VA'S ABILITY TO RESPOND TO DOD CONTINGENCIES AND NATIONAL EMERGENCIES

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BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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MONDAY, OCTOBER 15, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to call, at 2 p.m., in room 334, Cannon House Office Building, Hon. Christopher H. Smith (chairman of the committee) presiding.

Present: Representatives Smith, Buyer, Stearns, Evans, Filner, Carson, Udall and Snyder.

OPENING STATEMENT OF CHAIRMAN SMITH

The CHAIRMAN. The committee will come to order. And good afternoon, ladies and gentlemen. It has been just over a month since the September 11 attacks that have forever changed the world that we live in. As our horror has turned to grief and then mourning and now to action, it is appropriate for Congress to continue examining how the government can best prevent and, if that fails, respond to future terrorist attacks.

Today we will examine the role performed by the Department of Veterans Affairs in emergency preparedness and response in national crises and whether that role is in need of serious updating and reform. In particular we will focus on the VA's role during wartime national disaster or major terrorist attacks on U.S. Soil.

As most of you are aware, the Veterans Health Administration's fourth mission after the provision of health care to vets, medical training and medical research, its fourth mission is to serve as a backup health care provider to the Department of Defense in terms of war or national emergency.

With more than 170 major health care facilities and hundreds of outpatient clinics, the VA currently has dedicated health care professionals, bricks and mortar, if you will, to care for thousands of service members in the event of massive casualties.

Today we will examine whether the VA's current structure as well as its ongoing transition to an outpatient-oriented medical system have implications or create new challenges in fulfilling the Veterans Health Administration's fourth mission.

Twenty years ago the VA had significant excess bed capacity. Today the infrastructure is badly in need of repair, and I might add that we have taken action in the House to begin addressing this problem. Earlier this year the House approved legislation that I authored, along with my good friend to my right Mr. Evans, H.R. 811, which would provide $550 million over 2 years to repair and

to rehabilitate VA medical facilities. First-year funding of $300 million dollars has already been included in the House-approved budget. We continue to work with our friends on the Senate side to pass this legislation so we can send to it the President for his signature.

Today's hearing will also examine additional areas of emergency and war preparedness and response where the VA has unique resources and responsibilities. With an overall annual budget in excess of $50 billion, and more than 220,000 Federal employees, the Department of Veterans Affairs operates the largest integrated health care system in the United States making it an essential asset in responding to potential biological, chemical or radiological attacks.

The VA has defined roles currently in both the national disaster medical system and the Federal Response Plan, or FRP, in the event of national emergencies. Among the specialized duties of the VA are conducting and evaluating disaster and terrorist attack simulation exercises, managing the Nation's stockpile of pharmaceuticals for biological and chemical toxins, maintaining a rapid response team for radiological events, and training public and private NDMS Medical Center personnel in responding to biological, chemical or radiological events.

As the credible threat of chemical, biological and radiological terrorism have crept into our national awareness, it has clearly become more apparent that our Nation needs to develop sufficient resources, we don't have enough now, and sufficient responses to deal with a major incident.

Currently there are, as we all know, a myriad of Federal departments and agencies each addressing different pieces of the puzzle, but there is no real unified strategy. That is why I applaud President Bush's decision to establish an Office of Homeland Defense and Security. This committee looks forward to working with its first Director Tom Ridge, particularly in these areas in which the committee has jurisdiction, a former member of this committee who used to sit just to my right here, sat right next to him.

It is absolutely clear that the VA can and must play a unique role in preparing for any response to a chemical, biological or radiological attack in the coming weeks and months.

Today we do have more questions than we have answers, and hopefully this begins a process of getting to those answers and then responding adequately. For example, how do we respond if something happens? You know the—the September 11 horrific events really show that there was some chaos. Everything did not go as planned, and had there been large numbers of victims rather than large numbers of fatalities, the system would have been overloaded very, very quickly.

There are no authoritative answers to some of the questions that we ask. In many instances we have no cures or treatments and no methods of detection and diagnosis, and detection is one area that I am most concerned about. Why do we have to wait until some of the symptoms begin to manifest themselves if there is a way of getting to the bottom of it immediately through better detection? We need to have these capabilities not only fully researched, but also deployed as quickly as possible.

I am today proposing and will shortly be introducing some new legislation creating four national medical preparedness centers, two for dealing with chemical and biological threats, and two for dealing with radiological threats, centers of excellence. These NMPCs would be run by the Department of Veterans Affairs in coordination with the Department of Defense, Health and Human Services, Energy, FEMA, CDC, NIH and other agencies and organizations with expertise in developing diagnoses, treatments, and responses to those terrible dangers.

The missions of these centers would be to research and develop methods of detection, diagnosis, vaccination, protection and treatment for these terrible threats such as anthrax and smallpox. These centers would serve both as direct research centers as well as coordinating centers for ongoing and new research at other government agencies and research facilities.

There is already ample precedent and experience within the VA for providing them with this new mission. Through their extensive medical research programs, the VA has expertise in diagnosing and treating viral diseases with devastating health consequences, such as HIV and hepatitis C. Furthermore, the VA currently operates two war-related illness centers tasked with developing specialized treatment for those injuries and illness that are particular to wartime. In essence, these new centers would similarly study those illnesses and injuries most likely to come from a terrorist attack using a weapon of mass destruction.

Under my proposal the VA would be given new and a separate appropriation to develop and operate these national medical preparedness centers. I would hope that all of our witnesses today would comment on this, or at least take back the idea and provide comments for the record.

Finally, I just wanted to say from my visit to the VA last month that I was privileged to join Secretary Principi in New York as we went around to the different VA centers that had responded and met many of the personnel, some of whom had lost loved ones in the World Trade Center. We were greatly—and I say we because we both came back, as did Pat Ryan, our Staff Director and general counsel—with the can-do attitude, the professionalism and the sense that the VA was there, and it was going to do everything humanly possible to mitigate the agony and the ugliness of this terrible event. And I hope as we move forward and that the VA will play even more of a role, because it certainly has a great deal of expertise to share.

[The prepared statement of Chairman Smith appears on p. 65.]

The CHAIRMAN. Mr. Evans, do you have any opening comments?

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate the opportunity to speak today. I want to thank so many Members, not that many here today, but the ones that are here today for giving up their Monday before we go back into session. I want to thank you, Mr. Chairman.

I some time ago went to the Hermitage Museum in St. Petersburg, at that time I guess it was called Stalingrad, and entered and

saw everyone wearing these little combat victory pins. And I asked our tour guide what was the significance of that? How is it that almost everyone had been given this medal? And he replied, Mr. Congressman, in the Soviet Union during World War II everybody was a veteran.

That is probably what we are going to be faced with in the near future, people that have not been in the Armed Forces before, never been hit by any kind of terrorist attack. We as a Nation have not suffered that kind of attack on a widespread basis. But we are all going to be in this together, and it seems to me that we have to be prepared for the worst, and that is what we are looking at today. Since September 11 a day doesn't go past when we aren't reminded of those cowardly acts and their tragic consequences. These events have changed our world and our lives. Today our Nation is at war against terrorism. Around the globe our men and women in uniform are in harm's way. On the home front we are still responding to emergencies, created by the attack of terrorists.

By law, the VA provides contingency medical care to our Armed Forces during the time of war or other national emergencies. In addition, VA has important Federal Response Plan Emergency Function responsibilities.

Since being tasked with those important responsibilities the VA has changed, in some respects dramatically. VA health care, for example, today is outpatient care oriented while the number of VA inpatient beds has declined dramatically in recent years. Is the VA fully capable and ready to fulfill the emergency missions it has been tasked with over the years? Today our committee will seek the answer to these questions and address other issues.

Mr. Chairman, I thank Tony Principi for joining us. His testimony before us will be very instructive, I believe, in what we have to do here to correct many of the discrepancies between our mission tasks and actual realty.

So I appreciate you holding this hearing today and yield back.

The CHAIRMAN. Thank you very much.

[The prepared statement of Congressman Evans appears on p. 72.]

The CHAIRMAN. Dr. Snyder. Ms. Carson.

OPENING STATEMENT OF HON. JULIA CARSON

Ms. CARSON. Thank you very much, Mr. Chairman.

I would like to welcome the distinguished members of the panel. And, Mr. Chairman, today I will ask questions of the panel members to determine if the national response plans that involve the Department of Veterans Affairs have been coordinated at all necessary levels and reflect current abilities and needs requirements.

All too often an agency's crisis action plans will sit on a shelf and gather dust until they are needed. They can become out-of-sight, out-of-mind abstractions. When we dust these plans off, we discover that they are a generation behind the times, calling for a horse-and-buggy response to a high-tech age.

We may find, for example, they call for computer support, but has the nature of that support changed over the years, or is that need now obsolete? We may explore and find that an unanticipated incapability has sprung up, sometimes due to hardware software

requirements that differ between the primary agency and support agencies for required functions.

Every major Federal agency has an office of emergency preparedness or emergency coordination. The challenge is unusual. They struggle to be heard when their expertise is not needed, but when their expertise is called upon, their days become quite long. These people need to be the most proactive people in the agency, and they must really think out of the box. The simple fact is that preparedness will not occur if limited to the walls of a disaster preparedness office. It must touch all parts of the organization.

The custodians of the emergency plan must not only be aware of changes in the capabilities of the tasked Federal agency, they must coordinate those changes outside of the agency to keep pace with the changing times. For example, the VA was able to provide an estimated 17,311 beds for contingency use in 1994. Today the maximum number of contingency beds available from the VA is only 7,574, almost 10,000, fewer beds. How does this change impact our national capability to respond under Public Law 97–174?

When we review the Federal Response Plan, we find that a myriad of Federal resources may be called upon in response to a crisis. How do we determine if the agencies will be able to work together? Have capabilities changed with time?

One solution is coordinated exercises. This goes beyond the desktop review of plans. Agencies periodically buy new equipment, integrate functions or simply contract out major portions of their mission. Does anyone oversee this function?

A useful example under emergency support function number 3 of the Federal Response Plan, the VA is to provide engineers to support the Public Works and Engineering Annex of the Federal Response Plan. Does anybody know how many engineers the VA can provide? Have we contracted out this function and not noticed this emergency mission, or does the primary action agency for this ESF, the Army Corps of Engineers, no longer need VA engineering assistance? If so, why do we have a current Federal Response Plan that lists that requirement?

Mr. Chairman, it is very important to assure that the VA is ready to undertake all of its missions. The costs of missing a key action can have great consequences.

And I want to welcome the Secretary of the VA, Mr. Principi, who has done a yeoman's job in the short time that he has been head of the Department of Veterans Affairs. I was blessed to have him in my district. He dedicated a home for homeless veterans. He is very sincere in his work on behalf of the veterans of America, and I want to thank him very much for his good work.

And, Mr. Chairman, I yield black the balance.

The CHAIRMAN. Thank you very much.

I would like to now recognize and invite to the witness table our first panel. That includes Cynthia Bascetta, who is the Director of Veterans' Health and Benefits Issues from the General Accounting Office. Ms. Bascetta is accompanied by Mr. Steven Caldwell, the Assistant Director For the Defense Capabilities and Management Issues, also from the GAO.

Mr. Udall, did you have an opening comment?

Mr. UDALL. I am fine. Thank you.

The CHAIRMAN. Ms. Bascetta, if you could proceed.

STATEMENT OF CYNTHIA BASCETTA, DIRECTOR, VETERANS' HEALTH AND BENEFITS ISSUES, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY STEVEN CALDWELL, ASSISTANT DIRECTOR, DEFENSE CAPABILITIES AND MANAGEMENT ISSUES, GENERAL ACCOUNTING OFFICE

Ms. BASCETTA. Thank you. Mr. Chairman and members of the Committee. I appreciate the opportunity to discuss with you today the impact of the September 11 events on VA's future role in homeland security.

With me today is my colleague Steve Caldwell, from GAO's defense capabilities and management team. Last week many of us attended memorial services for victims of the attacks on the World Trade Center and the Pentagon, and we learned of several anthrax cases in three States and now in Senator Daschle's office. These are gripping reminders that constant vigilance will be necessary to blunt the threat and consequences of terrorism at home.

Today I would like to first recap VA's current role in emergency preparedness and then discuss its potential capabilities as the Nation shores up our homeland security.

As you know, besides wartime backup of our military health care system, VA has made important contributions to assist other agencies during natural disasters and acts of terrorism. First, VA jointly administers the National Disaster Medical System to enhance the health and medical response capabilities of State and local responders if they are overwhelmed. In the immediate aftermath of the September 11 attacks, VA hospitals in New York, Washington, Baltimore, and Pennsylvania were ready to handle casualties. And in prior emergencies, VA deployed more than 1,000 medical personnel and provided medical supplies and equipment as well as the use of its facilities.

Second, VA has conducted many disaster response simulation exercises to practice the coordinated intergovernmental response to scenarios including weapons of mass destruction attacks. VA has a good track record of evaluating its participation in these exercises and in particular developing lessons learned to improve interagency coordination.

Third, VA supports the Nation's stockpiles of pharmaceuticals and medical supplies. For HHS's Office of Emergency Preparedness and for CDC, which have lead responsibilities for the stockpiles, VA purchases stockpile items and manages contracts for the storage, rotation, security, and transportation of these items. Inventory from these supplies can be delivered anywhere in the Nation on very short notice. Our work this year shows significant improvement to increase accountability and reduce inventory discrepancies that we had noted 2 years ago. Nonetheless we recommend additional steps to further tighten the stockpile security.

Mr. Chairman, you also asked us to think about VA's fourth healthcare mission post-September 11. We are all familiar with its substantial medical infrastructure of 163 hospitals and more than 800 outpatient clinics strategically located throughout the United States. In addition, VA runs the largest pharmaceutical and medical supply procurement system in the world. And especially rel-

evant today, VA operates a network of 140 treatment programs for post-traumatic stress disorder and is recognized as the leading expert on PTSD diagnosis and treatment.

Other assets include well-established relationships with 85 percent of the Nation's medical schools and graduate medical education slots in disciplines associated with preparedness for mass casualty attacks.

1998's Presidential report to the Congress on Federal preparedness noted that VA's emergency plans were well integrated into the plans of most local communities, but important deficiencies included the lack of capability in the VA system as well as in the private sector to handle mass casualties, especially these resulting from bioterrorism and the lack of decontamination equipment.

In our view, VA has significant capabilities that have potential applicability in an era of heightened homeland security. At the same time it is clear that some of these capabilities would need to be strengthened. How best to employ and enhance this potential should be an explicit part of the larger effort currently under way to develop a national homeland security strategy. This broad strategy will require partnership with the Congress, the executive branch, State and local governments, and the private sector to maximize the effective alignment of resources with strategic goals.

We believe that expanding VA's role may be deemed beneficial, and that an expeditious analysis of the potential impact on the Agency's primary health care missions, the resource implications for its budget, and the merits of enhancing its capabilities relative to other Federal alternatives would help determine how VA can best serve the Nation's homeland security interests.

Mr. Chairman, this concludes my remarks, and we would be happy to answer any questions you or the committee members may have.

The CHAIRMAN. Thank you very much for your testimony and for your ongoing work.

[The prepared statement of Ms. Bascetta appears on p. 82.]

The CHAIRMAN. I have noted and I have read, as have many of the members of our committee and the subcommittees, your previous comments that have been made with remarks to the lack of proper management for the chemical—for the pharmaceutical stockpiling as have you pointed out in the past. I mean, it looks like it was a mess. It was chaotic. There was undercounting. There were expiration dates that were not adhered to. And today in your testimony you seem to indicate that things have improved substantially.

Secretary Principi in his statement later makes note of 12 recommendations that his senior-level working group, in-agency working group, have come up with, and one of them does have to do with the issue of inventories of equipment and pharmaceuticals not being adequate.

Now, given—and you pointed out in your testimony I think it was like about $160 million over 3 years that have—through CDC and other agencies—have been spent on acquiring or procuring these pharmaceuticals and other items. What is your sense as to the adequacy or inadequacy? Can you assess these on the expiration issue, which I was intrigued about in one of your earlier re-

ports that there was an attempt being made to see if there could be an extension of what the expiration date may be; that it was still a valid and potent antibiotic, for example, but just simply—it ran out, the date ran out.

Ms. BASCETTA. I can try to explain our views at this point.

First of all, we were very happy to note in our report that was issued in May of this year that no expired items were found in the current inventories. So that was a very substantial improvement over our work that was released in October of 1999.

One of the recommendations that we did make in May was with regard to a problem with temperature control, and I believe one of the facility recommendations related to CDC and HHS making sure that they had contacted the FDA to assure that the potency of the antibiotics that were stored in those extensive temperatures would not have been adversely affected. I understand from the agencies' comments, both CDC, HHS and VA, that they are acting to comply with those recommendations.

But, overall, the recommendations that we made recently have directed the CDC and HHS, not the VA, except in one case where we recommend that, again, at one facility, some of the personnel weren't familiar enough with the operating plans, and we suggested that CDC and HHS assure that they have the appropriate training.

The CHAIRMAN. Let me ask you, GAO states that the VA operates as a support rather than command agency under the umbrella of several Federal policies and contingency plans for combatting terrorism. Do you believe that that concept needs to be rethought? Should they be a lead agency?

Ms. BASCETTA. Mr. Chairman, we haven't done the kind of work that would allow me to make a recommendation on that. But I—I think that under the circumstances, everything should be on the table. We would certainly hope that this kind of discussion would be taking place in the new Office of Homeland Security.

There is—there are funding mechanisms in place to transfer money to VA. As you know, they don't have any direct appropriations themselves for weapons of mass destruction. I think what is compelling is that given the—not on the bricks and mortar, the personnel and supplies that we have in place, but also the—the network that they have, that could be tapped into for communications is a very important asset not to overlook.

We also have—through our work we also reviewed a draft budget from 1998 that actually made some rather modest budget proposals that would greatly enhance the Department's ability to play a role in Federal preparedness. The budget was $60 million over 5 years, which would barely show up in the 50 billion. Thirty-eight million of it, interestingly, was for decontamination in VA's own facilities. So with rather modest sums, it appears that VA could play an enhanced support role at least. I don't—I don't know about extending that to a lead role.

The CHAIRMAN. Do you know how many facilities there are in the Natural Disaster Medical System, and since you mention decontamination, I know that Dr. Sue Bailey will be testifying later, pointed out that decontamination facilities at all hospitals, that is

a recommendation she is making, but it appears that we don't have it.

Do we have any sense as to how many VA hospitals have such capabilities and how many do not?

Ms. BASCETTA. I don't have those numbers. I know they are very limited. Maybe a handful.

The CHAIRMAN. Let me ask one final question.

You point out, as we all know so well on this committee, that the VA has incredible—a wealth of health care assets. And just for the record, as you say in your testimony, over and above the actual provisions of health care, the Agency has well-established relationships with 85 percent of the Nation's medical schools. More than half of the Nation's medical students trained there. Nearly all medical residents receive some of their training at the VA. If in your concluding observations, in talking about the analysis of potential impact on the health care mission, since we really are at a pivot point, and the VA has this wealth, it seems to me to be a go-to agency for trying to mitigate these problems that we are facing with regards to terrorist attacks and the potential response and the like.

Have you done any analysis about the—the impact on the budget and whether or not the capacity of the VA is up to snuff with regards to what we are looking at?

Ms. BASCETTA. Well, if you are talking about hospital capacity to take—capacities in a mass casualty situation, we haven't done extensive work in the VA, in the VA area, but our health care team has looked at the capacity of the entire hospital system, VA as well as private hospitals, and they don't appear to have the capacity to handle mass casualties.

But, for other issues like graduate medical education where you are in a preventative mode, they could certainly be a tremendous facilitator to training physicians, either emergency room physicians or internal medicine physicians who haven't seen anthrax, plague, smallpox, and they could facilitate a learning curve so that new hospital—new physicians and physicians who need retraining could get the knowledge that they need.

The CHAIRMAN. Thank you. Mr. Evans.

Mr. EVANS. In your written statement you list a number of response simulation exercises that the VA has hosted or participated in and that have a terrorist-related event or a weapon of mass destruction as their central theme to elicit a medical response from the VA. To what detail are these exercises played out? Do they, for example, actually move casualties in addition to providing treatment? How far do they go beyond a tabletop type of exercise?

Ms. BASCETTA. That is a very good question. I am going to ask Mr. Caldwell to answer that. But let me say in the way of preface that our understanding is that the exercises overall have greatly improved both in their frequency and in their realism in the recent past, and part of this is because of the Congressional mandate in 1999 to do no-notice field exercises, which also add to the realism.

But, Steve, if you could elaborate.

Mr. CALDWELL. Yes, sir.

We have observed a number of interagency counterterrorism exercises over the years, and our focus has generally been on the

interagency and intergovernmental nature of those. We focus more on the lead agency than the VA, but we have observed some and read the after-action reports of several others that VA was the prominent sponsor of.

I think that several of these exercises did incorporate a lot of the characteristics we would want in a realistic exercise in that they were field exercises that actually did move patients to remote facilities using DOD's air transportation system. These exercises were interagency exercises where VA interacted with the other lead national agencies as well as the other support agencies. These exercises were also intergovernmental exercises involving State and local facilities, including private facilities, and these also included some aspects of crisis management. But, as we understand, VA's role is more in the consequence management side of treating victims with health care, and so that is where the emphasis of these have been.

Just to sum that up real quick, I would state that VA has done a pretty good job in these exercises and taking—they are quite expensive and big things to manage, but they have done a pretty good job in that, sir.

Mr. EVANS. Has any exercise simultaneously exercised the National Disaster Medical System with both domestic casualties and moderate numbers of returning military casualties?

Mr. CALDWELL. I am not aware of any of those, sir.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Evans.

The Chairman of the Oversight and Investigations Subcommittee Mr. Buyer.

OPENING STATEMENT OF HON. STEPHEN E. BUYER

Mr. BUYER. Thank you, Mr. Chairman.

I want to follow up, Mr. Caldwell. As you discussed these exercises, did the VA only do a self-evaluation?

Mr. CALDWELL. VA does do evaluations on their own behavior, and some of them at the macro and some at the micro level. An example of those at the micro level would be an evaluation done in radiological exercises where they evaluate their medical emergency radiological response team. So they look at that, actually their own team, how long it took to deploy, where those people trained, did they know how their counterparts worked.

At the more macro level, VA has also done evaluations of its role, and I think in contrast to some of the other agencies that we have looked at, their evaluations do include some discussions of the—their interactions with the other lead agencies.

Mr. BUYER. So the answer to the question is no? I asked whether or not.

Mr. CALDWELL. I would say that they do.

Mr. BUYER. It is only self-evaluated?

Mr. CALDWELL. Yes.

Mr. BUYER. So there is no outside evaluation?

Mr. CALDWELL. No.

Mr. BUYER. Let me ask this: How realistic do you think the exercises were?

Mr. CALDWELL. The ones that were field exercises where they are actually moving patients is quite good. Now, we haven't personally observed those, but read the evaluations of those type. That would actually have patients that would be irradiated, set up decontamination, direct the patients through these, track the treatment, and then move them as necessary and actually physically move the patients.

