertise in security, freight forwarding, crowd management, and all other aspects of vaccine management, distribution, and administration, have also been incorporated into the plan.

In recognition of the time lag in development and production of sufficient strain specific vaccine, Virginia has focused much effort in the refinement of its Antiviral Distribution Plan. Governor Kaine has authorized the purchase of over 770,000 courses of antiviral medications. This state stockpile constitutes the Commonwealth's entire allocation under the DHHS antiviral discount purchase program, and is now centrally stored in Virginia with a private sector partner. It is hoped that the FDA will approve a shelf life extension program for the states, thereby protecting our investment and extending the longevity of these medications. In preparing for a possible pandemic flu event, the Commonwealth will distribute to the target population through a regional delivery network to private sector pharmacies, military (Tricare) clinics, community health centers, dispensing physicians, healthcare facilities, and local health departments.. The general tenets of this plan are:

- This stockpile of antivirals has been purchased with state funds and as such is under the control of Virginia Department of Health (VDH).
- This plan will not be implemented until there is an imminent or actual outbreak of pandemic influenza. The antivirals are specifically designated for use during a pandemic. If this occurs, state officials will authorize the release of this inventory. The stockpiles will be distributed through a pre-arranged distribution chain and will not require pre-stocking. Inventory replenishment will employ traditional means through the designated distributor.
- The distribution will be accomplished using the traditional medical model. Patients will obtain prescriptions from approved prescribers and present them to participating pharmacies for dispensing.
- The plan is designed to provide antivirals to treat up to 25% of the state's population. This percentage is based on worst case models from the 1918 Pandemic.
- All patients with valid prescriptions for the antivirals are eligible.
- Participating pharmacies will receive the medications at no charge.

- Participating pharmacies will dispense these antivirals at no charge.
- A tracking system will assure each individual receives only one course of treatment through the program.

Medical Surge

State Surge Capacity within 4 hours of event – Estimated 3,630 staffed beds available statewide for influx of surge patients within four hours of incident. Hospitals will immediately activate procedures to provide a rapid in-patient intake capability (i.e. stop elective procedures, expedite early discharges and utilize 100 percent of staffed beds). This immediate bed surge capacity in the NCR (Virginia) is 778.

Surge Capacity within 24 hours of event - 5,670 patient surge capacity above normally staffed beds statewide. This capacity is 50% more than the benchmark established by HHS (500 beds per million of population). Hospitals will activate procedures to provide maximum hospital based in-patient treatment facilities within the region (i.e. activate all available beds, utilize healthcare facility surge areas; i.e. out-patient services areas [same-day surgery, sleep study], conference rooms, semi-private conversions, medical office buildings, etc. With the help of HHS funding this capacity increase has been achieved within the past five years by: 1) enabling hospitals to expand capacity within the facility and in ancillary buildings on campus; 2) establish alternate care facilities at off-campus sites such as physician practices and urgent care centers, 3) purchase mobile medical facilities to expand capacity on campus or for deployment as needed. Bed surge capacity (within 24 hours) in the NCR (Virginia) is 1,110, which is slightly below the benchmark level (1,162) for that population area. The primary reason for this shortfall is that these urban area hospitals are already operating at close to capacity on a normal basis, and the capacity for on-campus growth is limited. In this area, more emphasis is being placed on establishing additional alternate care centers.

Alternate Care Sites (ACS): Virginia continues to identify additional potential sites to enhance capability for the treatment of patients in a pandemic or other medical surge scenario. These sites will provide supplemental surge capacity to the healthcare system through integration of local, state and federal resources in safe, sustainable alternate care sites located in communities throughout the Commonwealth. An ACS model of operations will optimize the allocation of scarce medical resources through a process developed collaboratively by healthcare coalition partners and adopted by the ACS staff of volunteer health professionals, community providers with guidance from hospital based providers.

Mobile Medical Facilities: Use of mobile medical assets is a valuable option for providing medical stabilization and treatment outside of hospitals. The same model of Stabilization and Treatment in Place (S.T.I.P) units is now in place in four of the six hospital regions in Virginia. When deployed, the combined patient capacity of these mobile facilities is approximately 200-250. Additional work is needed for continued development of these assets in order to expand the current patient throughput capability, provide for more sustained operations, enhance the scope of treatment capability, train professional and volunteer staff, and evaluate deployment procedures and performance by inclusion in community, regional or statewide exercises. The envisioned final product

will provide a rapidly deployable mobile capability to provide medical stabilization and treatment in place in the vicinity of the event or in support of hospital operations. Mobile medical assets will be capable of limited independent operations with resources for facility support, medical supplies, equipment, pharmaceuticals and trained medical staff. These assets will be capable of deployment anywhere in the Commonwealth or in support of interstate response where needed to supplement medical surge capacity. In response to a pandemic medical surge, these mobile facilities will likely function as triage areas and diversion management resource points to help redirect patients to the most appropriate treatment site (hospital, ACS, clinic, home).