Mr. BUYER. Let me ask this: Since the VA is not on the front line of this, they are in sort of the alternative, and in your written testimony you said the VA had allocated 5,500 beds for DOD casualties, would—if, in fact, we had to use those 5,500 beds, is the VA adequately staffed to handle casualties of that magnitude right now?

Ms. BASCETTA. We have not done an evaluation that would allow us to come up with a definitive answer to that question, but I can tell you that we had concerns about this in 1992 before the Gulf War, and some of the concerns back then I know have been ameliorated. Back then, for example, the bed estimates were based on authorized beds. Now they are based on operating beds, but, nonetheless, they are still estimates and they are generated for planning purposes.

Our understanding is that they are goals, commitments that the bed reporting exercises that they routinely go through with DOD are exercises, but in terms of knowing whether or not those resources could be effectively mobilized, we are not sure.

Mr. BUYER. You know, as the VA has been changing and reshaping how it provided medical services more towards outpatient and less inpatient, closing certain wards, closing beds, tell me how do you think that whole metamorphosis that is occurring right now plays with this plan of the VA to step in and help out with regard to a national disaster? I mean, are we kind of caught here in two things at once?

Ms. BASCETTA. Well, that is a very good question. You probably are aware of their CARES initiative to realign their capital assets.

I know that part of the job of the contractors in undertaking that process was to consider all missions of the VA, including their backup mission both to the Department of Defense and to civilian hospitals in the event of an emergency. But, frankly, I don't think it got too much attention because it—it simply wasn't on everyone's radar screen the way it is now.

We need to take a very hard look at the capacity in the hospitals as well as in the outpatient clinics. One of the—you know, the hospital capacity would clearly be needed for people who are acutely ill. One of the problems that we would undoubtedly be facing is that if people are ill with a contagious disease like smallpox, I don't think that anyone is prepared to have the kinds of isolation facilities that we might need, including the VA.

The CHAIRMAN. Will the gentleman yield?

Mr. EVANS. I think it is also important to remember in the Persian Gulf we had sometimes a double count of the VA doctors who belonged in the Reserve units. So we need to get not only the numbers, but to make sure that we look beyond the numbers in terms of seeing if there isn't a double count of those individuals, the significant impact on the local community of a lot of skilled doctors that are not available.

Ms. BASCETTA. That is correct. We had noticed both in the NDMS participating hospitals and the VA back in 1992 they were not as aware as they should have been of the qualifications and the availability of the reservists, but I understand that they have been working on that.

Mr. BUYER. Mr. Evans, I was only asking the question from a macro sense. If we have got a systems analytical approach going right here, if the VA is to be the backup, or not necessarily a backup, if the President turns to the VA and says, we have a disaster of such proportion that the VA needs to step in and assist, while at the same time you know we are reshaping how we provide medical care in the VA, we need a great deal of coordination integration with how we think about a new plan. That is the only reason I was looking at that.

The CHAIRMAN. Thank you, Mr. Buyer.

The Chair recognizes the Ranking Member of the Oversight Subcommittee Ms. Carson.

Ms. CARSON. Thank you very much, Mr. Chairman. And I have one quick question. That is, do you know if any of the nonmedical taskings of the VA under the Federal Response Plan are also exercised engineering support, mass care, resources and to what degree?

Ms. BASCETTA. No, I don't. That is an excellent question. The Federal Response Plan has a number of emergency support functions. Public Works and engineering, as you pointed out, is one. The two that—the two other that VA plays a role in are a provision of mass care and, of course, health and medical services, which is the subject of our statement.

Ms. CARSON. Thank you.

The CHAIRMAN. Thank you very much.

The Chair recognizes the gentleman from Florida Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. I just ask unanimous consent that my opening statement be put in the record.

The CHAIRMAN. Without objection.

[The prepared statement of Congressman Stearns appears on p. 79.]

Mr. STEARNS. I was going to mention what a laudable role the Department of Veterans Affairs did after the September 11 attack deploying personnel from burn nurses to post-traumatic stress disorder counselors within hours of the World Trade Center airplane crash, and that further the VA carries outs essential disaster simulations and maintains pharmaceutical and medical supply inventories for rapid distribution. And I guess all of this—those emergency response roles fall under the VA's fourth health care mission, if I understand it correctly.

And my question goes to this—relates to this Public Law 97–174 where the VA served as a health care backup for DOD, and secondarily communities in homeland security efforts. As I mentioned, this is a fourth mission of the VA, and I don't think a lot of us knew that. In the event that these efforts need to be employed on a continuing basis, Ms. Bascetta, do you believe the VA would still be able to meet its first mission, which, of course, is a treatment of veterans?

And perhaps this has been asked, but I would like to reiterate and hear from you what areas perhaps are compromised if you have a very strong, extended long mission for the fourth mission, and the first mission of the VA would be compromised?

Ms. BASCETTA. I wish I had a good answer to your question. Of course, the ability to respond for the VA and the entire hospital system, which is also experiencing less and less excess capacity, is a function of how severe the casualties might be. We can all imagine limits within which we could cope.

You are right that VA has, in one of its directives, a mission to stand in for civilian backup in the event of a—an attack on U.S. Soil of catastrophic proportions, and they have plans to do things like discharge all veterans who can be discharged, and they are supposed to do periodic reviews of how well that system is working or how effectively they could actually make a determination as to who could be discharged. And, of course, they would also postpone any elective procedures. But beyond that I can't—I can't tell you what the implications or what the repercussions could be on the first mission.

Mr. STEARNS. So at this point if you were heavily involved with a fourth mission, and providing, as I mentioned earlier, deploying personnel from burn nurses to post-traumatic stress disorder counselors, then are you saying today that the first mission would not be affected, or would be? Just yes or no. The first mission would be affected?

Ms. BASCETTA. It could potentially be affected depending on the degree of the casualties.

Mr. STEARNS. Do you think it is important for you to work out some type of matrix to see the trade-offs on your missions in the event that we had a very severe type of crisis, perhaps in a subway, or chemical, biological warfare where you would shift your mission, how it would work, and what effect would it have, for example, on the veterans in any one of our States? And would that be necessary to do on an emergency supplemental?

And so I think some kind of—analysis on a what-if scenario would be helpful for you folks.

Ms. BASCETTA. I would agree, and I would hope that part of the mission of the agencies that are charged with homeland security would be looking at the role of the VA as opposed to other alternatives, that part of what would be weighed in would be the implications on that first mission, how we could compensate in cases where there might be a temporary or a more prolonged adverse impact.

Mr. STEARNS. Mr. Chairman, it might be helpful for her to come back in writing with more specifics, what would happen to the mission in the event of some—something like this and to try and give us an idea of whether we should have legislation, or whether it is more services, or just maybe some kind of anticipation of what this committee could do to help her, help the VA.

The CHAIRMAN. We intend on asking the GAO to formally undertake such an analysis. In Ms. Bascetta's concluding remarks she makes that point that there needs to be more analysis in that area. The point is made. As a matter of fact, it was made. It is going to be made in testimony presented by the American Legion that the

United States will not engage in any major global or regional conflict during this time, in the strategic plan, 2001 to 2006.

The assumption is we are not at war. We are at war, and we have to change our mentality. Everything is pre-September 11 and post-September 11, and that—indeed the four missions, the main missions of the VA, and one of our VSOs even says this local home security really constitutes a de facto fifth mission because it is so large and filled with an enormous responsibility for the VA to respond.

So I think the gentleman's point is well taken. We will compose—consider yourself asked, if you are not already doing it. But we will be asking more formally to really scope out these needs. I thank the gentleman for raising that.

Mr. BUYER. Will the gentleman yield to me? I think Mr. Stearns has asked the—the $1 million question here, and that is—the answer, even if you were to provide a written answer today, is not going to be the answer that is going to help us 3 weeks or even 5 months from now, because we don't all know how this—the Homeland Defense, how this Agency is going to work, how it is going to interface with Secretary Principi and the VA. And we have to think outside of the box.

I think Mr. Stearn's point here is our first mission, we have to make sure those whom have served this Nation in other great causes of this country get taken care of; that we are not that demand agency, but that support agency.

So I want to compliment Mr. Stearns for asking the $1 million question, but it is one that we have to be very careful about. If we demand a specific answer today, it is not going to be the one that is helpful.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. I think he has asked the $1 million question, but the real issue is the $1 billion question; that is, the resources. How are we going to do both the new demands and the previous demands?

We are going to have to get additional resources. We are going to talk to the Secretary when he gets onto the panel, but I am sure he is ready for this. This Congress is going to have to deal with upgrading the amount of resources we have given for missions one, two and three. They are $800 million or more behind now. If the VA is going to take on additional responsibilities, we are going to have to be prepared to give those resources. And I think that part of this question you asked, Mr. Stearns. It is a resource question. How much more money are we going to have to provide to meet the initial or the basic mission in this new emergency circumstance?

Mr. STEARNS. And they should be prepared to tell us in sort of incrementally at least.

The CHAIRMAN. I thank the gentleman, and I now yield to Dr. Snyder, the gentleman from Arkansas.

Dr. SNYDER. Thank you, Mr. Chairman. I wanted to pursue a couple of questions about what you called the fourth mission, this local response to events. I recall—it has been over 25 years ago, back before I was a doctor, back when I was an orderly. People have done these kind of exercises for years. I think they have got-

ten better, more sophisticated. But it was a very proud day for me, because I was put out on the street and told, don't let any traffic come in here, no exceptions. And I turned away the hospital administrator, who was trying to get to the normal parking place close to the hospital. So I was proud of myself. I became a folk hero in the hospital.

But on page 3 of your report, you give a figure of $7.9 million and say that less than half of 1 percent of the VA budget goes to this fourth mission, this local medical response. I would think that is a hard number to calculate. I mean, how do you—for example, if there is a trauma, grand rounds on femur fractures, acute femur fractures, would that be counted as part of your local medical response even though it deals with the kind of injury that you may get in a mass response? How do you—what was included in 7.9 million?

Then the second part of the question. Then you put a footnote down at the bottom that says that HHS gave 62 million, which really dwarfs the half of 1 percent. So now we are getting whatever 62 plus 8 is. $74 million. I am not sure what is the appropriate amount of money in a category that is a bit hard to quantify.

Ms. BASCETTA. The 7.6 million, 7.9 million, I believe, for this year, represents the staffing essentially for the EMSHG, the Emergency Management Strategic Health Group. It does not include moneys that are provided to the VA, that—the money in the footnote, for example, that pays for the stockpiled items that are purchased through their national acquisition center for the national pharmaceutical stockpile. And it also does not include the much small number, I believe it is 1.9 million, for the pharmaceutical caches that VA manages to support, the national medical response teams which are specialized teams under the National Medical Disaster System.

So that number is—is for the—the emergency management expertise, if you will, that is within the Department that can be deployed to assist others, but it doesn't reflect the costs that they could incur if they actually have—if they took casualties, of course, or if they deployed their staff for long periods of time.

Dr. SNYDER. We have hospitals in our communities, in our States or in our districts that have been through emergency situations. In Arkansas, our most common natural disaster is tornadoes, and twice in my 4½ years here, half my counties have been declared Federal disaster areas for tornadoes, including deaths both times.

Is it fair to say that in the normal sequence of a natural disaster, that a lot of communities deal with, that the VA hospitals do not have occasion to have their resources challenged as much as the private hospitals? Is that a fair statement, that generally when a disaster occurs, most patients would be taken to the private network and would only then come over to the VA system if a veteran specifically requested it, or if there was really an overload of the system, which I wouldn't think most disasters incur?

Ms. BASCETTA. I can't say for sure, but they will take civilians on an emergency basis, as a humanitarian action. But their role in the NDMS is to—there are 50 VA hospitals that serve as Federal coordinating centers, and their role is to do triage, to do some lim-

ited treatment, but basically to distribute victims of a disaster to the civilian hospitals.

The CHAIRMAN. Thank you very much, Doctor.

Tom Udall, the gentleman from New Mexico.

Mr. UDALL. No. I am not a doctor. Thank you very much Mr. Chairman; I appreciate it.

I would also like to put in a letter that I directed to Secretary Principi earlier in the year and a statement.

(See p. 78.)

The CHAIRMAN. Without objection, the statement and letter will be part of the record.

Mr. UDALL. Ms. Bascetta, you mention in your GAO report here that the Veterans Administration has this well-established relationship with 85 percent of the Nation's medical schools, and according to the VA, more than half of the Nation's medical students and a third of all medical residents receive some of their training at VA facilities.

I am wondering, from your perspective and your knowledge, do you think the VA in playing this role is in a position to recommend the kinds of training that are needed for medical doctors to respond to things like bioterrorism, chemical attacks, nuclear attacks, those kinds of things, which we really haven't seen on any large scale here?

Ms. BASCETTA. I wouldn't be in a position to suggest that they do that alone, but certainly with their colleagues in the medical schools, at CDC and at HHS, in the Public Health Service, through the American association of Medical Colleges and the American Council for Graduate Medical Education, those bodies, I believe, could come together to develop curriculum.

Mr. UDALL. Have you done any of your studies on the curriculum now and whether they cover these kinds of areas, whether there is a lack of training in specific areas?

Ms. BASCETTA. We have not. My public health colleagues on the health care team at GAO did look at inadequacies and infrastructure in the public health system overall, and they noted that provider training does seem to be a problem. It varies across the country, but clearly, there are not enough physicians who have—who, fortunately, have seen these kinds of diseases.

Mr. UDALL. Shifting subjects a little bit here, I have seen on the nightly news about this antibiotic—that there is a run on because of anthrax, and you talk in your report about the inventories and the ability of the VA to move inventory and drugs around the country.

Has the public's response to some of these reports hurt the ability of the VA to respond, lowered these inventories in any way for drugs like Cipro or some of these others that would be used for anthrax?

Ms. BASCETTA. Those inventories would not be touched in the run on ciprofloxacin, which is, I believe, in pharmacies, private physicians writing prescriptions for private patients. But those stockpiles are closely guarded. The—for the first time, the national pharmaceutical stockpile, one of the 12-hour push packages, was deployed to New York. But I don't know whether any Cipro was utilized from that stockpile.

Mr. UDALL. And you would think the stockpile—from your knowledge, the stockpile that is there for these kinds of drugs is still intact and ready to be deployed?

Ms. BASCETTA. Absolutely.

Mr. UDALL. From your point of view, if the VA was tasked to support both missions under Public Law 97–174, the contingency support of DOD medical care and the Federal response plan, how would VA support both and which should have priority?

Ms. BASCETTA. I should probably think about that one and answer you for the record. I believe that DOD contingency has priority over the Federal response plan responsibilities that they have, and I wouldn't want to comment on which should have priority. I think, as the chairman has pointed out, our environment is so dramatically changed that those are the very kinds of questions that probably need to be rethought, depending on what kinds of circumstances might befall us next.

Mr. UDALL. And that would be acceptable to me for you to respond to the record as to which, under current circumstances, would have priority or not; and then we can look at the "shoulds" later on.

Thank you Mr. Chairman.

The CHAIRMAN. Thank you.

[The prepared statement of Congressman Udall, with attachment, appears on p. 75.]

The CHAIRMAN. Mr. Filner.

Mr. FILNER. Thank you very much. I did look at the written testimony, and I didn't find anything on what I call the "billion dollar question." .

It seems to me obvious that the VA mission is going to expand, but they are going to have less people to do this mission. I don't know if anybody asked you about the number of reservists, for example, who are part of the VA staff and will be called up. I think this was a problem 10 years ago, and I will be asking the Secretary about the consequences of a reduced staff.

The VA has an increased mission. And a number pops into my head, and again I will ask the Secretary later, that the VA was preparing its field people for an $800 million reduction somewhere around that figure, I remember. So it seems obvious that we need to have additional resources for the Veterans Administration. They are going to have to continue their basic job. They are going to have to expand their mission.

It seems to me, Mr. Chairman, to follow up Mr. Stearns' question about a letter to the GAO, I think we have to move quicker and go up the ladder. We have a $40 billion supplemental that we approved. I am not sure that the VA has any of this.

We should request, Mr. Chairman—a billion sounds like a good figure to start with. Since the VA is behind and they are going to have increased responsibilities, it seems to me this committee ought to make sure that the VA is part of the upcoming supplemental appropriations.

So I see Mr. Stearns. I will yield to you.

Mr. STEARNS. I just want to add on to what you are saying, that if the GAO or the Secretary comes back to us and says that in the event of this scenario, I would need X dollars, if they could do that

quickly, then the chairman would know, and we can get this in one of the emergency supplementals; as you point out, that is going to be on the floor.

And we have a huge network of hospitals and nurses and doctors who could help out.

Mr. FILNER. I think the answer is obvious. I don't have the exact number—although I bet the figure comes out around that billion figure. And we ought to do it as soon as possible, because "the train is moving," as they say.

Congress is making those decisions on how at least our $40 billion is going to be spent; and the President is coming along with another supplemental. So it seems to me this committee ought to speak up for the VA. We will have the Secretary on in a moment, and I am sure he can tell us about what he thinks is an exact number.

We ought to be taking the lead in doing what has to be done. We cannot neglect the responsibilities for the emergency, and the VA has incredible resources to deal with any that might occur. But we have responsibilities to those who have served. And I think we can do them both; I think we can handle them. It is a question of prioritizing resources in such a way so we do.

Mr. Chairman, I hope that we speak up on behalf of our veterans. We will get a more precise reading on that from the next two panels. But we ought to act so that the Congress hears what we are saying before everybody makes up their minds, or have made up their minds already about what they are going to get from that supplemental appropriation.

The CHAIRMAN. I thank the gentleman. And I want to thank our very distinguished witnesses for their testimony, their insight; it is ongoing and comprehensive.

And I should point out for the record, one of the reasons why I am convening this hearing today is to get all of the information on the table. Very often the VA is underheralded in the magnificent job it does do, particularly in a crisis. As I said in my opening statements, the Secretary and I traveled to New York and we met with Jim Farsetta, who will be speaking soon, and the other people who were part of the response—ready, willing and able. But the big question was, did we provide sufficient resources, had it been a different type of scenario, which could happen in the future?

I think that is the big question that has to be asked now. And you have helped us somewhat and we thank you. You fulfilled what our request was, but we will be asking you much more as we go forward because, again, there have been total changes since September 11.

Ms. BASCETTA. We understand and we are ready to help.

The CHAIRMAN. I would like to ask our next panel, Panel 2. And I want to thank Secretary Principi. Very often Secretaries, members of the Cabinet, insist on going first, but the Secretary insisted on listening to GAO and the responses that the GAO would make to the questions posed by the members of this committee. And I want to thank him for that.

Our first witness will be Secretary Anthony Principi, a combat decorated Vietnam veteran. Mr. Principi has worked on national policy issues and has held several executive-level positions in Fed-

eral Government throughout his career. He chaired the Federal Quality Institute in 1991 and was chairman of the Commission on Service Members and Veterans Transition Assistance, established by the Congress in 1996.

Mr. Principi served as Deputy Secretary of Veterans Affairs, VA's second highest executive position, from March 17 of 1989 to September 26, 1992, when he was named acting Secretary of Veterans Affairs by President George Bush, 41.

Mr. FILNER. I think the Secretary is asking the Chairman to forget his résumé.

The CHAIRMAN. We have a very, very distinguished member of the Cabinet who has tremendous credentials, and I would proceed.

From 1984 to 1988, he served as the Republican Chief Counsel and Staff Director of the Senate Committee on Veterans Affairs. He was—he has had many other jobs as well. He was—he is a 1967 graduate of the U.S. Naval Academy at Annapolis and first saw active duty aboard the destroyer USS Joseph P. Kennedy. He later commanded a river patrol unit in Vietnam's Makong Delta.

He earned his law degree from Seton Hall University in 1975.

And with that, we look forward to your testimony and just introduce the other members of your panel. We have Frances Murphy, Deputy Under Secretary of Health for the Department of Veterans Affairs; Jim Farsetta, who is the Director of the VA New York/New Jersey Healthcare System, VISN 3; and John Donnellan, Jr., who is the VA New York Harbor Health Care System Director as well.

And we are joined by Claude Allen, Deputy Secretary of U.S. Health and Human Services. Thank you Mr. Allen.

STATEMENTS OF HON. ANTHONY J. PRINCIPI, SECRETARY, ACCOMPANIED BY FRANCES M. MURPHY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH; JAMES J. FARSETTA, DIRECTOR, VA NEW YORK/NEW JERSEY HEALTHCARE SYSTEM, VISN 3; JOHN J. DONNELLAN, JR., DIRECTOR, VA NEW YORK HARBOR HEALTH CARE SYSTEM, VETERANS' HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND HON. CLAUDE A. ALLEN, DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The CHAIRMAN. Mr. Secretary, please proceed.

STATEMENT OF HON. ANTHONY J. PRINCIPI

Secretary PRINCIPI. Mr. Chairman, Mr. Evans, and members of the Committee. It is certainly an honor to appear before you this afternoon to talk about a very, very critical issue. And I am with the real experts today.

It is also a pleasure to be here with Deputy Secretary Allen. We worked very, very closely with Secretary Thompson, and the Department of the Health and Human Services, in the leadership role they have played in responding to this disaster.

I think if we are to succeed in responding to crises of this nature, it will be due in no small part to the ability of agencies of government to work cooperatively together. And I believe that has been the earmark of the current crisis that we have faced in New York, as many of the members have mentioned, along with Ms. Bascetta.

VA is a very, very large organization of government, with 1,200 sites around the country not only in large urban areas, but also in rural areas totally under Federal control. I think that is a very, very significant part.

All 215,000 employees—all 1,200 sites are under Federal control, and with the closing of the Public Health Service hospitals and, somewhat, the downsizing of the DOD direct health care system, VA plays a very important role in supporting HHS and as a backup to DOD in times of national emergency and certainly in the event of casualties from conflicts abroad.

We have responded well in the past crisis and in the future are prepared to provide assistance to the National Disaster Medical System, to Director Ridge and the Office of Homeland Security, and to the Department of Defense. I ordered reexamination of our plans in anticipation of VA's role in support of and in response to the current conflict.

The key issues are VA's response to September 11, VA's emergency response missions, VA's challenges, and most importantly, our response to those challenges.

Mr. Chairman, in response to the events of September 11, we activated VA's Continuity of Operations Plan immediately following the second impact into the World Trade Center. Alternate sites were operational and key personnel were deployed within a few hours. VISNs 3 and 5 activated their command centers in the greater New York and DC areas, respectively—in New York, under the leadership of Mr. Farsetta and Mr. Donnellan, VA cared for patients, managed emergency situations, heightened security, deployed staff, shared inventory and ensured continuous communication all very very close to Ground Zero. We are all grateful for their leadership and the splendid job they did in assisting all New Yorkers in the aftermath of the terrorist act. We are now gearing up for the emotional and traumatic impact likely in the weeks and months ahead.

The Veterans Benefits Administration also responded with assistance to victims and family members of the victims of the attack on the Pentagon and in New York. The National Cemetery Administration responded, as well, in caring for the families and, probably already, for burials, and honored requests for weekend burials and extended hours.

Mr. Chairman, VA's response to the September 11 attacks was swift, orderly, and effective. Our plans worked well. We know that improvements can be made, but everything went according to plan.

That response is consistent with VA's history. We were there in the wake of Hurricane Hugo and Hurricane Andrew. We were there for the earthquakes in northern California. We were there for the floods in the Midwest in 1993, and certainly played a very, very important role in Houston during the recent devastating floods.

Caring for America's veterans is and will always be our primary mission. But in times of emergencies in this country, we are also a national resource for all communities in America.

Mr. Chairman, my written statement lists several authorities governing VA's emergency mission, including our backup to the Department of Defense, our partnership in the National Disaster Medical System, and our support for the Public Health Service,

stockpiles of antidotes and pharmaceuticals. VA works very closely with HHS, with DOD, with FEMA and CDC to provide the health and medical response following disasters, including terrorist incidents. We have significant medical assets available to treat casualties.

VHA supports HHS's Office of Emergency Preparedness in maintaining adequate stock piles of antidotes and other necessary pharmaceuticals nationwide. Four pharmaceutical caches are available for immediate deployment with HHS's National Medical Response Team in the event of a chemical, biological, or radiological incident.

VA also procures, as was pointed out earlier, pharmaceuticals for the Centers for Disease Control and Prevention National Pharmaceutical Stockpile Plan.

VA and DOD contingency plans for our medical support to the military health care system are reviewed and updated annually.

Mr. Chairman, shortly after September 11, I formed an Emergency Preparedness Working Group at a very senior level, under the chairmanship of Charles Battaglia, to assess our ability to carry out our missions in case of a biological, chemical or radiological weapons attack. The group also examined our capacity to reconstitute our ability to meet our mission, if need be. The working group identified challenges that I will summarize without detail, but I would be more than happy to provide details to members and staff after the hearing.

Our challenges include: meeting veterans' health care needs and treating mass casualties at the same time; responding to multi-scenario crises; training on decontamination procedures and on the diagnosis and treatment of injuries and illnesses resulting from chemical or biological weapons; and meeting staffing needs in the face of Reserve or National Guard mobilization, or when a crisis prevents staff from reporting to work. In addition the concern raised by Mr. Evans—counseling for post-traumatic stress for military personnel, veterans, their family, VA employees and civilians; as well as addressing emergency operations command and control and mobilizing personnel to relocation sites; exercises in training to test our responses; and employee and veteran education on the realities of chemical and biological agents, including self-protection.

I have directed an immediate review of the working group's recommendations and expect implementation of corrective actions within 90 days.

Our emergency operations center will institute around-the-clock coverage with secure data and voice communication links to keep all of our systems functioning in the event of a crisis. Our preparedness assessment will help us develop emergency response training and medical education materials to share with civilian health professionals across America, especially with our affiliated medical schools.

Mr. Chairman, Mr. Evans, members of the Committee, I can assure you we will take all necessary steps to ensure that VA can fulfill all of our missions. Our primary mission will always be to America's veterans. In any discussion of homeland defense, I want to assure our Nation's 25 million veterans that we will stand tall with our Federal, State and local colleagues to protect them, their families and their communities.

Thank you, Mr. Chairman. That concludes my statement.

The CHAIRMAN. Thank you very much, Mr. Secretary. Let me ask you a couple of questions and then members of the panel, if you would like to.

[The prepared statement of Secretary Principi appears on p. 96.]

The CHAIRMAN. My understanding is, Dr. Allen, you wanted to present some testimony.

STATEMENT OF HON. CLAUDE A. ALLEN, DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ALLEN. Thank you, Mr. Chairman, Congressman Evans and members of the Committee. It is a pleasure to be here with you on behalf of the Department of Health and Human Services and its Office of Emergency Preparedness to discuss our Federal response plan.

The terrible events of last month very clearly demonstrated that our country can respond quickly, efficiently and effectively in the wake of a national emergency. However, it is important that we now accelerate our efforts to build a strong infrastructure for the possibility of future terrorist attacks, particularly those that involve biological and chemical weapons.

If a disaster or disease outbreak reaches the kind of significant magnitude that we witnessed on September 11, local resources will be overwhelmed and the Federal Government will be required to provide protective and responsive measures for the affected populations. This is why a Federal response is necessary and why we must be prepared to move quickly in order to detect the problem accurately, to control the epidemic spread and to treat the victims.

Under the leadership of Secretary Tommy Thompson, at HHS our efforts are focused on improving the Nation's public health surveillance network and preparedness response. As you know, Congress will appropriate $20 billion towards recovery efforts and preparedness measures. To ensure the safety and well-being of Americans here and abroad, the administration will request more than $1.5 billion in new funds for bioterrorism preparedness at the Department of Health and Human Services. When combined with the administration's original request of $345 million, it would provide a total of more than 1.8 billion in fiscal year 2002.

Secretary Thompson and I examined closely the current and future needs of the national pharmaceutical stockpile, and this new funding will include $643 million dollars to expand the existing stockpile. This would include adding to the eight push packs of medicine and supplies that are stationed throughout the Nation so that needed vaccines and general medical supplies will be ready for distribution at a moment's notice. The money would also be used to provide enough anthrax antibiotics to treat 12 million people for 60 days, an increase from the current supply of 2 million people for 60 days.

We will also initiate additional procurements of smallpox vaccine. We will request funding to expedite the Food and Drug Administration's work on bioterrorism vaccines, drug therapies, diagnostic tests, and consulting services. Training for State and local distribution programs will also be funded, as well as packages to build up State and local caches of pharmaceuticals.

For States and localities to be prepared for possible bioterrorist activities or incidents, it is necessary for us to provide additional funding to develop and coordinate State and local emergency plans and to increase the number of epidemiologists with our epidemiological intelligence service training from the Centers for Disease Control that are assigned to each State.

Hospitals across the country will be our first line of response and defense, and we have to make sure that they have the latest equipment and training in the event of an attack. Tying into hospital preparedness is the importance of strengthening the coverage of the health care network and the capacity of our metropolitan medical response systems for highly populated areas. To provide immediate and up-to-date information, the State and local lab capacities across the country will have to be increased, and our ability to detect exposure to chemicals through blood and urine tests, or what we call our "rapid toxic screens," must be enhanced.

Another very important piece of bioterrorism preparedness is protection of our food supply. We must add inspection, compliance and lab staff, as well as improve information technology support in the purchase of scientific equipment to ensure our food is safe. Within minutes of the terrorist attacks on the World Trade Centers, HHS had activated the Department's emergency operations center, knowing that our Department, our National Disaster Medical System partners, including the Department of Veterans Affairs, Department of Defense and the Federal Emergency Management Agency might be called upon to assist New York in its response.

By the end of that painful morning, Secretary Thompson had declared a section 319 emergency under the Public Health Services Act. He then ordered the activation of the entire EMS system, including notification of all of its 7,000 volunteer health workers and 2,000 hospitals. All of the resources we had in place allowed us to be as prepared as we were on September 11.

We need to continue to be prepared, and in order to do this, we must enhance the capabilities of our first responder services, such as CDC's laboratories, our disaster medical assistance teams, the epidemiologic intelligence service and vital communication systems. Security at our laboratories must also be given the highest priority.

The Department of Health and Human Services is committed to assuring the health and medical care of its citizens. And we provide—we are prepared to mobilize quickly the professionals required to respond to a disaster anywhere in the United States and its territories, and to assist local medical response systems in dealing with extraordinary situations, including meeting the unique challenges of responding to the health and medical effects of terrorism.

The Departments of Veterans Affairs and Defense are central partners in these efforts, and I want to thank both Secretary Principi and Under Secretary Chu for their assistance. The Departments of Veterans Affairs and Defense share responsibility for definitive care activities, including managing a network of about 2,000 non-Federal hospitals to ensure that hospital beds can be made available through a system of Federal coordinating centers.

The VA is partnering with the HHS Office of Emergency Preparedness on other activities, as well. The VA is one of the largest

purchasers of pharmaceuticals and medical supplies, and capitalizing on this buying power, OPM and VA have entered into an agreement where the VA manages and stores the four national medical response teams specialized pharmaceutical caches. VA also assists us in the procurement of many of our supplies.

And the Department of Health and Human Services is committed unequivocally to ensuring that the American people are protected from bioterrorism whether through thwarting the spread of an epidemic disease or containing a chemical attack. We will be ready.

And, of course, we must sustain high vigilance, always looking for ways to improve. Much has already been done and our fellow citizens can be assured that the Federal Government has a plan in place that, in a time of national crisis, can offer quick and effective assistance to address emergency needs.

Mr. Chairman, that concludes my prepared remarks, and I would be pleased to answer any questions.

The CHAIRMAN. Thank you very much, Dr. Allen.

[The prepared statement of Mr. Allen appears on p. 113.]

The CHAIRMAN. Dr. Murphy.

Dr. MURPHY. I don't have a prepared statement.

The CHAIRMAN. I want to thank you for being here and I know you come prepared to answer any questions.

Let me make the point at the outset, Mr. Secretary, that clearly the challenge that you face and your Department faces is to meet this fourth mission adequately and in a comprehensive way without in any way doing harm, damage or weakening missions 1, 2, and 3, which is the veterans' health care itself, research and the training of medical personnel.

But this fourth mission can't be seen as an adjunct. It is a vital part of the VA's mission. And it seems to me that many in the government do not understand the vital role that the VA has, can and hopefully will play in going forward, and I just wanted to ask you—and I want to commend you for convening that Emergency Preparedness Working Group, that senior-level working group.

You make 12 very candid recommendations as to what needs to be done, and I hope all members will look very carefully at those 12 recommendations. It points out that there is an inadequacy. And I don't think there is fault to be borne by any of the administrations, past or present; this has come up on us, I think, very, very quickly. No one could have foreseen this is what we would be talking about in mid-October of the year 2001.

But you make the point that health care workers need to be trained. There was a piece in the Washington Post on Sunday talking about how inadequately doctors are trained throughout the country. There is a general lack of information, woeful lack of information with regards to biological attack and anthrax and all of these other terrible threats.

You also point out that there is a need for decontamination; and that has been pointed out in some of our other submissions that we have gotten, and perhaps you might speak to how many of our VAs actually have a decontamination capability.

Does Manhattan VA have it, for example? I don't know, but it is something—I will throw out a few questions and then ask you to respond.

The post-traumatic stress, Mr. Secretary, as you know—and you have been a prominent proponent of, as I think every member of this committee has been—the VA has written the book on post-traumatic stress disorder and has experts capable of lending considerable expertise and curing expertise to those who are now and will soon suffer from post-traumatic stress—the firemen, for example, in New York and many others who have suffered so immensely.

You and I have talked about how well the VA is positioned to provide that expertise to these hurting individuals and you might want to speak to that as well.

Let me ask a couple of other questions in regards to capacity and especially, specifically, beds and the availability of beds. I read a GAO report that—it was in 1992, Readiness of U.S. Contingency Hospital Systems to Treat War Casualties; and a major faux pas was made by that administration in miscounting the number of available beds, counting those that had been authorized as opposed to those that were operational. And I am just wondering now, in 2001, do we have a clear indication of how many beds are out there should casualties begin to mount either on the domestic home front or as a result of overseas.

Secretary PRINCIPI. Mr. Chairman, the task force did identify 12 major deficiencies that we need to correct. I believe it will take roughly $250 million to correct those deficiencies—primarily training, protective equipment, decontamination equipment, pharmaceuticals for the caches to support local communities. So additional resources would be required going forward.

With regard to the capacity issue, clearly the assumptions that we worked with prior to September 11 have changed rather dramatically, and we need to consider the multi-scenario crises that we could be faced with in this country, both at home and abroad, and VA's ability to respond to those crises.

Much has changed in the past decade in the delivery of health care with regard to inpatient care, outpatient care, and how we can best provide that care. But, clearly, bed capacity is one issue that we have to be concerned about. We believe that we have 7,500 beds available to DOD, to HHS, within 72 hours of a crisis.

The CHAIRMAN. Dr. Murphy.

Dr. MURPHY. Those are staffed beds.

The CHAIRMAN. You mentioned 250 million. Is that a request that has been made to Congress?

Secretary PRINCIPI. That request has not gone forward.

The CHAIRMAN. Will that go forward soon? Does that come out of the 40 billion, or is that something that will be coming out of a new appropriation?

Secretary PRINCIPI. I intend to make that request to the administration to correct the deficiencies that I believe we need to move forward with.

The CHAIRMAN. Appreciate that.

You, in your testimony, point out there is a technical advisory committee of both VA and non-VA experts that was established in 2000 to advise VA on weapons of mass destruction issues. What they were supposed to come up with was both precautionary and response measures at all VA facilities. And according to your testi-

mony, that will be—the report will be forthcoming by the end of 2001.

Is there any preliminary indications from them? I mean, especially as we go through the budget process, that information, I think would be vital and very timely in terms of our response.

Dr. MURPHY. We have some preliminary information from the technical advisory committee, and actually their recommendations were incorporated into the 12 recommendations that the Secretary has already addressed. They are primarily related to training of our VA staff, and then how VA would assist HHS in training the NDMS hospitals to provide the appropriate pharmaceuticals in case of a chemical or a biological warfare attack, and how our physicians should be trained to use those; and also the appropriate decontamination guidelines that VA would implement throughout our health care system.

The CHAIRMAN. Let me ask if Congress were to assign the VA an additional training responsibility associated with national emergency medical preparedness, would it have the potential to harm the basic educational mission of the VA, or would it complement it and why?

Dr. Murphy, I think it is probably for you.

Dr. MURPHY. Would you repeat the question?

The CHAIRMAN. If we were to add medical preparedness, especially post-9/11, would that add to or diminish from the current training that goes on within the VA with regards to medical training?

And Dr. Allen, you might want to respond to that as well.

Dr. MURPHY. The medical training that goes on in VA facilities incorporates training in primary care and all of the specialties that exist in medicine. We also train allied health care providers. Much of that training is relevant to the response to an emergency situation. We need to augment that training with specific training that is related to weapons of mass destruction.

VA has already begun to implement training for weapons of mass destruction. We have offered that training in the past, but frankly, it wasn't well attended. We now have the attention of our health care providers across the country. We have begun running satellite video broadcasts on both chemical and biological warfare, diagnosis and treatment across the VA system. In addition, tomorrow we will be broadcasting a 1-hour satellite video on chemical and biological warfare, and we will be joined by staff from HHS and DOD. So it is a joint——

The CHAIRMAN. Prior to 9/11, was that training mandatory or was it voluntary?

Dr. MURPHY. It was voluntary in the past, and it is voluntary now. We will have a performance measure in the 2002 network director's performance measure that incorporates weapons of mass destruction training in the required training for VA staff, so that will fulfill their educational requirements.

The CHAIRMAN. Has there been any hesitancy on the part of M.D.s and any other medical personnel?

Mr. DONNELLAN. We have conducted several training sessions in conjunction with both the national programs and at local grand rounds conducted at our facilities. While staff was strongly encour-

aged to attend, there was absolutely no problem in achieving very good attendance. This is something that both our medical professionals and our academic affiliates are interested in.

The CHAIRMAN. Let me ask both of you gentlemen, if you would, lessons learned since you were right on the cutting edge of the horrific incident on 9/11.

Mr. FARSETTA. I think there were a number of lessons learned. And as I indicated to both Secretary Principi and yourself, Mr. Smith, we are still writing the book.

I would like to comment on something that was mentioned earlier. We—I don't think we still know what the casualties of this event are. I think a lesson from Vietnam was, we looked at battlefield casualties, but we didn't recognize the psychological casualties until about 5 or 6 years later.

There is no question that the World Trade Center was witnessed by hundreds of thousands of people. In addition to the rescuers and the individuals involved in the recovery, there are many people who saw this; and we have yet to understand the psychological impact this is going to have, and we don't know how many casualties we are going to get. And I think the VA is perhaps one of the few organizations in the United States, perhaps in the world, that is really uniquely qualified to take care of this problem.

As you are no doubt aware, insurance providers don't offer mental health services. They offer very little in the area of mental health. We certainly are an organization that provides a full range of mental health services. We know about 20 percent of the fire department members were veterans, and we certainly are looking to extend services to those individuals. But it seems to me we may also have a responsibility to extend services beyond that, because if someone were to come in with a ruptured spleen, we would not even think about whether we should repair it. If someone comes in, emotionally shattered, 90 days after the event, it seems to me we have the same responsibility.

An additional lesson learned is communication. You know, the—where the plane struck was the Verizon information center for the city. About 3 million lines went down. We were fortunate in that we were able to maintain communication. The necessity of where our supplies were, how to move supplies, the fact that traffic wasn't moving in the city and how could you get from point A to point B, the ability to discharge patients, the fact that home care services really didn't function because there was no way for people in the lower end of Manhattan, where our agencies were, to get out to patients. So it required us to really look at the whole delivery of services, because no one in their wildest imagination, whatever scenario planning we had done as it relates to disaster, whatever simulations we had done.

The New York Harbor Health Care System had a disaster drill probably about 2 weeks earlier, probably as close to a simulation that you could do, but nothing compared to the magnitude that we encountered and just the total devastation.

The only thing that prevented more casualties was simply the time that the planes hit the buildings. It had nothing to do with the weapon that was deployed, because in all honesty at about midday there probably would have been about 50,000 people in that

building instead of maybe about 11,000 or 12,000 people in that building.

And I will ask John—John has some firsthand lessons-learned issues.

Mr. DONNELLAN. First lesson, I would like to say, in spite of any self-critique we may do of our disaster planning, I think we did remarkably well. I cannot compliment the staff and VA New York Harbor Health Care System and VISN 3 enough for the work they did responding to this, while many of them did not know the whereabouts of their loved ones.

Any time you did this, you sit back and reflect on how you might have approached it better. I think Jim pointed out correctly that nobody would have planned for something on this large scale. This has caused me to stand back and already appoint a team of people led by a very senior member of my executive staff to look at that—look at how we might change our disaster planning and our disaster drills to start looking at very large-scale catastrophic events and looking at situations where the ETA of victims or casualties and the number and type of casualties arriving are very, very variable and potentially very, very large.

Another lesson learned, one that we did remarkably well at, but it occurs to me that something we should think about is the way in which we adapted. Early on, certainly within the first 12 hours, we were focused on potential casualties. It became very apparent in that period of time that there weren't a huge number of casualties coming out of this, but a role emerged as a support for medical supplies and material needed for the disaster. It became readily apparent that we needed to provide traumatic stress counseling for victims, for their families who were seeking information, and for our own staff who had witnessed this occur.

It also became apparent, and we agreed within about 24—within 24 to 36 hours, to provide backup support to 3,000 New York State Army National Guard troops deployed to the area, and that we really needed to gear up in that support role. That pointed out some the issues that I think we can improve on in terms of our communication—our medical information infrastructure; there may be a better way we can look at rapidly communicating information about military personnel that VA would be called upon to provide medical support for.

The CHAIRMAN. Thank you. Mr. Evans.

Mr. EVANS. Mr. Secretary, this panel has given a lot of evidence for us to justify holding in abeyance plans to impose any medical bed shutdowns or diminished medical care or mass care capacity VA-wide until the impact on our Nation's ability to respond to research and medical care needs are analyzed and reported to the committee.

In addition, I think it also justifies us spending more on post-traumatic stress disorder. I was out at the ceremony at the Pentagon. And if you look at the pamphlet it put out, it had the names of the people missing in action and also the people killed; and I would say roughly one-third of them were women. Women have been moving up the rank structure and are in areas in this new world of combat really on the front lines because there really aren't any front lines anymore.

So how will we address the issues of women who need our services, traditionally in not using the VA so much in the past, but maybe more demanding? Would you care to comment about that?

Secretary PRINCIPI. Well, I think the VA has moved forward aggressively in the care of women veterans across our system. Almost every medical center I visit has a very dynamic women's health center where they address the broad range of health care needs.

In the area of PTSD, for example, perhaps there is more we need to do. We have 400 trained counselors, people who are experts in PTSD around the country; and I think we need to look at that as one of the lessons learned, one of the areas that we need to do more work. But clearly, as Mr. Farsetta indicated, I think the health care needs of many, many people will not be known for some time yet, as we learned during the Vietnam War and Persian Gulf War.

Mr. EVANS. I have one other comment. Chiropractic doctors work very hard in the clean-up and counseling of people. I hope you will keep that in mind as you deal with the chiropractic care issue that we have raised at other forums.

Secretary PRINCIPI. We had a very, very good response time in New York and Washington with employees from the National Center for PTSD in Palto Alto and others from around the country.

Mr. EVANS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. Thank you, Mr. Secretary. I want to compliment you, the VA and your staff in your response on September 11. I note in your testimony—I suppose I am going to compliment you first, how is that? I was pleased also with working with DOD to obtain direct on-line access to DEERS. Hopefully, that continues and we don't just do it for now.

Claims were processed within 24 hours, that is great, considering it normally takes over 200 days. To do it in 24 hours shows that, in fact, the system can work.

I have a question for you. In your testimony, you say the VA works closely with the Federal Emergency Management Agency to ensure compliance with the Presidential Directive 67. Are those just words, or do you think you really have a good working agency with FEMA, and they understand what resources and capabilities you have to offer in a contingency?

Secretary PRINCIPI. I will ask Dr. Murphy to respond, and perhaps Deputy Secretary Allen as well.

Over their years at the VA, but certainly during this crisis and also during the crisis shortly after I became Secretary, in Houston, I believe that the working relationship has been top-notch and that the barriers have come down to effective communication and collaboration across agency lines.

Can more be done? Absolutely. I think the Office of Homeland Security will further tie in the disparate agencies of government to work collectively together.

But during my 7-month or 8-month tenure, Mr. Buyer, I have seen good cooperation.

Again, I think there is room for improvement. We have learned a lot in this crisis. And just to further point what Mr. Donnellan was getting at, the ability to get medical records from DOD to VA,

is terribly important. The government's computerized patient record that allows the electronic transmission of medical records from DOD to VA, is important today; and we are working diligently with DOD to make that a reality, but clearly more needs to be done.

Mr. BUYER. I notice that FEMA lists twelve emergency support functions. They include possible problem areas during a national emergency, whether it is transportation, communications, health and medical services, et cetera. But—of these twelve areas, there are four in which the VA is positioned very well to respond, but at no time is VA ever mentioned as a resource for FEMA.

Obviously, that tells me you are correct. There is a lot of room for improvement.

I also—the gentleman from HHS made a comment with regard to the anthrax vaccine that you are—wanted to purchase up to 12 million doses; is that correct?

Mr. ALLEN. Treatment for 12 million persons.

Mr. BUYER. Treatment. Not vaccines.

Mr. ALLEN. This would be a prophylaxis treatment.