Expand Equipment, Supply and Pharmaceutical Cache through Vendor Managed Inventory (VMI). A VMI plan now under consideration proposes to provide medical surge materials in two primary locations. Each of these locations would manage a portion of the stored surge materials, proportionate to the designated patient base as determined by VDH in partnership with the healthcare provider community. These facilities will be positioned to provide immediate provision of materials, but physically located in separate parts of the Mid-Atlantic region. By this method, travel times can be enhanced to widely diverse part of the Commonwealth and the loss of any one facility will not eliminate the response capability. The purpose of these two primary support facilities is to ensure that the requested surge materials can be staged and delivered within a 12-24 hour fulfillment window. In addition to these two primary facilities, the vendor under consideration also maintains a series of secondary or remote distribution storage facilities. Acquisition of medical surge materiel occurs using the contractual opportunities or pricing available to the vendor. The product is then placed into storage at the least possible acquisition price. While in-stock, this material is managed as in-stock inventory. In addition to cost avoidance benefits, a VMI program, such as currently exists with the DOD, provides a continuing contractual assurance that the material requested during a time of crisis will be in the quantity and condition needed over any extended period of time. Any additional expenses for the delivery and staging of the material are incurred only if and when emergency situation arrives. Using a suggested stockpile list provided by HHS as a guide, the VMI will include:

- Respiratory ventilators and associated air-way management supplies
- Oxygen concentrators/generators
- Respiratory system monitors
- Personal Protective Equipment such as hand hygiene gel, gloves, gowns, full-face shields, masks, respirators, medical waste bags, sanitary equipment, mortuary supplies (including body bags and tags, litters).

Strategic Planning and Exercising

All planning is derived from the envisioning and gap analyses which originate in the Commonwealth and its Agencies' strategic planning process. Pandemic Planning has evolved to its current iteration as Virginia's statewide, multi-agency, cross-functional Pandemic Influenza Plan. The plan has been developed by the Commonwealth Preparedness Working Group with oversight from the Governor's Office of Commonwealth Preparedness, and has been exercised, updated and validated regularly. Virginia conducts a proactive, robust exercise program. In August, 2006, VDH hosted a

statewide Pandemic Influenza Tabletop Exercise. As with all our exercises, it was Homeland Security Exercise and Evaluation System (HSEEP) compliant. Lessons learned were collected and analyzed; shortfalls were identified and turned into new exercise objectives for retesting. A follow-on statewide functional exercise was conducted in October '06. It tested many scenario-based response objectives, exercised the deployment of the Strategic National Stockpile, tested Isolation and Quarantine procedures, cross-border coordination in the national Capitol region (NCR) with MD and DC and mass vaccination, and non-pharmaceutical interventions such as social distancing, school closings and public event cancellations. All thirty-five local health districts participated, operating 77 clinics and vaccinating 10,795 citizens with state-provided annual flu vaccine. This last element produced a set of performance metrics which will be retested this flu season with a new target audience of 10,000.

Last month, Governor Kaine led a Cabinet-level Pandemic Flu Tabletop Exercise conducted in the State Emergency Operations Center. All Cabinet Principals, their staffs and agency heads participated. The exercise focused on executive level decision making and emphasized communication, coordination, problem identification and resolution. Identified legal issues attendant to a pandemic were then addressed by the Commonwealth's Attorney General's Office September 26 Tabletop Exercise with partnering state agencies and local representatives. Virginia Department of Health and the Centers for Disease Control and Prevention have scheduled a Tabletop Exercise on October 9 to look at the implications of social distancing in a pandemic. In November, Virginia intends to fully participate in a National Governors' Association Regional Pandemic Exercise in the NCR.

Protection of First Responders and Other Critical Personnel

State and regional caches of 5-day anti-viral treatment courses are in place to provide treatment courses to over 37,000 hospital staff, approximately 30% of the Commonwealth's hospital workers. This is in addition to the state purchased cache of anti-viral medication to treat members of the public who develop influenza.

Antiviral medications will be dispensed to other key personnel as described above in the Treatment Plans section. Antivirals are in sufficient quantity to allow for this. Should unanticipated shortfalls be identified, prioritization will be enforced.

As stated earlier, vaccine will be administered in accordance with priority groups determined by the Commissioner of Health based on USPHS/DHHS and Pandemic Influenza Advisory Group recommendations. For priority groups that have been identified, VDH central office and local health departments will:

- Determine whether vaccine will be shipped directly to vaccine providers or to public health departments for further distribution. At this time, distribution through local health departments is planned.
- Identify organizations that will provide vaccination to persons in priority groups (e.g., local health departments, occupational health clinics, private clinics identified by the employer or union of an occupational group). At this time vaccination by local health departments is preferred.
- Identify contacts and obtain written commitments from each clinic or facility responsible for vaccinating a priority group.

- Work with these contacts to develop strategies for rapid distribution and administration of vaccines, taking into account vaccine security issues, cold chain requirements, and transport and storage issues.
- Estimate the size of the priority groups that will be vaccinated based on extrapolation from national data or on local data, where available.
- Identify locations for vaccination clinics that will be operated by health departments and enter into memoranda of agreement with organizations that agree to provide vaccinators or other staff.
- Develop procedures for collecting, removing, and disposing of used syringes, needles, and other vaccination supplies.
- Develop a plan for training vaccinators and other staff responsible for mass vaccination.
- Maintain a vaccine database.

Summary

In summary, Virginia has planned extensively for a possible pandemic of influenza with a broad range of partners and stakeholders within Virginia as well as with partners in the Maryland and Washington DC portions of the NCR. While a great deal has been accomplished, much remains to be addressed. As with overall emergency planning in the NCR, collaboration among Virginia, Maryland and Washington DC in planning for a possible pandemic of influenza has been extensive and productive. Increased direct involvement of federal agencies in this planning process is needed, both to assure appropriate coordination of efforts and to guarantee that federal employees receive appropriate information and care within the jurisdictions where they live. Thank you for the opportunity to address this committee.