Mr. BUYER. We had a little discussion here early on on the fourth mission, and what is difficult in my mind to assess here is, I don't know how we define what is robust in your fourth mission so that you can sort of work backwards. I know Mr. Stearns made a comment about "incrementally" on the fourth mission.

Sometimes I look at the VA and say, you know, the VA is an national asset to our medical systems within our country. There are things that we identify that the VA does very well.

And as you have your relationship with DOD, I think that America sits out there and believes that there is such great integration between you, and on the issue of weapons of mass destruction, if a hospital out there—anywhere in the country, if they needed expertise with regard to a biohazard or a chemical attack, they think they can go right over to the VA and get that support, and that that doctor is well trained to do that, or can step right in.

Do you think they are prepared to respond to an NBC attack or hazard?

And let me add one other thing. All these teaching hospitals that you have out there, are you going to make it part of the curriculum? Or maybe it already is.

Dr. MURPHY. I think, in general, as far as I know, the only medical school in the country that makes NBC training or weapons of mass destruction training part of their curriculum is the Uniformed Services University of the Health Sciences.

You know, we can do more training of our own staff in VA and have begun to do that. Our staff are well qualified to provide this treatment today; they will be better qualified over the next several months.

We also have an MOU with the Department of Health and Human Services to develop an education program for the NDMS, the National Disaster Medical System, hospitals to provide them training. DOD has excellent programs already put together on biological agents and chemical agents. We have utilized their expertise in developing our own training programs, and we will do an assessment and survey the NDMS hospitals to find out what they

already do, what they have available to them, and how we can augment that and make sure we fill in the gaps in their training, in addition.

Mr. ALLEN. I will just add to that.

One of the key points to recognize with regard to graduate medical education, dealing with mass destruction training for physicians or health professionals, actually goes to the heart of the core curriculum, and that is dealing with public health issues, dealing with infectious disease issues.

As we are looking at these types of vectors and weapons that can be used against us, or biological or chemical agents, a lot of that is being able to detect it early on, being able to identify it; and upon identifying it, what is the appropriate course of treatment for addressing the particular issue.

And so I think that a very critical issue that we need to address is, what is the core competency that a physician is required to have; and how we build upon that core so that you have some more specialized training, perhaps in dealing more specifically with biohazards or chemical issues.

The CHAIRMAN. Ms. Carson.

Ms. CARSON. Well, I think probably, Mr. Chairman, it is not a question for the VA. I get confused on the overlapping on the responsibility and jurisdiction.

What my concern is is the exposure, the major exposure to a lot of our troops that are going into these various places. I have to look at C-SPAN and see where they are today, but we will find out.

Is there some mechanism in existence now where if there is a major infusion of just the big "A" word, that I don't like to call—would the VA be in a position to respond? And you have got the National Guard, you have got the Reservists, the Active military, you have got all these military people out here.

Mr. Secretary?

Secretary PRINCIPI. Position to respond if service members return with——

Ms. CARSON. Yes, exposure

Secretary PRINCIPI. We are prepared to respond. Clearly, there are some areas where we need to work on our training. But by and large, VA is there to back up the Department of Defense, to assist and treat these casualties if need be.

Ms. CARSON. I am sure I heard this question earlier and didn't hear the answer.

Is there a moratorium on closing down beds now, pending the resolution of this conflict—this war?

Secretary PRINCIPI. There is no moratorium currently in place. We are not closing down beds currently, if you will. We have the CARES process under way. No recommendation has come up to my office yet on the closure of beds of any VA medical facility in the system.

Clearly, we need to ensure that any recommendation with regard to closure or change of mission or enhancing the mission of a VA medical center around the system takes into consideration the important role we play today, post-September 11, and the ability to meet our primary mission, as well as the mission that we have all talked about today, backup to DOD and assistance to HHS and

other agencies of government in the discharge of their responsibility.

Ms. CARSON. I heard the gentleman earlier talking about the post-traumatic stress, and we have been through that conversation a long time and the fact that there is going to be a time lag there before we discover the widespread impact of post-traumatic stress and the fact that there is no way right now—and not your fault; I mean, you are doing a great job. But right now there is no way to really accommodate and to treat all of those soldiers, if you will—veterans, who are affected by post-traumatic stress.

And then you have got the World Trade situation, those firemen. Those people are going to suffer for years to come. Even though they still have their life and their limbs, they are just injured beyond description.

Secretary PRINCIPI. Certainly in the area of post-traumatic stress counseling, we will do everything we possibly can with the resources available to us, and certainly consistent with our mission and law that we treat veterans, to assist people with needs that they might have. I am not sure we have the capability to care for the tens of thousands who might need counseling who are not veterans, but we certainly can offer our expertise, training and whatever is necessary.

I think it is important for us to be a resource to the community, to the Nation, and to the extent we are capable of doing so, whether it be PTSD or assisting HHS, however they need us, we will be there for this country.

Ms. CARSON. Does CARES consider the crisis mission of the VA?

Does it consider the crisis mission of the VA?

Secretary PRINCIPI. Dr. Murphy has been working closely on that, and clearly our backup to DOD is a factor.

I am not sure whether we have considered multi-scenario crisis backup to DOD, handling a major crisis like New York, as part of the deliberation.

Dr. Murphy.

Dr. MURPHY. I think the Secretary has said it well.

The CARES evaluation does look at DOD backup as one of the major functions that needs to be carried out within the network that is being studied. However, it did not adequately address multiple scenarios occurring at the same time, for instance, an ongoing combat activity, a wartime situation and a terrorist attack here on U.S. Soil, with other combinations of both civilian and military backup.

And so we will be reassessing the adequacy of the study criteria in the light of the activities that occurred in September.

The CHAIRMAN. Will the gentlelady yield for a moment on that point?

Dr. Murphy, could you tell us what is the time line? I mean Booz-Allen has undertaken these studies, as we already know. They are independent contractors working at the discretion or at the advisement of the VA.

Will instructions go out to include enhanced criteria, that would be this mission for—especially related to, you know, the possibility of a weapon of mass destruction or some other terrible scenario?

Dr. MURPHY. Chairman Smith, as you know, we completed one network study in Network 12, the Chicago area, and we have not made final recommendations to the Secretary based on the evaluation that Booz-Allen did and the comments that we got on their proposed option. We probably won't be doing that for several weeks yet.

In the meantime, Mr. Principi asked us to put together a team to reassess the CARES study, not only the criteria that were used, but the data that were used, and to tell him whether the process should change, how it could be improved, what the lessons learned were. And before we go on to do any further studies, we will be making that report to him and changing the statement of work for the contractors as is appropriate, based on those findings.

The CHAIRMAN. Thank you very much, Dr. Murphy. Thank you.

The Chair recognizes Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. And let me also echo the comments of my colleagues and to welcome you and to applaud you for the efforts that you are doing in this serious crisis that we have.

And, Mr. Secretary, you indicated that following—or you did form an Emergency Preparedness Working Group. You mentioned $250 million. And I wanted to talk about that a little bit in light of the fact that GAO earlier in her testimony had indicated that in 1998, a Presidential report to Congress on Federal, State and local preparations and capability to handle medical emergencies resulting from weapons of mass destruction pointed out there were three areas that needed improvement. So we knew this even before the World Trade Center.

And just to review with my colleagues, the four missions here are treat veterans; secondly, medical education and training of the VA staff; and the third is to conduct medical research; and now the fourth is to back up the Department of Defense, but within that, support commitment if it is needed. So within your fourth mission, first of all, you are supposed to back up the Department of Defense. So we are talking about that like it is the first priority within the fourth mission. But it looks to me, if I read this correctly, you really have to support the Department of Defense first.

Now, within—within the GAO report they mentioned three areas, as far back as 1998, that need corrections. So I submit that when you come in, Mr. Secretary, for additional money, these three should be part of this.

And, Mr. Chairman, their VA hospital does not have the capability to process and treat mass casualties resulting from weapons of mass destruction. And number two, the VA hospitals and most private sector medical facilities are better prepared for treating injuries resulting from chemical exposure than those resulting from biological agents or radiological material. And thirdly, VA hospitals, like community hospitals, lack decontamination equipment, routine training to treat mass casualties, and adequate on-hand medical supplies. So if it is true back then dealing with weapons of mass destruction, certainly it is going to be true today with some of the new things that we have.

So I guess my question is, sort of as a suggestion is, and when you look at this 250 million, these three that I mentioned tie in,

and I suggest that you provide—when you provide your request to the committee, that you also include those three as well as we are also coming up with your preparedness report.

Secretary PRINCIPI. Mr. Stearns, the task force did, in fact, look at the 1998 study and did incorporate its findings.

Mr. STEARNS. So that 250- is part to cover these three discrepancies?

Secretary PRINCIPI. Yes, sir. The need for decontamination equipment, the need for more adequate training, stockpiling of antidotes, things of that nature have been included.

Mr. STEARNS. Well, that is encouraging then, because, I hadn't heard about these discrepancies, and I am glad to see that you are addressing them.

The other question I have is just dealing with—when you offer post-traumatic stress disorder counseling at the site as a result of the September 11 attack, how do you evaluate the effectiveness and how do you measure success in these kinds of activities? Is there any way to do it in terms of—of how it is going and whether we should improve it and in what ways we can?

Secretary PRINCIPI. I would like to turn it over to Dr. Murphy, but I believe that Deputy Secretary Allen has a comment about the first part of the question, the important part you raised about the funding.

Mr. ALLEN. Sure. I can also address a portion of the second question as well.

I think it is important to recognize that a lot of—of the request, HHS's $1.8 billion request, much of that focuses on State and local response preparedness. And so we would be working with VA with regard to the training of local and hospital personnel, the first responders in large part. So much of what we are talking about is going to be in collaboration with VA under the MDS plan.

Mr. STEARNS. So the money that you are requesting would also help the VA hospitals in the three areas?

Mr. ALLEN. In part, but particularly with regard to training and helping us to prepare at the local level. That is an area we are working with them on.

In addition, in response to your question regarding post-traumatic stress, of course, the first responders in those areas are going to be from New York City, and the role that not only VA played, but the role that the Federal Government played was not to be the primary responders. That came first from New York City.

That was then augmented by the State of New York, and then we were there in large part to provide assistance and backup support. In fact, Secretary Thompson and I—we traveled there the Thursday after the 11th and met with the Mayor and met with the Commissioner of Health for New York City, the Commissioner of Health for the State of New York, and we talked very specifically about these issues.

Post-traumatic stress does not occur immediately. We are going to incur this not only days from the event, but weeks, months and even years. And so I think the standard of measure is how quickly do we identify that someone is experiencing post-traumatic stress and how effectively do we deal with it, how effectively to bring the resources to bear? And then, in this regard, VA can augment much

of what is already in the civilian area. But it is not necessarily going to be a primary response. It will be supportive.

Ms. MURPHY. If I could just add a few comments to that, Mr. Stearns. VA is very expert in post-traumatic stress disorder research and treatment. However, our experience is primarily in the long-term chronic effects of PTSD. I think that very few people in the United States, few groups, have experience with what the best way to deal with these disaster situations is, and it would be helpful to have more research done on acute effects and what is effective in preventing the long-term consequences of this kind of a traumatic exposure.

In fact, on Saturday, Mr. Donnellan, Mr. Farsetta participated with some local representatives in talking through how they should adapt their programs to treat the responders, and how we should track their success over time, and what research they should do, and what instruments could be used in that research.

So we are working with the local New York staff and the local agencies in that response.

I don't know if you want to say something else.

Mr. STEARNS. Mr. Chairman, I would point out if we are going to extend this program over a period of time, we should have some way to measure the success or failure. So I suggest if any letter—we work on that kind of understanding, you know, in dealing with the things we had from Vietnam as well as from the Gulf War, trying to understand that would be helpful.

The CHAIRMAN. Thank you very much, Mr. Stearns.

The Chair recognizes Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

Good afternoon, Mr. Secretary. I appreciate you all being here.

If I might, I think I want to do more of a kind of rambling statement, then have you comment on it, rather than just asking a precise question.

One of the things that has gotten to me the most personally in this whole post-September 11 thing is I had my staff the day afterwards go back and look through some of our House Armed Services Committee hearings about what has been said before about predictions of terrorism. And I served on the House Panel on Terrorism for a year and a half or so, and we had multiple hearings about Osama bin Laden and all of those kinds of folks.

But the one that got to me the most was this year, March 21 of this year, 6 or 8 months ago, Floyd Spence, who passed away the last week of August before any of this occurred, had an open hearing on the—the Rudman-Hart report in kind of a rambling question. But I remember some of specifically what he said is he was talking about attacks on the American homeland. He said to Senator Hart, this is not a risk of the future. He said, it is right now. Then his exact words were, we will lose large numbers of people.

So that is the House Armed Services side of things that I think all of us have sat through some of this. But then I hear some of statements here, and I don't mean to be critical at all. I am concerned that we are not getting information to you from the Armed Services side, or DOD is not communicating with you.

But here, the gentlemen who work in the area where we had the 1993 bombing of the World Trade Center are telling us that it

didn't envision that level of catastrophe, but the plan was to topple one tower in 1993 into the other one, and take them both down.

The bombing in Kenya in 1998, I believe there were several hundred killed, there were 5,000 wounded, a lot of them penetration injuries because it was a two-phase bomb. A small one went off, everybody ran to the windows in all of the surrounding buildings, the big one went off, and there was a lot of penetration injuries.

When I read through your statement earlier today, Mr. Secretary, I was struck by—you were very clear that this has been something that you all and we all together have been directed to look at before. But I guess the reality is it is one thing to look at it as an academic exercise; it is another to look at it when you have had the heartbreak of September 11.

So my first question is, why did you have to form a working group? Why wasn't this an ongoing function of what—how do we respond? The scenario for this month is how we respond to massive casualties in South Korea transported back to be cared for by our VA hospitals. A scenario for next month is what do we do if there is a repeat attack on New York? That was part of the mandate from Congress that we have all been dealing with.

When I looked at your list of things, the 12 recommendations, these are things, I think, that are lessons already learned. The—the National Guard and Reserve units will be called. That is what happened in 1991. Mr. Buyer didn't work in the VA hospital, but wherever he was working at when he was called up was a problem.

That there will need to be a lot of post-traumatic counseling, that would certainly would be the situation if we had a massive conflict in South Korea.

The VA needs to have increased security forces. I know you have been dealing with that because of animal labs, you have incidents occur where people have targeted your animal labs in VA hospitals, and they are a Federal facility. We had the bombing of a Federal facility by Timothy McVeigh.

The cyberthreats. That has been a concern, as you indicate in your statement.

The possibility of needing to expand cemetery space. That should be something that we all have been—would be planning for if there was a major event in the Korean Peninsula.

So my question is—and I am not pointing fingers at anyone because we are all in this together—what has happened now is a heightened awareness of the reality of this, I mean, because, in fact, it has been the mandate for all of us here in the Congress, in the DOD to prepare for these kind of events, because, as Floyd Spence pointed out, we will lose large numbers of people in the American homeland. He said that 7 or 8 months ago. Do you have any comments?

Secretary PRINCIPI. Yes, Doctor Snyder. It is heightened awareness, and I certainly don't mean to imply by creating the Emergency Preparedness Task Force that we have not been working in the past. And indeed, VHA, the Department, has, in fact, done so.

In the area of cybersecurity we have brought on a cybersecurity director to assist with intrusions and viruses and things of that nature, and VHA has been working with HHS.

But I felt that because of this crisis and the multiple scenarios that might be going on with DOD overseas in a warlike footing, and perhaps other terrorist acts at home, that we needed to be prepared. I wanted to see where we were, where we had deficiencies and what steps we could take immediately to shore up in the event of an additional crisis. But it clearly has moved from an academic exercise to a more serious one.

Dr. SNYDER. I think the Chairman and I and some others here were trying to read your expression when we got the number from OMB in the budget, And as I look at some of these things on the list of 12, there are things, my guess is, that you had tried to fund earlier than now. And I think the committee is certainly supportive of you.

The CHAIRMAN. Thank you. Mr. Filner.

Mr. FILNER. I am going to talk to the Secretary a little bit about resources.

Mr. Allen, you had an exchange with Mr. Buyer where the figure 12 million came up, and I guess I wasn't paying attention too much, but 12 million treatments? What were you talking about?

Mr. ALLEN. We are requesting additional funds to expand our current pharmaceutical stockpile, which currently treats 2 million citizens for a course of 60 days for exposure to anthrax. We are expanding that to a course of treatment for 12 million, actually expanding it to 12 million for a course of 60 days.

Mr. FILNER. That is what I thought I heard. So you are telling me that this administration, which is on the air and saying, relax, go to dinner, travel, go to Disneyland, is preparing for 10 million additional anthrax victims? Is that what you are telling me?

Mr. ALLEN. It is called preparedness. We are not——

Mr. FILNER. I understand. But the American people need to understand what we are talking about here. If we are going to be concerned, let us know. Now, you are telling me something that I had never heard from the President before, that we need to be prepared to treat 12 million people for anthrax? Is that what you are saying?

Mr. ALLEN. I will be glad to answer your question. But I think that you are taking it out of context. The current stockpile is prepared to address mass casualties in the case of anthrax or plague or tularemia or others to the tune of about 2 million people.

We believe that it is important for the stockpile to be adequate to address any future threats to our Nation, that we would expand that to cover 12 million. That is not to say that we are anticipating that to be the case, but it is better to be prepared than to be sorry.

Mr. FILNER. I agree with you about being prepared, but I am surprised that that kind of announcement comes from the Deputy Secretary for Health, Education, and Welfare instead of the President of the United States. So I think this committee and the American people ought to look at that with some degree of apprehension.

It leads into my questions for Mr. Principi. When you were confirmed, Mr. Principi, many of us, including myself, said you were the man for the job. And when you were confirmed, we supported your appointment, and I think now with this crisis, you are the man for the job.

And I would like to know, given the Congress' approval of a $40 billion appropriation, have you as the Secretary requested any of that money for your use?

Mr. PRINCIPI. The money I have requested is to reimburse VA for an amount we expended in New York to respond to this crisis. And the $40 billion basically is to allocate resources to the Department that have been called upon as a result of this crisis.

Mr. FILNER. If you would like some unsolicited advice, as someone who supports your Agency, I heard from the Under Secretary that Governor Thompson is requesting a billion and a half. It seems to me as a VA Secretary you have got to be in there fighting.

My reading of the situation is as follows, and correct me if I am wrong: contrary to the recommendations of this committee, Congress for fiscal year 2002 came in with a budget for your Agency that could barely keep up with inflation. As I said earlier, I have heard, and I don't know if that was in writing or just I heard, that you are preparing your field people for a deficit of roughly $800 million. If you add that deficit to the new demands now, including 12 million anthrax victims, it seems to me you need to get in there and fight for, as I said earlier, a billion dollars, if those figures are accurate.

And you know when we had your hearings, you may recall it may have been me who suggested that the previous Secretary was not in there fighting in the bureaucratic struggles. You assured us that you were going to be in there fighting. I hope you are. You know, the squeaky wheel gets the grease.

I know that there is a national concern. We are all trying to be united. But if the Governor is in there for a billion and a half, and we are in there for $200 million, I can tell you that we are not going to get what we ought to have.

Secretary PRINCIPI. I appreciate your sentiments, Mr. Filner. I can assure you that I have been fighting from day one for the resources I feel the Department needs to fulfill its mission. I will continue to do so. I will never shy away from doing so. And then once the figures are given, then I will comply.

But with regard to the $800 million shortfall in 2002, I am not aware of that figure.

Mr. FILNER. Some of your hospital administrators have been told that.

Dr. MURPHY. We have been doing some budget planning. Related——

Mr. FILNER. I would like to talk to the Secretary, if I might.

I have heard the $800 million figure from various people that they have had internal communications saying they have to be prepared for real cutbacks. But, regardless of that, we are passing legislation here. I won't mention the piece of legislation, but it is going to put new demands on you. So we haven't kept up with the old demands, we have new demands, and we have an emergency.

Now is the time, and we are prepared to support you, at least I am, and I am sure the Chairman is, for additional resources to do the job you have outlined here, and there have been incredibly good questions. I thought the Chairman's questions on what you have learned were incredibly good, and I thank you, Mr. Chairman. And what you have learned means there is more work to do, more

training, more, as you mentioned, real life, taking this thing not as an academic exercise any longer.

So there are new demands on you. I hope you are in there fighting for those, because I don't want to tell my veterans who are waiting 200 days, well, now you are going to have to wait 400 days or we can't give that kind of medical help because we are engaged in this emergency.

I have already read the testimony of Dr. Murphy here. I want you to get the resources that we can to do the total job. My advice, unsolicited.

Secretary PRINCIPI. Thank you.

The CHAIRMAN. Thank you.

I just have a couple of final questions I just want to make, and I think the record should be very clear about this. I alluded to it earlier when we heard from the GAO, but just as recently as March 8, 2000, GAO did a scathing report about the Veterans Administration as well as the Office of Emergency Preparedness, OEP, and the Marine Corps Chemical Biological Incident Response Force, the CBIRF, that they did not manage the stockpiles of pharmaceuticals very well, and it was a very, very disturbing report.

Just 2 years later, a little over 2 years later, in testimony delivered today by that same author. That same investigative team, Ms. Bascetta, the Director of Health Care, she is pointing out that the VA has improved, that the stockpiles are now—while they are not enough the way—that is one reason why we are here today—that you have made—done yeoman's work in inventory management and ensuring that they are potent and that they are up-to-date, and I want to commend you for that, Mr. Secretary, and your very distinguished team. She makes note that we have ongoing concerns about security, but I think that is in every one of our agencies.

So I want to thank you for that, and, I mean, what a difference just those several months have made. And you did respond, and you responded very, very admirably, and, again, I wanted to thank you for that.

I do want to ask Dr. Allen, we know that the VA has done much in the area of the—the scenarios. And could you summarize what lessons we learned from the TOPOFF 2000 and Dark Winter exercises?

Mr. ALLEN. Sure. I think there are a number of lessons that can be learned from those; first of all, the clear need for coordination. We need to coordinate with the State and local governments that are first responders. We also need to coordinate with the media that can be an ally in circumstances like this. Those are very clear areas that we need to work on.

We also need to work very closely with VA in positioning our stockpile resources to be able to be utilized, broken down to smaller units so that they can get to the sites, multiple sites, at the appropriate time. These are some of the areas that we have talked about.

We have also understood the need that—in the case of our stockpile resources, they need to be under government control so that we can have access to them. Some of them are in the hands of private corporations that manufacture them.

And so there are quite a number of other issues that we have learned from these exercises. I think the clear one, though, is prior

coordination. That is what we are working very closely with our partners at DOD, VA and FEMA and others to accomplish.

The CHAIRMAN. The national pharmaceutical program is divided into two components, 8-hour, 12-hour push packages and vendor-managed inventory. I wonder if you can tell us, any member of our panel, what responsibilities does the VA have? I know that you stockpile, but what about coordinating and disseminating these vaccines and those medicines when they are needed?

Mr. ALLEN. I think we can share this response, but I think it is very important to note that there is a very clear role for VA. First of all, they are the purchaser of many of the items that go into the stockpile. Because of the purchasing power that the VA has, we contract, and in many cases exclusively, with the VA to purchase items for the stockpile.

Also, the VA has a role in the rotation of the stockpile, maintaining relationships with the vendors, with our vendor management inventory, There is a considerable amount of additional training required as well so it is a very broad role that VA plays, at least from our perspective, one that is very vital to the accomplishment of our mission.

The CHAIRMAN. In terms of the amount, is the amount enough in—I noticed we spent, what, $62 million from Health and Human Services in fiscal year 2001? I think it was a little less than that a year before. Are we procuring enough?

Mr. ALLEN. As I stated earlier, one of the things we will be doing is augmenting the stockpile. We have looked at it to try to decide what we need to purchase more of. We will be making a significant augmentation to the stockpile, so depending on the circumstances, what we want to deal with—trying to deal with the multiple sites, multiple scenarios may be necessary in trying to make that available. And I think the answer would be, no, it is not sufficient. That is why we have asked for additional resources.

The CHAIRMAN. Let me ask one final question. As we all know, the President has said we are at war. There seems to be no doubt about that given the events on September 11. Now, the VA's strategic plan, the current one that obviously was drawn up before that horrific event, the working assumption is there will be no war during that time period that the strategic plan is in effect. Does that now cause a reevaluation of the working assumption in terms of how much money we need?

I know I am going at it from a little bit different from—does this help you, perhaps, with other agencies of government, including the Office of Management and Budget, to say, look, we are not playing games here with this money, we need it now, we are at war. And the VA is an absolute vital component in the delivery of health care and an important and vital service in a war scenario.

Secretary PRINCIPI. I believe so. Absolutely.

Mr. FILNER. Can I just ask a quick follow-up? Have you put a number on this, Mr. Secretary? It has been a month since September 11. How much money is the VA going to need to meet its fourth objective plus the first three? Have you come up with a figure?

Secretary PRINCIPI. Right now to correct the deficiencies that my task force recommended is $250 million. That is the figure that we have today. Now, based upon new planning assumptions under-

taken by the NDMS, that is all of the key players in emergency management preparedness, if the assumption is of the additional beds, additional capacity, then that number will go up. But for the deficiencies that we have today the figure is $250 million.

Mr. FILNER. There is going to be a bureaucratic struggle for this $40 billion. I would go way up since you are going to get less than what you ask for.

If my figures before were correct, which you didn't correct me, so I will go with that—we have real needs here, and we are prepared to support that. I hope you will fight for them.

Secretary PRINCIPI. Well, I certainly will. I am just fighting to get the Senate to agree to the House mark.

Mr. FILNER. But $40 billion, as I said.

Secretary PRINCIPI. I am having a tough time in both the House and the Senate to get an additional $300 million for emergency construction, emergency repairs. Now I have been taken to the woodshed because I am up here indicating how important it is to VA that we have that additional increase. I am having difficulty because of the allocation here in Congress to get the money necessary to implement H.R. 811.

So, yes, I would love to get a bigger part of the $40 billion, half of which is going to defense—for this war effort, and much of it is going to New York to assist the victims and the families.

So, Mr. Filner, I can assure you I am going from office to office on the Hill here doing what I can as well as OMB and the White House to try to get the resources necessary.

Mr. FILNER. Think about the $1 billion figure.

The CHAIRMAN. I want to thank you, Mr. Secretary, because we have passed out of this committee and out of the Congress on the House side a number of important bills that beef up the health care component. Tomorrow the Homeless Act will be up, which is a very comprehensive piece of legislation to assist the 215,000 plus homeless veterans who on any given night find themselves without adequate shelter. That will be up tomorrow. That costs money. We also have an important bill dealing with additional health care, and you have—this gets, unfortunately, over to the Senate side, and they are good friends and colleagues, but we hope that they will move on this legislation soon.

So I want to thank you, because you have been walking the halls and the corridors of the Senate to get 811 out. We called that the emergency hospital repair bill because it is. You backed us to the hilt. You testified in favor. We passed it. It was bipartisan. It sits and languishes on the Senate side. Hopefully this week, at latest next week, that bill gets down to the President; gets passed by the Senate and then down to the President. That is emergency. We have got to expend that money to fix our hospitals.

Mr. Buyer, you had a follow-up question.

Mr. BUYER. I do, but I have got some thoughts, too.

You know, it is easy for us here in Congress. We even get to make the rules. We even get to build the woodshed that we take you to. And we even sometimes craft rules that are almost unrealistic that you cannot achieve. So when we did the eligibility reform, this Congress, this committee, did not anticipate the level of utili-

zation from category 7. If anybody says they did, I don't think they are being truthful with themselves, let alone with the public.

So we create a problem within the health system. So then you come up here, and we beat you up as to whether you have been able to accomplish your mission or not. I am not going to be tough on you. I think in my own opinion Mr. Filner is a little overly critical here, because Congress created this problem, and we are going to have to take on the issue of reexamination of eligibility reform, its impact upon those who are supposed to receive the core competency missions of the VA.

With regard to this apprehension comment that Mr. Filner made, I don't understand where he is coming from. Mr. Filner, I don't. Number one, I find no paradox between a President who says to a Nation that you need to get back on with your lives, but at the same time his chief law enforcement officer says to the public at large to trust your senses. You know, the first responders—I used Mr. Allen's comments about first responders, Mr. Chairman—are law enforcement to include our military. They probably are most attuned to their senses that if it doesn't look right, feel right, smell right, you know, it probably isn't right.

And the population as a whole have been going out there carrying on their lives and not really paying attention to their senses. Now we have a Nation of 280 million who are paying attention to their senses that, hey, it is okay. If something doesn't look like it probably isn't right, I can go ahead and report it because we haven't been that suspicious as a society.

So when a President says to a Nation, let's get back on with our lives, and the top law enforcement officer says, it is okay for you to trust your instincts, and at the same time we turn then to our health system and we are going to examine our health system not only from this committee, but from other committees, as they begin to look in toward—with regard to our stockpiles, we always talk about military medical readiness, but what about that medical readiness of those health delivery systems and how they integrate with each other and coordinate? I don't see any of the stuff in a vacuum. So I find no paradox and no necessity for "apprehension."

I also, Mr. Chairman, want to make this comment. I know we are going to receive testimony from Dr. Sue Bailey with regard to this stuff about, gee, they should be apprehensive if it is this large a number. I remember former Secretary Bill Cohen. Bill Cohen tried to alert the Nation and held up that 10-pound bag of sugar and said, you know, this is the amount of anthrax, if you put it in aerial sprayer, this is what the consequences would be, it would go across States.

Now, I think it is extraordinarily responsive for Health and Human Services then to create stockpiles, because it was a former administration—I compliment Bill Clinton, and we didn't exchange Christmas cards. He went out and he got—he chose the SOCOM commander to become the Chairman of the Joint Chiefs of Staff.

Mr. Chairman, I don't see these things in a vacuum, but now I have got two questions I have to ask after that I will get off my soapbox, because I won't take you to the woodshed.

Mr. Allen, you used the word "first responders." you have used that repeatedly. I want you to define that.

Mr. ALLEN. In our category, first responders are those who would be part of the emergency system at the local level. They would be your fire, your police, your hospital, local hospital, who will be the initial persons on site to deal with the casualties, to do the triage, to determine what is necessary as we begin to bring additional resources to bear on that location where an event occurs. So that is what we refer to as first responders.

Mr. BUYER. All right. Help me here. You have got your police officers, your firefighters, your EMTs. So to you first responders does not stop at the emergency room door?

Mr. ALLEN. Not at all.

Mr. BUYER. Tell me where it stops.

Mr. ALLEN. It also does not stop at the local level, because then you have the State system that kicks in. You also have the Federal system. For example, New York was a good example of that. Whereas New York's EMTs, fireman, their hospital system, all were activated at the same time, we also were activated to address the emergency by moving and positioning resources there. That included working in partnership with VA to position people as well as the stockpile there. We also were there to help assist with evaluation. And that all comes under—the Federal Emergency Management Agency works with us to get that done as well.

Mr. BUYER. My last question, it is almost—put it this way. I know we are going—Dr. Chu is going to come up next. So I want to sort of get Dr. Chu to sort of think about this. We talked about the lessons learned and, I think, about the Gulf War and the Gulf War illness issues.

So now we have the 10th Mountain Division going to Uzbekistan, and now the 101st may be deploying. We have special forces deployed, and I don't know if we have baselined those soldiers prior to deployment. We had a lot of hearings, a lot of discussions on what to do about the force. It was to be coordinations between the VA and DOD about medical records and base-lining so we have got something so when they come back, I don't want to have, you know, illnesses, undefined illnesses number two.

So, Mr. Secretary, have there been ongoing discussions? If not, when can we anticipate them?

Secretary PRINCIPI. You know, I saw it coming during the Gulf War when I was Deputy Secretary of VA. I just thought to myself we had just gone through this enormously controversial history with Agent Orange and dioxin. And as I was sitting there in my office watching the fires in the Gulf, I said to my staff, we better build a registry so we can track people so that 10, 20 years after their service we have some baseline upon which to make this thoughtful decision with regard to their disabilities. And, again, it is beginning to happen again, and we need to have that baseline, to work cooperatively with DOD so we know about the people who are going into harm's way, and so that when they do return and they claim disability benefits, we have some basis upon which to make the right decisions.

I think we are making great progress, but I still believe that we have a ways to go, and perhaps you can talk a little bit about it.

Dr. MURPHY. We have worked very hard over the past 10 years to improve the prescreening and postscreening after a deployment,

but DOD has really taken a force health protection look at their system and creating a lifelong medical record. And the surveillance system, I won't tell you that it is perfect, but I will tell you that it is much better than it was in 1991 and that we are continuing to refine those programs.

I will let Dr. Chu talk about the DOD response this time.

Mr. BUYER. Mr. Secretary, I want to work with you on this one, because I have got great fears about what's coming up. I think we are very naive if we think that there aren't chemicals or biologicals in these caves, and to think that we are sending some forces in there, we need to prepare ourselves.

The CHAIRMAN. Thank you.

Mr. FILNER. If I might.

The CHAIRMAN. Very brief.

Mr. FILNER. I understand. Mr. Buyer had almost 10 minutes on his soapbox and he personally referred to me, and I would like to respond, if I may.

The CHAIRMAN. Briefly, please.

Mr. FILNER. He asked where I was coming from. Like you, Mr. Buyer, I am not looking at this in a vacuum. We are at war. The President said it. Our Chairman has said it. It is a new kind of war. It is a war that requires the unity of this Nation as we have never had before.

A lot of lessons were learned from Vietnam. My lesson from Vietnam is you don't get that unity unless you are honest with the American people and honest with the United States Congress. We are not getting that information from this administration. I have been at classified briefings, as have you. I have been at meetings. We have never heard this preparedness for another 10 million anthrax vaccines.

The President tried to keep only eight Members of this representative body informed of what was happening. That has been enlarged, but it hasn't been enlarged up to me, I will tell you.

I will tell you where I am coming from. I want to support this President. I have supported this President. But I want information about what he is doing. I don't want to hinder our war effort. I don't want the kind of information that is going to give the enemy advanced notice of anything. But I need the information to make intelligent decisions about that war and about our support of that war, and about the kind of actions that this government is going to take, and we are being asked to make decisions without information, Mr. Buyer. That is where I am coming from.

The CHAIRMAN. Let me thank our very distinguished panel.

Ms. CARSON. Can I ask one very brief question?

With respect to medical records, I have a lot of constituents that were exposed to Agent Orange, and their records have been lost. Is there a mechanism in place now to preserve the records of veterans? I mean, is there a backup system? You know what I am saying? A lot of people's records have been lost.

Secretary PRINCIPI. The records are maintained by the Department of Defense and the National Records Processing Center in St. Louis. Those records are then transferred to VA when a veteran files a claim for disability compensation or pension. Regarding medical records, DOD and VA are working on a computerized pa-

tient record, that will be backed up, but by and large the hard copy is maintained by DOD.

Ms. CARSON. I understand a lot of the hard copies were lost, according to my veterans.

Mr. PRINCIPI. During the fire. Prior to the 1956 fire, I believe.

The CHAIRMAN. Again, Mr. Secretary and panelists, thank you for your work on behalf of the American veterans.

I would like to ask our third panel if they would make their way to the witness table, beginning with Dr. David Chu, who is the Under Secretary of Defense for Personnel and Readiness. He is the senior policy advisor on recruitment, career development, pay and benefits for 1.4 million Active Duty personnel and 1.3 million Guard and Reserve personnel, and 680,000 DOD civilians, and he is responsible for overseeing the state of readiness.

Dr. Chu, we welcome you.

We also have a very distinguished panel that includes Dr. Sue Bailey, who was the Assistant Secretary of Defense, where she headed the $17 billion medical system coordinating the care for some 8 million beneficiaries.

We will also hear from Mr. Kenneth Kasprisin, who is the Associate Director for Readiness, Response and Recovery Directorate for FEMA, the Federal Emergency Management Agency.

Mr. James Krueger, a 35-year veteran of the American Red Cross, who will also provide his insights and expertise. Thank you for being here.

And finally Ms. Annie Everett, the Acting Regional Administrator for the National Capital Region of the GSA, the General Services Administration.

Doctor, if you could begin. Dr. Chu.

STATEMENTS OF DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE, PERSONNEL AND READINESS, DEPARTMENT OF DEFENSE; SUE BAILEY, FORMER ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS; KENNETH S. KASPRISIN, ASSOCIATE DIRECTOR, READINESS, RESPONSE AND RECOVERY DIVISION, FEDERAL EMERGENCY MANAGEMENT AGENCY; JAMES KRUEGER, EXECUTIVE VICE PRESIDENT, CHAPTER SERVICES NETWORK, AMERICAN RED CROSS; AND ANNIE EVERETT, ACTING REGIONAL ADMINISTRATOR FOR THE NATIONAL CAPITAL REGION, GENERAL SERVICES ADMINISTRATION

STATEMENT OF DAVID S.C. CHU

Dr. CHU. Thank you very much, Mr. Chairman. It is my pleasure to be here and have the opportunity to present the DOD's views on the Department of Veterans Affairs role as the principal backup to the Department of Defense in the event of war or national emergency.

The Department of Defense places enormous value on all of its sharing partnerships with Department of Veterans Affairs. Since the outset of this—since the outset of the sharing program, which was established in the 1982 legislation, Department of Veterans Affairs and Department of Defense Health Resources Sharing Emergency Operations Act, DOD has subscribed to the premise of im-

proved economy of operation that health resources sharing has held. In addition to greater sharing of peacetime health care resources between VA and DOD, this legislation authorized the VA to serve as the principal health care backup to DOD in the event of war or national emergency that involves armed conflict.

The military health system consists of nearly 80 hospitals and several hundred clinics worldwide serving an eligible population of 8.3 million. In addition, we have medical units capable of deploying with our Armed Forces to provide the preventative and resuscitative care that our troops may require while serving outside of the United States.

Because of our constant vigilance and need to be prepared to support the Armed Forces at any location around the world, military medicine has the tremendous ability to provide health and medical capabilities rapidly in a mobile or deployed mode. Some of these capabilities include field hospitals, specialized medical augmentation teams, field laboratory diagnostic capabilities, and so on. Additionally, we have our stationary military medical facilities located around the Nation that have inpatient capabilities.

The military health system continues to leverage the wartime capabilities of the men and women in our Armed Forces for domestic consequence management in support of the civil authorities.

The military medical team was ready to respond to the events of September 11. The hospital ship USNS Comfort was dispatched within 48 hours to New York City with Navy medical personnel from the National Naval Medical Center. The Army's DiLorenzo clinic staff at the Pentagon was among the first responders to the attack on that building. Additionally, Walter Reed Army Medical Center immediately dispatched three trauma teams, a preventative medicine team and two combat stress teams to respond to the Pentagon attack.

In response to the law authorizing a new contingency role for the VA, a memorandum of understanding was executed between The Secretary of Defense and the Administrator of Veterans Affairs, now the Secretary of Veterans Affairs, specifying each agency's responsibilities under the law. This MOU outlines the plan for the activation of the VA/DOD contingency hospital system. The system is activated by the VA after the Secretary of Defense determines that DOD needs VA medical care resources because of medical conflict or another type of national emergency. The Secretary of Defense notifies the Secretary of Veterans Affairs in writing of any need for medical care contingency support. The Secretary of Veterans Affairs commits VA to provide support and communicates this commitment to the Secretary of Defense in writing. Through the VA/DOD contingency hospital system, DOD receives periodic estimates of VA contingency bed availability. This plan is jointly reviewed and updated each year by the DOD and VA.

Within the Department of Defense, the Commander in Chief U.S. Joint Forces Command has overall responsibility to ensure integrated medical operations in the continental United States. Consequently, an integrated medical operations plan is in place that coordinates all United States medical assets in support of DOD casualties. This operations plan is supported by the VA/DOD contingency hospital system plan.

The VA and DOD bed contingency plans are also supplemented by the National Disaster Medical System. This robust bed expansion capability will be activated subsequent to a war or national emergency requiring more than the combined resources of the DOD and the VA.

DOD is the primary Federal agency responsible for administering the NDMS. The NDMS may be activated by the Assistant Secretary of Health for Health Affairs in support of military contingencies when casualties exceed the combined capabilities of the VA/DOD contingency care system.

When the Assistant Secretary of Health and Human Services activates NDMS in response to a domestic conventional disaster, DOD components when authorized will participate in relief operations to the extent compatible with U.S. National security interests.

The success of this joint venture was aptly demonstrated immediately following the September 11 attack on the World Trade Center towers and the Pentagon. In anticipation of receiving casualties, as Mr. Allen has testified, the Secretary of Health and Human Services activated NDMS, whereupon both VA and DOD began to report that availability to the Global Patient Requirement Center located at Scott Air Force Base in Illinois. There were, however, tragically, no casualties evacuated as a result of this event, as local resources were able to handle the treatment needed.

In summary, Mr. Chairman, the events of September 11 have highlighted the importance of a coordinated Federal response to national disasters. While each of us must ensure that our health care system is capable of meeting the demands of our respective missions, we recognize the vital role of the Department of Veterans Affairs in providing backup to the Department of Defense in the event of war or national emergency.

The CHAIRMAN. Dr. Chu, thank you very much for your testimony.

[The prepared statement of Dr. Chu appears on p. 121.]

The CHAIRMAN. And, Dr. Bailey, if you would proceed.

STATEMENT OF SUE BAILEY

Dr. BAILEY. Chairman Smith, members of the Committee, thank you for inviting me today to testify.

In my role as Assistant Secretary of Defense for Health Affairs, I was responsible for the health system and was the principal advisor to the Secretary of Defense on issues of health, health force protection, and chemical and biological warfare.

Key aspects of meeting wartime and peacetime requirements are DOD's Integrated CONUS Medical Operations Plan, which coordinates CONUS medical resources; the VA/DOD Contingency Hospital System; and the National Disaster Medical System, NDMS, which supplements the national energy needs of the VA and the DOD. During the recent attacks on September 11, HHS did, in fact, as you have heard, activate the NDMS. While the low number of casualties allowed local Federal medical facilities to cope, we cannot assume that future national emergencies would play out similarly. Clearly in the wake of the attacks, the domestic aspects of VA and DOD participation in the NDMS takes on a new relevance.

I believe there is much we can do to leverage the superb private and public health resources of this country in order to improve our capacity to respond.

While there are differences in the VA and DOD health systems, these differences do not mean that the two systems cannot be powerful assets to defend our homeland. On the contrary, the experience, the facilities, equipment and personnel of those agencies are essential to an effective civilian response.

But the potential consequences of the successful attack could be devastating. In the one exercise known as Dark Winter, Federal and private officials simulated an attack on a major U.S. City that was done with smallpox. It ended in chaos and demonstrated our inability to contain a bioterrorist attack involving an infectious pathogen.

Potential large-scale national energies that recent events call upon us to consider point up that despite the success of existing systems to respond in these emergencies, it is easy to imagine resources being overwhelmed by even a medium-scale weapon of mass destruction attack. It is vital that the resources of the VA and DOD systems be included in those efforts so that in the event the NDMS is activated again, the full capacity of the Nation's medical resources may be brought to bear. Thus the Veterans Administration will play an integral part in our homeland defense.

Mr. Chairman, I have specifics that I would like to recommend. Specifically, I will not go into some of the details that are in my written testimony, but it is important that we improve drastically our ability to communicate, that we have adequate detection equipment as is used by DOD and enhanced laboratory capacity. We must coordinate our surveillance. Oftentimes the only way we will know that we have been attacked is because symptoms present. We have to accelerate our training. It is possible. After hearing the discussion today, it should be required. We should ensure rapid access to stockpiled medications and vaccines. Decontamination facilities should be provided at all of our hospitals. Every hospital in Israel has a decontamination facility. And we must enhance our ability to increase bed capacity, that is called surge capacity, and track the patients and where they are.

Mr. Chairman, I would be happy to answer any questions.

The CHAIRMAN. Dr. Bailey, thank you for your testimony.

[The prepared statement of Dr. Bailey appears on p. 128.]

The CHAIRMAN. I would like to ask Mr. Kasprisin.

STATEMENT OF KENNETH S. KASPRISIN

Mr. KASPRISIN. Good afternoon, Mr. Chairman and members of the subcommittee. I am Kenneth Kasprisin, Assistant Director—Readiness, Response and Recovery Directorate for the Federal Emergency Management Agency. It is my pleasure to represent Director Allbaugh at this hearing.

The FEMA mission is to reduce the loss of life and property and assist in protecting our Nation's critical infrastructure from all types of hazards. When disaster strikes, we provide a management framework and a funding source for response, recovery and mitigation efforts.

The Federal Response Plan is the heart of that management framework. It brings together a team of experts from 26 Federal departments and agencies and the American Red Cross. It is organized into emergency support functions based on the authorities and expertise of the agencies as well as the needs of our counterparts at the State and local level.

Our plan is designed to support, not supplant or replace, State and local response structures. Since 1992, the Federal Response Plan has been the framework for managing major disasters and emergencies regardless of cause. It works. It worked in Oklahoma City, and it worked at the World Trade Center. It works because it builds upon existing professional expertise, disciplines and relationships. As lead agency for the Federal Response Plan, FEMA manages the allocation of Federal resources to assist State and local governments. We validate their needs and provide the right resources to the right place at the right time.

A Federal department or agency may be able to provide the resources under its own authority and funding. If not, FEMA issues a mission assignment or reimbursable work order to cover the cost. These missions usually fall within the scope of 1 of the 12 emergency support functions identified in the plan.

FEMA assigns the mission to the primary agency for the function. In turn, the primary agency may task its supporting agencies as required. The VA is the supporting agency under emergency support function number 8, health and medical services. The Department of Health and Human Services, the primary agency for ESF 8, would subtask VA for health and medical missions as appropriate. I defer to both organizations to discuss their work under ESF 8 and the national disaster medical system in more detail.

VA is also a supporting agency to the United States Army Corps of Engineers under ESF 3, public works and engineering; to the American Red Cross under ESF 6, mass care; and to the General Services Administration under ESF 7, resource support.

Since FEMA's concern is resource allocation, we want to have as large a pool of available resources as we possibly can. We recognize that as one of the Nation's largest health care providers, the Department of Veterans Affairs has substantial assets, including medical facilities, medical staff and pharmaceuticals.

Mr. Chairman, you convened this hearing to ask about the role of the Department of Veterans Affairs in domestic attacks. In essence, they play an important supporting role to four of our ESF leads. We are pleased to count the VA among the agencies supporting the Federal Response Plan.

Thank you, Mr. Chairman. That concludes my remarks.

The CHAIRMAN. Thank you very much for your testimony, and we will get to questions momentarily.

[The prepared statement of Federal Emergency Management Agency appears on p. 144.]

The CHAIRMAN. Mr. Krueger from the Red Cross.

STATEMENT OF JAMES KRUEGER

Mr. KRUEGER. Mr. Chairman, members of the Veterans' Affairs Committee, I am Jim Krueger. I am executive vice president of the Red Cross. On behalf of Dr. Healy, our president and CEO, I am

honored to be here today to share with you our response to September 11 as well as our interaction with the Veterans Administration in times of national emergency.

With a presence in almost every community, Red Cross employees and volunteers are among the first on the scene when disaster strikes, and we were work closely with local responders; first responders, that is. Immediately following a disaster, before a Presidential declaration is made triggering Federal response and resources, the Red Cross is on site sheltering, feeding victims, their families, those fleeing from the areas, as well as the first responders.

The Red Cross has a nationwide capability to help prepare for and respond to disasters of every kind quickly and routinely. We can mobilize a trained network of employees and volunteers in communities throughout the Nation, experts in logistics, nursing, counseling, spiritual care, communication and sheltering. The American Red Cross is a trusted independent organization that can serve as a vital link between all levels of government and the American public during events of this magnitude.

We are mandated by our congressional charter, and we derive our authority from this charter that was signed in 1905. This charter directs us to carry out a system of national and international disaster relief. The Red Cross is also entrusted to serve as the medium of communications between people in the United States and members of the Armed Forces.

During times of war, the charter defines the role of the American Red Cross as an auxiliary to the United States Government in the fulfillment of the Geneva Convention to protect victims of conflict. Under the Federal response plan, as you just heard, the Red Cross is the lead agency for emergency support function 6, mass care. We meet the needs of disaster victims by providing food, clothing, shelter and by operating a family-linking service to report on the status of those affected and to reunite them with their families. The Red Cross also supports the Department of Health and Human Services and EFS 8, and FEMA, of course, is lead agency for information and planning ESF number 5.

To assist in carrying out our roles, we certainly work with the eight Federal agencies that are designated as support. American Red Cross' response to September 11, we have never faced a disaster of this size, scope or intensity. At New York City, at the Pentagon and in Pennsylvania, 36,000 dedicated disaster relief volunteers have been working tirelessly providing humanitarian assistance. The Red Cross has provided a safe refuge for 4,000 people in 76 shelters. We have served over 7,000 meals to survivors, emergency personnel and stranded travellers in airports across the country. We have helped 90,000 people by providing crisis grief and spiritual counseling.

Under our family gift program, the Red Cross has already helped over 2,100 families with financial support for rent, mortgage transportation and other living expenses. We have committed $100 million to this program and to date, have spent 32 million. We have positioned blood and blood products in the event that they will be needed and have accelerated our strategic blood reserve for the purposes of supporting the military and the Nation in general.

And just last Thursday, the Red Cross was asked by the President of the United States to administer America's fund for Afghan children where the children of America are encouraged to donate $1 to be used for delivering food, medicine and other needs and services to children of Afghanistan. We also have a Web site with information for the public and it covers all ages, all questions, et cetera, that people can tap into, because we do take our role and information sharing seriously. In collaboration with the Veterans Administration as a support agency to the Red Cross and mass care, the Veterans Administration has provided variable assistance with counseling services.

Following a disaster, no matter if it is local, State or Federal, Veterans Administration's counselors and members of the VA chaplain's services have helped provide grief counseling and spiritual care under the auspices of Red Cross disaster services. VA counselors are currently serving at family assistance centers in New York City, a unique setting that has been created to help families who lost loved ones in the World Trade Center buildings. It has become a safe haven for victims and their families as well as a place for people who lost their jobs and homes to seek assistance.

In addition to providing counselors and chaplains to support the work of the American Red Cross, the VA has agreed to make available facilities suitable for shelters to provide medical supplies for use in these facilities. As we continue our planning for future WMD events, we will work with the Veterans Administration to identify how and when these facilities may be used and other opportunities for collaboration.

The American Red Cross response in following the weapons of mass destruction event, planning efforts have been underway for almost 2 years. Our major planning and preparedness initiatives are described in my written statement, but I would like to summarize several of those services. In many of these areas, we will need partners including the Veterans Administration.

First of all, mobilizing volunteer expertise. The Red Cross must train and recruit volunteers with a wide range of expertise such as employees of the Veterans Administration to be ready to meet extraordinary demands. We are establishing a mercy battalion, a corps of medical and other professional volunteers to be deployed across the country. As envisioned, this corps will supplement the work of those medical professionals supporting the Department of Health and Human Services national disaster medical system.

I mentioned earlier our strategic blood reserve. The Red Cross will also work with public health officials to assist with large scale emergency vaccinations as needed. We will work with the Centers of Disease Control to mobilize volunteers to assist in dispensing the national pharmaceutical stockpile. And we will continue to strengthen our capacity to deliver counseling services and spiritual care targeted to meet the needs of people directly and indirectly affected by the WMD event. Today, the Red Cross can mobilize 4,000 licensed trained practical professionals for grief counseling and spiritual care, and we will build upon this capacity.

And finally, the provision for food, shelter and basic health support. Biological weapons provide the greatest challenge in terms of shelter and contaminant since the attacks may not be success-

fully detected and identified for days afterwards. Infection of thousands of civilians fleeing or evacuating from attack sites could require weeks to months quarantines. Hospital facilities may be overwhelmed. The Red Cross will not only be asked to provide food and shelter and basic first aid to those displaced by disaster, but to augment existing health facilities. Therefore, our mercy battalion could be critical to fulfill the needs of the trained medical professionals.

In conclusion, the Red Cross is certainly an important private sector partner with Congress and the executive branch agencies in the development of a national strategy. We are an independent humanitarian organization with a history of trust and caring with the American people as well as being recognized as effective leaders in responding to disasters, domestically and internationally. To coordinate and carry out this role, we need support from agencies such as the Veterans Administration. Our more than 100 years of experience in helping people recover from disasters and coordinating relief will contribute to your leadership efforts to address this major national security issue. Thank you for including us in this important hearing.

[The prepared statement of Mr. Krueger appears on p. 133.]

The CHAIRMAN. We thank you very much for your good work and for your testimony. I would like to ask Ms. Everett if she could close out the statements.

STATEMENT OF ANNIE W. EVERETT

Ms. EVERETT. Thank you, Chairman Smith. Chairman Smith and members of the Committee, thank you for inviting the General Services Administration to this hearing and for allowing me to testify. I am pleased to appear before you today to discuss with you the role and responsibilities of the General Services Administration in preparing for and responding to domestic disasters and national security emergencies. GSA is assigned specific domestic and national security emergency preparedness responsibilities under executive orders 12656 and 12472. The key responsibilities included are to: number 1, provide rapid and efficient logistical support and telecommunications; number 2, assist client agencies in their recovery; number 3, provide support to those Federal agencies assisting victims of disaster or emergencies; and number 4, ensure the continuity of GSA operations.

These responsibilities are the same whether they are peacetime or wartime emergencies. Unfortunately, on September 11, GSA had our most challenging experience yet in carrying out these responsibilities. GSA has also been asked to comment on its interaction with the Department of Veterans Affairs in times of national emergency. While the Department of Veterans Affairs has responsibility for the acquisition of medical equipment and supplies pursuant to a delegation of procurement authority, GSA is available to provide whatever assistance the Department of Veterans Affairs or any other Federal agency may need to ensure the provision of medical equipment and supplies during national emergencies.

In the immediate aftermath of the terrible terrorist attacks in New York City and the Washington, DC Area, staff from across GSA, in accordance with our continuity of operations plans, imme-

diately activated our New York region COOP. Our associates literally worked around the clock to produce logistical miracles within a matter of days. In lower Manhattan, many buildings that had been leased by GSA for occupancy by Federal agencies were heavily damaged or destroyed. For example, one major World Trade Center low rise located at the base of the Twin Towers and occupied by the U.S. Customs Service was completely destroyed.

In addition, 6 major federally-owned GSA buildings in lower Manhattan were closed due to loss of power, loss of telecommunications in their proximity to the World Trade Center. In the Washington, DC Area, officials at the Department of Defense asked GSA to locate, make ready for occupancy and totally equip nearly 850,000 square feet of space. These facilities were needed to provide a place for DOD employees to relocate from many areas within the Pentagon. By September 17, six of GSA's lower Manhattan federally-owned buildings were reopened for essential personnel of the tenant agencies.

By the same date, GSA had negotiated 14 leases totaling approximately 1.3 million square feet of space in New York City and New Jersey. This includes space acquired to house FEMA operations and several displaced agencies. An additional nine sites for a total of approximately 700,000 square feet are being acquired for other tenant agencies that have been displaced or need additional space as a result of the tragic events of September 11. Remarkably, by September 17, GSA had also located, outfitted and prepared for occupancy 850,000 square feet of space for Department of Defense in northern Virginia. Officers from the Federal Protective Service immediately began helping evacuate the buildings in New York City and helping people to safety.

Within 2 hours of the first collision, GSA had set up an emergency command center in New York to begin providing affected agencies with the supplies and services needed to restore operations. In total, GSA has been called to provide nearly 3 million square feet of replacement space in New York, New Jersey and Virginia along with furniture, telecommunication systems, computers and all other items that are needed in today's office environment.

When GSA briefed representatives of all the agencies being supported in New York, our representatives received widespread praise and the warm applause of heartfelt appreciation. A DOD official summed GSA's ability to anticipate its needs by stating that GSA is 4½ hours ahead of anything we can think of. In my opinion, Mr. Chairman, the GSA associates who produced those results are heroes in every sense of the word. I am proud of them.

Mr. Chairman, this concludes my statement and I will be glad to answer any questions you and the committee may have.

[The prepared statement of Ms. Everett appears on p. 139.]

The CHAIRMAN. Ms. Everett, thank you very much for your testimony. I would like to ask, I think mostly Dr. Chu and Dr. Bailey this first question. How has the Department of Defense shared the benefits it has gleaned and garnered from research into weapons of mass destruction? Obviously, that information is used for the benefit of our troops as it ought to be, but is it shared with FEMA? Is it shared with the VA and all the other disparate agencies of government so that it is usable?

Dr. CHU. That certainly is our intent, subject to the limits of classification. I think it is also important to emphasize the benefit of sharing this knowledge with the civil medical system as far as domestic attacks of the kinds we just sustained are concerned. As Mr. Allen's testimony emphasized, and I think FEMA emphasized in its presentation, they are the first responders, and it is critical that they have the knowledge they need to be able to deal with those situations.

The CHAIRMAN. You said that is your intent. Has it been the practice of Department of Defense to do so?

Dr. CHU. Yes. I am sorry, sir.

The CHAIRMAN. Dr. Bailey.

Dr. BAILEY. There are many different ways in which what we have done—our country has done in biowarfare can be applied directly to homeland defense. You can imagine DOD is the agency that has already encountered exactly what it is that we are concerned about. So their efforts to develop systems of pretreatment, premedications, vaccines, autoinjectors in the case of chemical warfare, detectors that will let us know when there, in fact, are nerve gas or biologic agents in the area. All of these things are things that, at this point unfortunately, I think America is going to have to think about as they go forward in applying that, because the technology is there, because of the United States military, I think is going to make us safer.

The CHAIRMAN. On your watch, was it your experience that this information was shared?

Dr. BAILEY. I know that many times there were sharing going on among the agencies. And some of that was through the kinds of wargaming and simulation of exercises that you heard about where we brought all of the agencies together and absolutely shared the ways in which we would cope with those weapons of mass destruction.

The CHAIRMAN. Let me just ask, Dr. Bailey, in your statement, you point out that there are significant inadequacies with regards to our response. And then you point out—you have a number of bullet points, then you go through that list, many of which are not in place now. I asked earlier of the VA how many decontamination facilities they had at their hospitals. And I am sure we will get back a response shortly. I am not even sure—I am sure members of the committee may be wondering as well what is exactly a decontamination unit, how much does it cost and how many do we have—how many does the Department of Defense have?

Dr. BAILEY. Well, the trouble is we don't have but a handful. We don't have them at military facilities or VA facilities, and certainly not in the private sector. But as I indicated, there are places in this country where they have been under the same circumstances we find ourselves in now where they have now prepared by having decon centers.

And even though that is something we are going to have to undertake, which sounds expensive, for one, the fact is it is not very expensive. You are talking about an area that doesn't mean building a wing on the hospital. It means putting up a structure big enough to allow you to essentially wash down, unclothe and reclothe in a safe way those who have been contaminated by either

a biologic or chemical agent. And most often, it is done with water and Clorox.

The CHAIRMAN. Let me just ask Mr. Kasprisin, in light of the 2000 Gilmore report to Congress, can you tell us why the Federal Government has not taken more steps to beef up its weapons of mass destruction preparedness? If my understanding is correct, the Noble Training Center in Fort McClellan in Alabama is the only federally-funded WMD program.

Mr. KASPRISIN. Yes, Mr. Chairman. I think the needs are well understood. I think it has been a continual matter balancing those needs with the available resources. Frankly, I am not sure that the priorities on this event prior to September 11 are the same as they are now. I would submit to you that the emphasis on that with what has taken place in the supplemental as well as future needs certainly places significant attention on that. But there will still remain a challenge to balance those needs with the available resources.

The CHAIRMAN. Mr. Krueger, you earlier talked about the 4,000 grief counselors and obviously the Red Cross does a great job in an emergency situation. Can you, perhaps, differentiate or give us the difference between post-traumatic stress, which is usually—my understanding is that after the Oklahoma City event, that 6 months later was when the real manifestation of post-traumatic stress disorder began to manifest as opposed to grief counseling, which might occur much earlier. And how does your agency work with the VA? Has FEMA looked to the VA for its expertise in the post-traumatic stress disorder? I mean, they have personnel, as you know, that are just exemplarily qualified.

Mr. KRUEGER. Well, in our experience, certainly after the Oklahoma City bombing, is exactly what you were saying and counseling goes on today. And I really—the VA system has been a tremendous resource for us in that way. And when you look at the placement across the country and the different ways it was accessed, it continues to be an absolute vital resource to us. And we really see that this is a whole area. And what is really interesting in this disaster, I think, has been the spiritual counseling in this early phase, which is also a resource from the VA hospital. And it is just the grieving and mourning period has been tremendous and the memorial services at the sites and aspects like this. But you are right. Now, and what comes after this and what comes, as you say, 6 months later, a year later and different occasions crop up where these things get very difficult.

The CHAIRMAN. Is there any partnering between the Red Cross and the VA?

Mr. KRUEGER. Yes. We have a statement of understanding. And all of the things that I had mentioned are in that SOU that we can—that we certainly work together and access.

The CHAIRMAN. Let me just—not only are we concerned about the veterans, but obviously, we are worried about anyone else who is suffering. And I know all of you feel that way. One often overlooked group of people—and I just say this for the record—are the pilots and the flight attendants. Their modus operandi—I know this because my brother is a 757 captain, and a former fighter pilot before going with the airlines, and he has told me that the impact

on the flight attendants and the pilots has been very severe. He went right back up and his wife who is a flight attendant had a difficult time.

And to some extent—and I say this for all concerned, they have been left out of—I mean, now they will fight. But before, it was fly them to Cuba or take them wherever it is that you need to take them because you want to keep the safety of your passengers at the optimum level. It seems to me that is a group that might have to be looked at that had been largely left out. Today, if it were to happen, they would fight and go down with the ship. But then on September 11, their FAA, as well as airlines' restrictions or guidance, if you will, was not to take that kind of action because of the risk to the passengers. So I think they have a peculiar and very special need in all this.

Mr. KRUEGER. And our relationship with the National Safety Board and so forth, where we respond as our agreement is to all air crashes, has a system built into it that deals with the same mental health and psychosocial issues with the airline people as well as the passengers and other people affected.

So that is something—and was very unique, of course, at this point in time because of the number of crashes involved. But, yes, we definitely work with the pilots and the flight attendants with those issues.

The CHAIRMAN. Let me just ask, Mr. Kasprisin, if you could. You heard much in the earlier testimony, and I know you surely read the GAO reports about how the VA has significantly beefed up its ability to deal with the warehousing of vaccines and the like—stockpiling. In your view, has the VA done a good job with regards to that component?

Mr. KASPRISIN. I wouldn't look at that strictly in isolation, the collective package of being able to identify the problem and what resources are needed. In that extent, we are very reliant upon the States to identify the needs for particular incidents, and in that case, to rely on Health and Human Services to identify the best means of doing that. But from all indications that I have seen, the VA has been very forthright and forthcoming in attempting to address those previous issues.

The CHAIRMAN. Just ask Ms. Everett, how quickly do you think the GSA could procure space and equipment to set up decontamination units in the aftermath of an unconventional attack?

Ms. EVERETT. There are a number of—it depends—kinds of statements I would have to make. It would depend on the amount of space, depend upon the area of the space. But I do know with what just happened on September 11, our office in New York was able to acquire space in a very short time so were we here in the Washington, DC Area. So it depends on the amount of space that is in question that is the best answer I can give at this point.

The CHAIRMAN. I appreciate that.

Dr. Chu, if I could, has DOD evaluated VA's periodic estimates of its contingency bed availability? Is it available beds you are interested in, or should it be the availability of health care providers that we should be interested in?

Dr. CHU. The Department and VA together conduct periodic exercises to test this system. The point of the exercise is exactly to

the conclusion of your question. What matters is not just the physical bed, but a bed staffed with the appropriate personnel, et cetera, so you can take care of the patient. And those are the numbers that we report in our system. And we started looking at that on an ongoing basis right after the events of September 11.

The CHAIRMAN. Ms. Carson.

Ms. CARSON. Thank you very much, Mr. Chairman. Number 1, can I ask that any questions we are not able to ask here be submitted for the record?

The CHAIRMAN. Sure.

Ms. CARSON. I know I would like to ask Dr. Chu a quick question and that is, since the Gulf War, the relationship of active duty and reserve components has evolved into more of a total force concept. During the last decade, Reserve Components have been used in greater frequency and interchangeability. Because a large number of reserves are employed by the VA, these people can be activated at any time when the VA's mission expands, diluting staffing ratios to maintain the contingency beds. What have the DOD and the VA done, in what we would assume to be many joint planning sessions, to resolve the impact of reserve activation diminishing medical staffing capability? If it takes you too long to answer that, you can submit that for the record.

Dr. CHU. I can answer promptly here, ma'am. This is an issue that affects all Federal agencies. Every agency is periodically invited to identify essential or key personnel. Those personnel, if so identified, are taken out of ready reserve units and put in a different status so that they are not subject to call up in an emergency.

We also recognize that the nature of this emergency is different from many of the emergencies agencies had anticipated when they conducted these reviews, the FAA being case in point. So we have offered to work with each agency to look at, on a case-by-case basis, whether any particular person is so irreplaceable that he or she should be exempted, notwithstanding the failure to designate an individual earlier as a key or essential person, or whether that person's call-up should be deferred for a short period of time to permit the training and preparation of a replacement person for that particular post.

But we have a system in place that allows the agency in advance, the VA included, to say this person is key or essential and should be exempted from call-up. That does mean the individual cannot serve in a ready reserve unit, however. They must move to a different status.

Mr. BUYER. Will the gentlelady yield?

Ms. CARSON. I will yield.

Mr. BUYER. Dr. Chu, in my own opinion, I don't believe that was very responsive to Ms. Carson's question, because she is asking basically the worst case scenario—I am putting words in your mouth, Ms. Carson—but if, in fact, you have to go to a national disaster and now we are talking about that which is robust, we know how to plan if you do worst case scenario. Your answer was sort of in the present contingency. What happens in worst case scenario? You are not going to say well, the VA needs them nationally and therefore they are going to be nondeployable assets.

Dr. CHU. I don't think I said that, sir.

Mr. BUYER. No. No. That is what I am saying you wouldn't be saying.

Dr. CHU. I think what I said is that we have a baseline policy, which is, if the individual is essential or key, he or she may be exempted from call-up. That is an agency choice. But it also means that the individual cannot participate in a ready reserve unit.

Mr. BUYER. Oh, gosh. Time out. Time out. If you go with Ms. Carson's scenario here, if you go with the worst case scenario and you have got docs that have to be activated in the military, and now you can't backfill because we already have a medical shortage, and if it is a national disaster—national priority first, does that mean—let me presuppose here—does that mean then that you would call out the military medical retirees into position?

Dr. CHU. It might. If I could finish my answer to your question, sir, we have, in response to this particular event, recognizing that each emergency may be somewhat different, implemented a process in which we look at whether it is sensible to call up those individuals or not—that is the bottom line. And so it is just not mechanistic in character. We look at the specifics of each situation, because each emergency will demand a different set of skills from the country as a whole and put stresses on different agencies that might not have been anticipated beforehand.

I don't wish to be too openhanded about this, however. It doesn't mean that we are suddenly going to say if your agency finds it inconvenient for you to be called, you are exempted. The question is, is there a real requirement here that cannot, as you suggest, sir, cannot be met in some other way?

Ms. CARSON. Will you yield back my time?

Mr. BUYER. I yield back.

Ms. CARSON. One quick question of Dr. Sue Bailey. Your testimony mentions, exercise Dark Winter. This exercise demonstrated a simulated attack on a major city with smallpox. You state that it ended in chaos and demonstrated our inability to contain a bioterrorist attack involving an infectious pathogen. What happened in that exercise and what could be done to make our response more effective for that type of a threat? You know, everyday now—you are scared to go to bed because you might have anthrax in your bed. That is an extreme, but what happens?

Dr. BAILEY. Well, it is not an extreme. Let me just say that I think anyone who is exposed to anthrax and picks up the form we are seeing, mostly the cutaneous, that is really treatable. But if you take Dark Winter and put it into real terms here today, if it is inhalation anthrax, that is the one where you get into huge problems if it were an aerial attack.

Now the good news there is, it is really hard to do that aerial attack. It has been tried by terrorists before and never done successfully. And it is really hard to get inhalation anthrax. I think we can take Dark Winter again unfortunately into our real world here. That was a simulated attack using smallpox. Let us just imagine, suppose Mr. Stevens had had smallpox; that we had been attacked with smallpox or plague, something that was infectious. And that is what Dark Winter showed us. That even though, for instance, smallpox only kills 30 percent of those it infects versus

the 90 or 95 percent from inhalation anthrax, the fact is that each one of those individuals goes on to continue to infect others so that you can end up literally with a worldwide epidemic. So imagine, again, either Florida or New York having been an infectious agent and we can see that Dark Winter would be very real and we would be overwhelmed.

Ms. CARSON. Thank you, Mr. Chairman. I yield back. Don't forget I am going to submit questions.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. Dr. Bailey, nice to see you. Now that you are on the outside looking in, your expertise and your candor will be very important to us. What advice would you give to Governor Ridge as he takes on these new responsibilities, I mean, about the VA and duty's role today? How would you combat terrorism in this new world order as you provide defense to a Nation and then, i.e., the health delivery system?

Dr. BAILEY. First of all, I suggest he not start from scratch. We all know in the government that we tend to bring in a new group or start a new agency or in this case, plan for another war-like situation or we call it that. And I think that there is tremendous expertise out there. What we have done on the battlefield, that those efforts to protect our troops against biowarfare can be directly applied to the homeland if we do it right. And if we look at the incredible private health care system that we have and combine with that the system that is unknown to the world—I mean, we have hospitals in the VA and DOD systems sprinkled across the country.

And here, what he really needs to do, he needs to connect all of those systems. We have to be able to communicate. We got to have surveillance because in the case of infectious agents, we are not going to know we have been attacked until people demonstrate those symptoms. So it is really surveillance and communication and coordinating all of those assets that we have and they are considerable.

Mr. BUYER. Dr. Chu, I asked the other panel questions about the lessons learned from the Gulf War. I asked the Secretary in particular, so I will give you an opportunity to think about that. As we have had soldiers deployed from the 10th Mountain Division to Uzbekistan and the 101st next, and Special Forces on the ground, what medical baseline was done to help us in case we have claims that come to the VA?

Dr. CHU. As the VA witnesses indicated, we have substantially improved the baseline data we take on all individuals. So that baseline, as it is normally collected from them in their annual physicals, for example, already exists. The additional step, and as you know from the Gulf War, this was a point of our greatest weakness, is to direct all the military departments to track by individual where everyone is actually assigned during the course of these operations.

The problem, as you know, that arose from the Gulf War situation, is that while we knew the units were present, we didn't always have accurate rosters, or who was in that unit, and therefore were unable to match a person's participation in Desert Shield, Desert Storm with his or her actual locations and therefore, the various situations to which he or she may have been exposed.

So we have taken the first steps in doing that. I don't want to pretend that it is perfect, but we are committed to try to learn from that lesson of the past and give ourselves a much better situation in terms of assessing health effects from these deployments this time around.

Mr. BUYER. Any vaccines other than normal regimes for deployments being given to soldiers that are headed to this area of the world?

Dr. CHU. Not anything different than we were doing before.

Mr. BUYER. All right.

Ms. CARSON. Would you yield, Congressman Buyer? Smallpox vaccine, there is a lot of debate about that. Wasn't there a time that everybody had to be vaccinated for smallpox?

Dr. CHU. Yes, ma'am. And the military continued that regime for the longest period of time until, if I recollect correctly, the late 1980s. And we actually have been in conversation with, to your question, Mr. Buyer, HHS, about—should we decide that smallpox vaccination is required—about usage of the limited national stockpile for that purpose. But we have not taken that decision at this juncture.

Ms. CARSON. Yield back.

Mr. BUYER. I then have to read between the lines. When you say we have not made this decision at this juncture, then obviously, the threat does—does not go to a particular level that would warrant the shots be given to military force.

Dr. CHU. No, sir. Not at this time.

Mr. BUYER. Now let me go to the question that Mr. Filner was asking earlier. Let me ask this. I will try to jump into his vein of thought if I can follow the logic. If Health and Human Services is making proposals for vaccines for smallpox and to prepare those stockpiles, is that really necessary if DOD is telling us that the threat level out there is not one that would warrant even the vaccination of our own soldiers? In other words, are we overreacting there on a health side?

Dr. CHU. Let me emphasize, I am not a clinician. So let me summarize what I understand to be the advice of the Nation's best clinicians on this point, which is that old adage: an ounce of prevention can be worth a pound of cure. My understanding of HHS's position is it wants to be ready should the threat or the situation, if any, changes. We don't expect it to at this juncture. But their job—just as their job was to assemble the stockpile of antibiotics that are now so useful—it is to be prepared. And so they have been looking at both the usage of the current stockpiled vaccine and at the accelerated acquisition, which was already underway before September 11, I should emphasize—even more accelerated acquisition of additional vaccine.

Mr. BUYER. Do you know the shelf life?

Dr. CHU. No, sir.

Mr. BUYER. Dr. Bailey?

Dr. BAILEY. Of smallpox? No, but I would like to add something to your question. The real issue here with smallpox is that there is some concern, as we know, even though the World Health Organization declared the disease eradicated in 1980, there were two repositories where it was to be kept under lock and key—the virus

itself. And one is here at CDC and one was in Russia. And as we all know, there is some concern that some of that may, in fact, may not be well contained. I am not saying that the risk is very high—but the probability is very high, but the risk is incredibly high. And the good news out of this would be if we had the vaccine—because no one in America and virtually no one anymore is protected against it, and it could literally be the scurge of the earth—the fact is, though, if there were an outbreak, we could prevent the Dark Winter—we could contain it to—to a large extent, if we got to it quickly.

Again, if we had detection capability, good surveillance and good communication between Federal, State and local and knew, in fact, that it happened, because within 7 days of a smallpox outbreak, if you get the vaccine, you can prevent the disease. It is a longer incubation period and you got about a week in order to get that vaccine moved to where you need it.

Right now, we have 7 to 15 million doses. We would like to see 40 million. And even that may be rapidly increasing. And it is really just a real protection against the possibility of a worldwide devastating epidemic.

Mr. BUYER. Mr. Chairman, I would like extend my compliments to Dr. Bailey. When she was formerly at the Pentagon in her civilian leadership position, she helped bring on the anthrax program on line which very controversial at the time. And the Nation wasn't prepared to receive that program. And I think she did a good job working with General Zinni, who understood the threat, along with our CIA and other intelligence to actually inoculate the force. And she is to be complimented. And I thank you for having her as a witness here today.

And Mr. Chairman, I know that you are preparing some legislation on bioterrorism preparedness. I would like to work with you as you prepare that legislation. In particular, I think it is important that if, in fact, we are going to have these—continue these great arrangements between DOD and the VA, doctors and their expertise with regard to not only identification, but treatment of a biological or chemical agent, that at our teaching hospitals, that we improve that relationship and make it part of the curriculum that we actually are—these doctors are taught how to recognize these things. Do you think that would be helpful? If you don't think it would be helpful, tell me.

Dr. Bailey.?

Dr. BAILEY. It absolutely would be helpful. I think there is no way that people today are going to recognize most of these symptoms. They can pick them out of a multiple choice, as we all said, back in medical school, but we haven't seen them.

So today, the uses, as you know, does require it being taught. And we require it because we want to protect our forces in the military. But the fact is, we need to protect our forces across the board, and the only way to be able to recognize it so you can see a trend developing and know you have been attacked.

Mr. BUYER. Thank you.

The CHAIRMAN. It is worth noting that the Veterans' Affairs Committee is fortunate to have Mr. Buyer, who used to be the subcommittee chairman of the Military Personnel Committee of the

Armed Services Committee. Now he runs our Oversight and Investigations Committee. So that kind of background and hands-on knowledge and the legislation that you have worked through Congress is very helpful, and what we do now at the VA. So I do thank you for that.

I do have one final question I would like to pose to Dr. Chu. After the attacks in New York, thousands of National Guardsmen were activated by the governor, as you well know. The VA agreed to provide health care to all of those troops even though they had not been federalized. Should this arrangement be made more formal and authorized in advance? Do we need to go back to the drawing board on that?

Dr. CHU. I think I would like to reflect on that before I answer.

The CHAIRMAN. I do have one final question for Dr. Bailey, if I could. You mentioned, again, in your recommendations the importance of detection. And I think one of my chief of staff's brother worked at Merrill Lynch and when the World Trade Center got hit, there was about a 15-minute scare where someone said it was a chemical attack. And he said he has never known such terror as during that 15-minute time frame. Even the emergency responders—first responders were halted in their tracks, according to this gentleman. It raises the question about detection.

Obviously, we can't have detection for all things all times everywhere. But we can particularly, in some instances, have some level of detection for certain chemical and biological, and certainly nuclear. What is the state of affairs in that area, if you could?

Dr. BAILEY. Again, the military has done incredible work over the years to develop this detection system. And you are right, we can't apply that all across America, but it could be in this building, could be in the Capitol. Could be at Disney World. Could be at the stadium. It could be in any major corporations in certain areas where a lot of people would gather that could be targeted. We could select where we would want to deploy those kinds of detectors. There is a bread box detector, a DNA detector that detects anthrax. There have been things—the portal shield that has been used on the battle field for years.

So, in fact, we have the capability, and I think we need to put a lot of research effort in that direction and step up the technology because at this point, some of these would take to develop further so that you could really determine what was in the air of large—in a large arena that would take several years to develop. We can step that up if we see how helpful that could be.

The CHAIRMAN. I do appreciate that because it seems to me that there was a time when smoke detectors and something as commonplace as that were far and few between, and now everyone has smoke detectors. I am not going to suggest every house will have this kind of detection ability. But as you pointed out, in very strategically located areas, it could make the difference between life and death.

Dr. BAILEY. Let me just add on behalf of our first responders, I do think that is one of the first things we need do. We need to get them the appropriate medications. If I were a first responder, I would want to have had, for instance, the anthrax vaccine. I would want to have whatever vaccines are available that make sense,

given the risk as it is estimated. There is also a badge-size chemical detector that is—can detect again those kinds of things. I am not saying which one it could detect, but there are things that very soon would be able to warn a first responder if he goes into the subway that would allow him to use the other things we use on the battle field, which are autoinjectors to counteract the effect, say, of a nerve gas. So there is much we can do, but it is going to take time. But I think we can, given all of our resources, plan for this.

The CHAIRMAN. Let me ask Mr. Kasprisin, on whose shoulders does that fall? Is it right now left to the discretion of localities or State governments, or is there some kind of coordinating response that FEMA does or is it something that Tom Ridge and his new agency will have to, you know, grapple with?

Mr. KASPRISIN. I think it is a combination of all the above. The first—and Dr. Bailey hit it, you identify the need. And I think the need is out there now. Second is you identify what resources you are going to respond with, at the Federal, the State and the local level. And she is absolutely right about what we need at some of the local levels with first responders. I think there is a great deal of discussion about it at the State and Federal level on which direction that is going to go.

The CHAIRMAN. Would any of you like to add anything? I know it has been a long day and I do appreciate your patience waiting to the third panel. If not, I would like to thank you on behalf of the committee for your expert testimony and for your great work on behalf of our American citizens and look forward to working with you. Hearing is adjourned.

[Whereupon, at 5:40 p.m., the committee was adjourned.]

October 30, 2002

APPENDIX

Statement of Chairman Chris Smith
Committee on Veterans' Affairs
October 15, 2001

It has been just over a month since the September 11th attacks that have forever changed the world we live in. As our horror has turned to grief and then mourning and now to action, it is appropriate for Congress to continue examining how the government can best prevent, and if that fails, respond to future terrorist attacks.

Today, we will examine the role performed by the Department of Veterans Affairs in emergency preparedness and response in national crises and whether that role is in need of serious updating and reform. In particular, we will focus on the VA's role during wartime, national disasters or major terrorist attacks on U.S. soil.

Most of you are aware that after the provision of health care to veterans, medical training and medical research, the Veterans Health Administration's fourth mission is to serve as a backup healthcare provider to the Department of Defense in times of war or national emergency. With more than 170 major healthcare facilities, and hundreds of outpatient clinics, the VA currently has dedicated health care professionals, bricks, and mortar to care for thousands of service members in the event of massive casualties. Today, we will examine whether the VA's current structure, as well as its ongoing transition to

an outpatient-oriented medical care system, have implications or create new challenges in fulfilling VHA's fourth mission.

Twenty years ago the VA had significant excess bed capacity; today the infrastructure is badly in need of repair. And I might add that we have taken action in the House to begin addressing this problem. Earlier this year, the House approved legislation I authored, H.R. 811, which would provide $550 million over two years to repair and rehabilitate VA medical facilities. First year funding of $300 million has already been included in the House-approved budget. We continue to work with our friends on the Senate side to pass this legislation so we can send it to the President for his signature.

Today's hearing will also examine additional areas of emergency and war preparedness and response where the VA has unique resources and responsibilities. With an overall annual budget in excess of $50 billion dollars and more than 2157,000 federal employees, the Department of Veterans Affairs operates the largest integrated healthcare system in the United States, making it an essential asset in responding to potential biological, chemical or radiological attacks.

The VA has defined roles in both the National Disaster Medical System (NDMS) and the Federal Response Plan (FRP) in the event of

national emergencies. Among the specialized duties of the VA are:

- Conducting and evaluating disaster and terrorist attack simulation exercises;
- Managing the nation's stockpile of pharmaceuticals for biological and chemical toxins;
- Maintaining a rapid response team for radiological events; and
- Training public and private NDMS medical personnel in responding to biological, chemical, or radiological events.

As the credible threat of chemical, biological and radiological terrorism have crept onto our national awareness, it has become apparer that our nation needs to develop sufficient resources and responses to deal with a major incident, whether from terrorism, accidents, or naturally occurring.

Currently, a myriad of federal departments and agencies each address different pieces of this puzzle, but there is no unified strategy. That is why I applauded the President's decision to establish an Office of Homeland Defense. This Committee looks forward to working with its first Director, The Honorable Tom Ridge, a former Member of this

Committee, particularly in those areas over which this Committee has jurisdiction.

It is absolutely clear that the VA can – and must -- play a unique role in preparing for any response to chemical, biological, and radiological attacks or events. As we watch, with a mix of fear, trepidation, anger and resolve the unfolding events regarding anthrax in Florida, New York, Trenton, New Jersey, which is in my Congressional District, and now even in Congress itself, it is becoming apparent that there is a need to ensure that our nation is prepared for such incidents, large or small, with timely, effective, and comprehensive responses.

Today, there are more questions than we have answers. How would we respond? Who would respond? How are these events quickly and accurately detected or diagnosed? What steps need to be taken once we have a chemical, biological, or radiological incident or attack? What protocols of triage and treatment should be implemented? What antidotes, antibiotics, vaccines, medicines, or therapies should be used? How should healthcare and emergency workers be prepared to protect themselves?

Today there are no authoritative answers our government can offer. In many instances, we may have no cures, no treatments and no methods

of detection or diagnosis until it is too late. This is simply unacceptable. We need to make a major effort, like we have in so many other areas, whether in putting a man on the moon or in combating diseases, like polio, to prepare America.

That is why I am today proposing, and will shortly be introducing legislation, to create four National Medical Preparedness Centers (NMPC), two for dealing with chemical and biological threats, and two for dealing with radiological threats. These NMPCs would be run by the Department of Veterans Affairs, in coordination with the Departments of Defense, Health and Human Services, Energy, FEMA, CDC, NIH, and other agencies and organizations with expertise in developing diagnoses, treatments, and responses to chemical, biological, or radiological dangers.

The mission of these Centers would be to research and develop methods of detection, diagnosis, vaccination, protection and treatment for chemical, biological, and radiological threats, such as anthrax and smallpox. These Centers would serve both as direct research centers as well as coordinating centers for ongoing and new research at other government agencies and research universities.

There is already ample precedent and experience within the VA for providing them with this new mission. Through their extensive medical research programs, VA already has expertise in diagnosing and treating viral diseases with devastating health consequences, such as HIV and hepatitis C. And as I mentioned, the VA also has its own Emergency Radiological Response Team for rapid deployment in the event of a radiological release.

Furthermore, the VA currently operates two War-Related Illness Centers tasked with developing specialized treatments for those illnesses and injuries particular to wartime exposures. In essence, these new Centers would similarly study those illnesses and injuries most likely to come from a terrorist attack using a weapon of mass destruction.

Under my proposal, the VA would be given a new and separate appropriation, $100 million over five years, to develop and operate these National Medical Preparedness Centers. I would hope that all of today's witnesses could comment on this proposal and I will also send them the full details when we have a final draft of the legislation.

One other important proposal I would make today, and this can, I believe, be accomplished without the need for legislation, is for the VA to bring to bear the depth and breadth of its expertise in diagnosing and

treating post-traumatic stress disorder – PTSD – to assist those thousands, perhaps millions, of individuals traumatized by the events of September 11th.

From my visit to New York City last month, I am aware that the VA already has a presence at the Family Assistance Center on Pier 94 in Manhattan, as well as in Arlington near the Pentagon. However, I am concerned that over the next several months there may be a delayed impact of significant proportions, particularly on those firefighters, police and rescue workers. I would propose that the VA work hand-in-hand in New York City with Mayor Giuliani, and in Virginia with Governor Gilmore, to provide direct care, support, training, or information, as appropriate, to those frontline responders for whom the impact of these horrific events will hit the hardest and last the longest.

As our witnesses will share with us today, the VA is a tremendous national resource, with some of the most able and dedicated personnel bare none. I look forward to working with Secretary Principi, Director Ridge, and others, as we examine how best to integrate the Department into a new homeland defense strategy.

Opening Statement of Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans Affairs
October 15, 2001

One month ago today, a devastating terrorist attack tore at the very fabric of America. Not a single day has passed since September 11th without that tragedy entering into our hearts and our minds. Every day, we think about the tragedy and about the safety of our fellow Americans.

We are barraged daily with warnings that terrorism against America and other nations that also cherish freedom -- will continue. We unfortunately believe that other Americans WILL die at terrorist hands moved to action by terrorist plans.

This Committee's jurisdiction includes oversight of the Department of Veterans Affairs. The VA is charged to complete many missions in peacetime that directly impact the welfare of veterans and veteran's families.

BUT, this hearing is not about the VA's fulfillment of its peacetime mission -- rather it is about the VA's ability to support contingency missions that arise in time of war or in time of national crisis. As we are now in a time of crisis, we are here to determine if the VA is able to fulfill those crisis missions.

When Congresswoman Julia Carson first requested this matter as the subject for a Subcommittee on Oversight and Investigations hearing, I heartily approved. If a problem exists with the VA's ability to support Federal contingency crisis obligations -- we must address that problem today before the Full Committee.

The recent terrorist attack was our wake-up call. It sends a message to the American people about the threat of terrorism and the danger associated with not taking that threat seriously. The VA is neither a law enforcement agency nor is it part of the intelligence gathering community. We don't look directly to the VA to stop a terrorist event. We do, however, look to the VA to mitigate the ***consequences*** of many types of catastrophic events in America. These could include providing medical care for returning military casualties of armed conflicts fought abroad or, the VA may be called upon to respond to domestic events that threaten our citizens.

Terrorism and the use of weapons of mass destruction are but two types of many, many events that could trigger the VA's support of the Federal Response Plan. Earthquakes, floods, nuclear accidents, pandemic events are but a few of the other events that could initiate VA support and charge that agency with providing services not focused directly upon our veterans.

Some of the plans for VA contingency support were drafted decades ago. The hallmark DoD/VA sharing legislation, Public Law 97-174, established the fourth mission of the VA – contingency support of DoD Healthcare. This became law in 1982.

When this provision was activated during the Gulf War, it took months to fully realize. Much had changed between the passing of the legislation in 1982 and the Gulf War in the early 90s. What has changed since we used this provision during the Gulf War and today?

Today, we must ask how the face of healthcare changed in the last two decades. How many medical beds were planned to exist in 1982, and how many are available today considering that outpatient treatment has replaced inpatient care in more cases. The result is that we have far fewer VA medical beds today than when this law was passed. We may even argue that counting the number of available beds is no longer a good measurement of the VA's medical care ability in time of crisis. We must identify better measurements of the VA's ability. How the role of our Reserve Components changed since 1982 is another important question that impacts the VA's ability to respond.

The Federal Response Plan calls for the VA to support four Emergency Support Functions (ESF). A different federal agency is designated lead agency for each of the 12 ESFs – the VA is a supporting agency to four of these under the Federal Response Plan.

Under ESF #3, the VA supports the lead of the Army Corps of Engineers in the Public Works and Engineering Annex of the Federal Response Plan. We will ask if changes to the mix of VA employees and contract employees have impacted the ability of the VA to support this function.

The American Red Cross has the lead under the Federal Response Plan for ESF #6, the Mass Care Annex. The VA is charged to provide for food preparation and stockpiling in its facilities during the immediate emergency --- are they prepared?

Under ESF #7, the VA supports the General Services Administration and has several specified responsibilities to include providing VA personnel knowledgeable in procurement and in also providing computer support. Has the VA identified how they will support a GSA request for either of these requirements? Is the GSA aware of all the capability of the VA and its other supporting agencies to assist with Resource Support under this annex of the Federal Response Plan?

Finally, the VA supports the lead of Health and Human Services under ESF #8 of the Federal Response Plan for Health and Medical Services. Today we will hear testimony on how well prepared the VA is to support this and the other specified missions. It is absolutely essential that we address any problems that inhibit the VA's performance of its contingency and crisis missions.

Congressman Tom Udall
3rd Congressional District of New Mexico
Full Committee Hearing
VA's Ability to Respond to DoD Contingencies and National Emergencies
10/15/01

Chairman Smith and Ranking Member Evans:

Good afternoon, it is a great honor and pleasure to be here today. Thank you for holding this hearing today about the VA's Contingency Missions. I am looking forward to hearing the testimony of our panel and would like to thank Secretary Prinicipi, and the other distinguished members of the panel for coming to testify today.

One area of particular concern to me today, as I am sure is the case with many other Members of the Committee, is the requirement under P.L. 97-174, that the VA provide backup medical care support for the Department of Defense in times of crisis and national

emergency. As I am sure many of us are aware, during the Gulf War, the VA was very inefficient in fulfilling this responsibility, and inaccurately anticipated the number and quantity of VA medical facility beds that would ultimately be needed to treat potential casualties.

However, in a letter to Secretary Principi following the horrific attacks, I expressed my confidence in his leadership abilities to ensure that we have an better-organized and efficient system. I would ask unanimous consent to include that letter in the record. I would like to reaffirm my confidences in you here today Mr. Secretary, and to again offer my assistance to you during this critical time.

Although the issue of medical care backup is of particular interest to me, I am very much looking forward to hearing the testimony about the VA's other equally important Emergency Support Function's under P.L. 97-174, namely public works and engineering support, mass care support, and resource support.

With that Mr. Chairman, I would again like to offer my thanks to our distinguished panel and thank you for the opportunity to offer my remarks.

SEPTEMBER 18, 2001.

Hon. ANTHONY J. PRINCIPI,
The Secretary of the U.S. Department of Veterans Affairs,
Washington, DC.

DEAR SECRETARY PRINCIPI: I am writing to you today with a matter of utmost national urgency. Under Public Law 97–174 the United States Department of Veterans Affairs (VA) is required to provide backup medical care support for the United States Department of Defense (DoD) during war or national emergency. Clearly, such a time is upon us.

As you may know, during the Gulf War, VA was unnecessarily slow in preparing to fulfill its responsibilities to provide medical care to U.S. military forces, despite the fact that VA had six months to prepare. Additionally, VA managers failed to take into account the large number of VA employees who were members of the Guard or Reserve components recalled to active duty during the action. As a result, VA did not accurately anticipate the number and quantity of VA medical facility beds that would ultimately be needed to treat potential casualties.

As a member of the Committee on Veterans' Affairs and as someone who represents a state with a large active duty military, this is an especially critical issue for my constituents. Our men and women in the armed services deserve prompt, quality medical care. I am confident that under your leadership we will have a better-organized and efficient system for any U.S. casualties as a result of this conflict.

If there is anything that I can do to assist you during this critical time for our nation, please do not hesitate to contact me. I stand ready to work with you.

Very truly yours,

TOM UDALL,
Member of Congress

Statement of Congressman Stearns
Committee on Veterans' Affairs
"VA's Ability to Respond to DoD Contingencies and National Emergencies"

October 15, 2001
331 Words

Mr. Chairman, thank you for holding this important hearing today. As it turns out, this hearing could not be more timely. Even as I speak, concern over anthrax spores in the mail delivered to all of our Capitol offices here is escalating. Moreover, lately our headline news has treated us to other frightening descriptions of anthrax exposures in Florida, New York and Nevada. And last Wednesday, a man sprayed a solution into a crowd of unsuspecting passengers on our Metro's Green Line. About 35 people who were on the train or platform were detained for decontamination and possible treatment, while officials determined that the bottle contents were a household cleaner. Finally, if you aren't convinced enough yet of the dire need to have our emergency response measures ready to go now, think back to 1995 Japan, where a terrorist cult released sarin into a crowded Tokyo subway, with fatal results.

The Department of Veterans' Affairs played a laudable role in its response to the September 11 attacks, deploying personnel, from burn nurses to post-traumatic stress disorder counselors, within hours of the WTC airplane crash. Further, VA carries out essential disaster simulations, and maintains pharmaceutical and medical supply inventories for rapid distribution. These emergency response roles fall under the VA's fourth health care mission: that of backup to DoD and support to communities. I support and salute the fulfillment of this mission. However, let us hear what you all have to say today, and collaborate and agree on plans that complement but do not compromise the first, second and third missions. Most importantly, as attention focuses on this fourth mission, the VA must continue its priority of caring for our nation's veterans who have done so much for so many.

For over a month now, Americans have been living with a collective chill in our spines, and the VA certainly can take a leadership role in addressing our readiness for acts of terrorism. I look forward to our witnesses' testimony. Thank you.

Statement for the Record

Honorable Mike Simpson
Chairman, Subcommittee on Benefits
Committee on Veterans' Affairs

Hearing to Examine VA's Role in Responding to National Disasters,
Terrorist Threats and Wars

October 15, 2001

Thank you, Mr. Chairman.

I have read today's testimony, and have read especially carefully the role of the United States Department of Veterans Affairs in responding to Department of Defense contingencies and national emergencies. I am proud of the selfless leadership provided by dedicated employees of VA's Veterans Health Administration, Veterans Benefits Administration, and the National Cemetery Administration in responding to the horrific events of September 11 at the World Trade Center, the Pentagon, and in Pennsylvania. These are engaging, compassionate, and resourceful individuals. They responded so well.

Secretary Principi, I want to thank you in a number of regards, some of which slightly exceed the scope of this hearing.

First, VA was there for the family of Master Sergeant Evander Earl Andrews of Mountain Home Air Force Base. As you are aware, Master Sergeant Andrews was killed in the line of duty on October 10 while helping build an airbase at Aludeid, Qatar, on the Arabian Peninsula. Master Sergeant Andrews leaves a wife, Judy, and four young children at Mountain Home Air Force Base, Idaho, where they have lived since 1992. Master Sergeant Andrews was the first announced American casualty of Operation Enduring Freedom. The Boise, Idaho Regional Office contacted Sergeant Andrews' family almost immediately with respect to life insurance, burial, dependency and indemnity compensation (DIC), and education and training benefits.

Second, I note that in the early 1990's when you were Deputy Secretary of Veterans Affairs you led the effort to reform DIC payments to the surviving spouses of those servicemembers who died in the line of duty, so the payments would not be based on the deceased servicemember's rank. Indeed, at that time

DIC was the only veterans' benefit that was based on rank. In my view, that was wrong, and Congress has fixed it. Thank you for leading that charge.

Third, the 1999 report of the bipartisan Congressional Commission on Servicemembers and Veterans Transition Assistance, which you chaired, made certain recommendations to ensure that active duty servicemembers and veterans have a full opportunity to participate in our free enterprise system sustained by their service. Public Law 106-50, the Veterans Entrepreneurship and Small Business Act of 1999, offers disaster loans to assist small businesses that suffer economic injury as the result of an essential employee being ordered to active duty. The Commission's report inspired this provision in law. I thank the Commission for addressing this issue because SBA reports that 12 small businesses have already filed for the assistance due to the owner or a key employee being called up for Operation Enduring Freedom.

Fourth, H.R. 1291, the 21st Century Montgomery GI Bill (MGIB) Enhancement Act, which passed the House 416-0 on June 19, 2001, would go a long way toward an improved recruitment incentive for our military. It would increase the MGIB educational assistance allowance from the $650 per month current amount to $800 on October 1 of this year, $950 on October 1 of 2002, and $1,100 on October 1, of 2003. The current $650 monthly allowance would need to be $1,025 for a veteran to attend a state college as a commuter student.

Mr. Secretary, I note that you and former Veterans' Affairs Committee Chairman Stump, current Committee Chairman Smith, and Ranking Member Lane Evans have said repeatedly over the past two years that America needs to return to a World War II-type GI Bill. This GI Bill would pay tuition, books and fees and a monthly living allowance as an incentive for our youth to join our All-Volunteer military. As then-Chairman Stump asked in January of 2000, why should our youth join our military when state and federal financial aid abounds for those who do not serve?

Fifth, please know that the Benefits Subcommittee has worked with Rep. Buck McKeon of the Education and Workforce Committee to introduce legislation so that reservists leaving their jobs and families in support of Operation Enduring Freedom may be relieved from making federal student loan payments while on active duty.

Lastly, Ranking Member Reyes and I are working with Chairman Christopher Smith and Mr. Evans on legislation to restore VA educational entitlement to active duty servicemembers and reservists (who had prior active duty service) who are mobilized and must disenroll from school.

In closing, I once again express my appreciation to VA's 220,000 employees for what they have done and what they undoubtedly will continue to do to defend our homeland. They are a national treasure.

United States General Accounting Office

GAO

Testimony

Before the Committee on Veterans' Affairs, House of Representatives

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HOMELAND SECURITY

Need to Consider VA's Role in Strengthening Federal Preparedness

Statement of Cynthia A. Bascetta
Director, Health Care—Veterans' Health and Benefits Issues

GAO-02-145T

Mr. Chairman and Members of the Committee:

I am pleased to be here as you discuss the impact of the September 11 events on the mission of the Department of Veterans Affairs (VA). As the Comptroller General recently stated,[1] we at GAO, along with all Americans, were shocked and saddened by the terrorist attacks last month on the World Trade Center and the Pentagon. Even before these catastrophic events, terrorism was the focus of concerted emergency response preparations by multiple federal agencies. Now, more than ever, we must keep our attention and vigilance focused on blunting the threat and consequences of terrorism.

While state and local governments have primary responsibility for managing the medical and other consequences of a domestic terrorist incident, the federal government, including VA, plays a key role to augment the efforts of state and local authorities. Indeed, consequence management—the measures taken to alleviate the mass damages and suffering caused by a terrorist incident—has increasing prominence for federal preparedness as the nation strengthens its strategy for homeland security. In this regard, one of VA's health care missions is to provide backup medical resources to the military health system and communities following domestic terrorist incidents and other major disasters.

In the wake of the devastating attacks, you asked us to discuss (1) the activities VA has undertaken in its emergency preparedness role and (2) VA's capabilities as the federal government plans for strengthened homeland security. To do this, we drew on our work on VA's participation in federal terrorism preparedness efforts,[2] other GAO reports on combating terrorism, and our broader work related to VA's primary health care mission.

In summary, VA currently plays a supporting role in assisting other agencies that have lead responsibility for responding to disasters, including terrorism. In its areas of responsibility—conducting disaster simulation exercises and maintaining medical stockpiles—VA has taken steps to enhance national emergency preparedness. Specifically, it has evaluated disaster simulation exercises to help improve medical response

[1] *Homeland Security: A Framework for Addressing the Nation's Efforts* (GAO-01-1158T, Sept 21, 2001).

[2] See related GAO products listed at the end of this statement.

procedures and strengthened the security of federal pharmaceutical stockpiles to ensure rapid response support to local authorities who may be overwhelmed by terrorist attack.

VA also has resources that could play a role in future federal homeland security efforts. Its assets include the bricks, mortar, and human capital components of its health care system, graduate medical education programs, and expertise involving emergency backup and support activities. In managing large-scale medical emergencies arising from terrorist attacks, VA's emergency response capabilities have strengths and shortcomings. For example, most VA hospitals and clinics coordinate their emergency plans with their local communities. On the other hand, like their community hospital counterparts, VA facilities are less prepared to treat victims of biological than chemical terrorist attacks. In our view, determining how VA can best contribute to homeland security is especially timely, given the extraordinary level of federal activity underway to better prepare for managing large-scale disasters.

Background

Of VA's $48.8 billion budget in fiscal year 2001, $20.9 billion was for carrying out its four health care missions. Its first, most visible health care mission is to provide medical care for veterans. VA operates a national health system of hospitals, clinics, nursing homes and other facilities that provide a broad spectrum of medical, surgical, and rehabilitative care. More than 3.8 million people received care in VA health care facilities last year. Under its second mission—to provide education and training for health care personnel—VA manages the largest medical education and health professions training program in the United States, training about 85,000 health professionals annually in its medical facilities that are affiliated with almost 1,400 medical and other schools. Under its third mission—to conduct medical research—VA funding was about $1.2 billion in 2000 for over 15,000 medical research projects and related medical science endeavors.[3]

VA's fourth mission—to serve as backup to the Department of Defense (DOD) health system in war or other emergencies and as support to communities following domestic terrorist incidents and other major disasters—has attracted greater congressional interest since the

[3]These funds come from appropriations, pharmaceutical manufacturers, National Institutes of Health, and foundations.

September 11 terrorist attacks in the United States. This role, however, is not new. Since the early 1980s, when a national system was put in place to provide for local medical responses when a disaster occurs, VA has been providing medical support. In fiscal year 2001, less than one-half of 1 percent of VA's total health care budget, $7.9 million, was allocated to this mission.[4]

VA was first formally assigned a federal disaster management role in 1982, when legislation tasked VA with ensuring the availability of health care for eligible veterans, military personnel, and the public during military conflicts and domestic emergencies.[5] In the immediate aftermath of the September 11 attacks, VA medical facilities in New York, Washington, D.C., Baltimore, and Altoona, Pennsylvania, were readied to handle casualties. In prior emergencies, such as hurricanes Andrew and Floyd and the 1995 bombing of the federal building in Oklahoma City, VA deployed more than 1,000 medical personnel and provided substantial amounts of medical supplies and equipment as well as the use of VA facilities. VA's role as part of the federal government's response for disasters has grown with the reduction of medical capacity in the Public Health Service and military medical facilities.

VA established an Emergency Management Strategic Healthcare Group with responsibility for the following six emergency response functions:[6]

- *Ensuring the continuity of VA medical facility operations.* Prior to emergency conditions, VA emergency management staff are responsible for minimizing disruption in the treatment of veterans by developing, managing, and reviewing plans for disasters and evacuations and coordinating mutual aid agreements for patient transfers among VA facilities. During emergency conditions these staff are responsible for ensuring that these plans are carried out as intended.

[4]In addition to this amount, in fiscal year 2001, VA received $62 million from the Department of Health and Human Services (HHS) to support various aspects of HHS terrorism-related preparedness.

[5]The 1982 VA/DOD Health Resources Sharing and Emergency Operations Act (P.L. 97-174) authorized VA to ensure hospital backup to DOD. At the same time, growing concern about the lack of a medical response plan for civilians led to a 1984 administrative establishment of a national medical system that would back up DOD and handle domestic disasters as well.

[6]Formerly, VA's Emergency Management Preparedness Office had this responsibility.

- *Backing up DOD's medical resources following an outbreak of war or other emergencies involving military personnel.* In 2001, VA has plans for the allocation of up to 5,500 of its staffed operating beds for DOD casualties within 72 hours of notification.[7] In total, 66 VA medical centers are designated as primary receiving centers for treating DOD patients. In turn, these centers must execute plans for early release or movement of VA patients to 65 other VA medical centers designated as secondary support centers.

- *Jointly administering the National Disaster Medical System (NDMS).* In 1984, VA, DOD, the Federal Emergency Management Agency (FEMA), and the Department of Health and Human Services[8] (HHS) created a federal partnership to administer and oversee NDMS, which is a joint effort between the federal and private sectors to provide backup to civilian health care in the event of disasters producing mass casualties. The system divides the country into 72 areas selected for their concentration of hospitals and proximity to airports. Nationwide, more than 2,000 civilian and federal hospitals participate in the system. One of VA's roles in NDMS is to help coordinate VA hospital capacity with the nonfederal hospitals participating in the system.

- *Carrying out Federal Response Plan efforts to assist state and local governments in coping with disasters.* Under FEMA's leadership, VA and other agencies are responsible for carrying out the Federal Response Plan,[9] which is a general disaster contingency plan. As a support agency, VA is one of several federal agencies sharing responsibility for providing public works and engineering services, mass care and sheltering, resource support, and health and medical services. VA is also involved with other agencies in positioning medical resources at high-visibility public events requiring enhanced security, such as national political conventions. VA also maintains a database of deployable VA medical personnel that is intended to help the agency to quickly locate medical personnel (such as nurses, physicians, and pharmacists) for deployment to a disaster site.

[7]Annually, VA's medical centers estimate the number of beds that could be made available to receive returning military casualties. As of 2001, VA's plan would provide up to 7,574 beds within 30 days of notification.

[8]Within HHS, the Office of Emergency Preparedness is in charge of NDMS activities.

[9]The Federal Response Plan is authorized by the Robert T. Stafford Disaster Relief and Emergency Assistance Act (P.L. 93-288, as amended).

- *Carrying out Federal Radiological Emergency Response Plan efforts to respond to nuclear hazards.* Depending on the type of emergency involved, VA is responsible for supporting the designated lead federal agency[10] in responding to accidents at nuclear power stations or terrorist acts to spread radioactivity in the environment. VA also has its own medical emergency radiological response team of physicians and other health specialists. When requested by the lead agency, VA's response team is expected to be ready to deploy to an incident site within 12 to 24 hours to provide technical advice, radiological monitoring, decontamination expertise, and medical care as a supplement to local authorities' efforts.

- *Supporting efforts to ensure the continuity of government during national emergencies.* VA maintains the agency's relocation site and necessary communication facilities to continue functioning during a major national emergency.

In addition to these functions, VA plays a key support role in the nation's stockpiling of pharmaceuticals and medical supplies in the event of large-scale disasters caused by weapons of mass destruction (WMD).[11] These stockpiles are critical to the federal assistance provided to state and local governments should they be overwhelmed by terrorist attack. Under a memorandum of agreement between VA and HHS' Office of Emergency Preparedness (OEP), VA maintains at designated locations medical stockpiles containing antidotes, antibiotics, and medical supplies and smaller stockpiles containing antidotes, which can be loaned to local governments or predeployed for special events, such as the Olympic Games. In fiscal year 2001, OEP reimbursed VA $1.2 million for the purchase, storage, and maintenance of the pharmaceutical stockpiles.

VA also maintains stockpiles of pharmaceuticals for another HHS agency, the Centers for Disease Control and Prevention (CDC). Under contract with CDC, VA purchases drugs and other medical items and manages a spectrum of contracts for the storage, rotation, security, and transportation of stockpiled items. VA maintains the inventory of pharmaceutical and medical supplies called "12-hour push packages,"

[10]For example, the Nuclear Regulatory Commission is the lead agency for an emergency that occurs at a nuclear power plant. In other circumstances, the Department of Energy or the Environmental Protection Agency could be the lead federal agency.

[11]The term weapons of mass destruction refers to chemical, biological, radiological, nuclear agents or weapons, and large conventional explosives.

which can be delivered to any location in the nation within 12 hours of a federal decision to deploy them. It also maintains a larger stock of antibiotics, antidotes, other drugs, medical equipment, and supplies known as vendor-managed inventory[12] that can be deployed within 24 to 36 hours of notification. In fiscal year 2001, CDC contracts included an estimated $60 million to reimburse VA for its purchasing and management activities associated with the stockpiles, including the cost of medical items.[13]

VA Has Taken Steps to Enhance Federal Emergency Management Preparedness

Consistent with the agency's fourth health care mission, VA operates as a support rather than command agency under the umbrella of several federal policies and contingency plans for combating terrorism.[14] Its direct emergency response activities include conducting and evaluating terrorist attack simulations to develop more effective response procedures and maintaining the inventories for stockpiled pharmaceuticals and medical supplies.

VA Has Conducted and Evaluated Disaster Simulation Exercises

Our prior work on federal coordination of efforts to combat terrorism found that VA led many disaster response simulation exercises and conducted follow-up evaluations.[15] These exercises are an important part of VA's efforts to prepare for catastrophic terrorist attacks. The exercises test and evaluate policies and procedures, test the effectiveness of response capabilities, and increase the confidence and skill level of personnel. Those exercises held jointly with other federal, state, and local agencies facilitate the planning and execution of multiagency missions and help identify strengths and weaknesses of interagency coordination.

[12]These vendor-managed inventories are carried on the manufacturers' inventory records as either "government owned" or "government reserved" and may be rotated with the vendor's normal operating stock in order to ensure freshness. The 12-hour push packages comprise approximately 20 percent of the stockpile; the vendor-managed inventory comprises the remaining 80 percent.

[13]CDC has been working with VA since 1999 to build its stockpiles. In addition to the fiscal year 2001 funds, CDC received $51 million in fiscal year 1999 and $52 million in fiscal year 2000 for purchasing items for the stockpiles.

[14]For a compendium of relevant policy and planning documents, see *Combating Terrorism: Selected Challenges and Related Recommendations* (GAO-01-822, Sept. 20, 2001).

[15]See *Combating Terrorism: Federal Response Teams Provide Varied Capabilities: Opportunities Remain to Improve Coordination* (GAO-01-14, Nov. 30, 2000).

VA has sponsored or participated in a variety of exercises to prepare for combating terrorism, including those involving several federal agencies and WMD scenarios. In addition, VA participates in numerous other disaster-related exercises aimed at improving its consequence management capabilities. The following are examples of terrorism-related exercises in which VA has participated.

- In March 1997, in conjunction with the state of Minnesota, VA participated in the "Radex North" exercise in Minneapolis, which simulated a terrorist attack on a federal building. The attack involved simulated explosives laced with radioactive material, requiring the subsequent decontamination and treatment of hundreds of casualties. One of the objectives was to test the capabilities of VA's radiological response team. The exercise had 500 participants and was designed to integrate the federal medical response into the state and local response, including local hospitals.

- In July 1997, VA participated in "Terex '97" in Nebraska. The exercise's main objectives were to provide federal and state public health agencies with integrated training in disaster response and to assess coordination among federal, state, and local agencies for responding to a catastrophic, mass-casualty incident. The VA hospital in Lincoln provided bed space for mock casualties wounded by simulated conventional explosives. In addition, VA management staff worked with other federal, state, and local health care officials to coordinate emergency response efforts.

- In May 1998, VA, DOD, and HHS cosponsored "Consequence Management 1998" in Georgia. The 2-day exercise trained and evaluated federal medical response team personnel in emergency procedures for responding to a WMD attack. In organizing the event, VA's radiological response team worked with the Marine Corps' special response force to decontaminate mock casualties. The VA medical center in Augusta supplied logistics support, including stockpiled pharmaceuticals.

- In May 1999, VA sponsored "Catex '99" in Minnesota. Over 80 groups representing federal, state, and local governments, the military, volunteer organizations, and the private sector worked with VA to train for a mass-casualty WMD incident. In a scenario depicting simultaneous chemical weapons attacks throughout the Twin Cities region, VA activated and oversaw an emergency operations center, which coordinated response efforts, including simulated casualty evacuations to hospitals in Detroit, Cleveland, Milwaukee, and Des Moines.

- In May 2000, VA participated in "Consequence Management 2000" in Georgia. Developed jointly by VA, DOD, HHS, and various state and local agencies, the exercise trained federal emergency personnel in procedures and techniques for responding to a WMD attack. The event also served to familiarize federal, state, and local agencies with the U.S. Army Reserves' role in the event of a catastrophic terrorist incident. Simulating a mass-casualty terrorist attack in Georgia, VA emergency response teams performed triage and decontaminated patients exposed to chemical and radiological agents. Several VA medical centers in Georgia, Alabama, and South Carolina provided care to simulated serious casualties.

- In May 2000, VA participated in "TOPOFF 2000," a national, "no-notice" exercise designed to assess the ability of federal, state, and local agencies to respond to coordinated terrorist attacks involving WMD. The event was the largest peace-time terrorism exercise ever sponsored by the Department of Justice and FEMA, and incorporated three main crisis simulations: a radiological scenario in Washington, D.C.; a chemical scenario in New Hampshire; and a biological scenario in Colorado. VA provided consequence management support to other federal agencies, identified hospital bed space for potential casualties, and dispatched medical personnel to various locations. VA also placed its radiological response team on alert.

VA also conducts follow-up evaluations of these simulation exercises. Evaluations typically include, among other things, operational limitations, identified strengths and weaknesses, and recommended actions. Our work shows that VA has a good record of evaluating its participation in these exercises. The evaluations generally discuss interagency issues and are disseminated within VA. Among the favorable findings from VA's reviews were that emergency personnel were activated quickly and were deployed to incident sites fully equipped and prepared; personnel demonstrated high levels of motivation and technical expertise; and interaction among federal, state, and local personnel and between civilian and military counterparts was positive. The reviews also identified the following concerns:

- On-site medical personnel experienced communications problems due to incompatible equipment.
- Communication between headquarters and field offices was at times hindered by an over-reliance on a single means of communication.
- Unclear standards and inadequate means for reporting available bed space also posed problems.

- Caregivers sometimes had difficulty tracking patients as they progressed through on-site treatment stages.
- Incident-site security was a recurrent concern, especially with respect to decontamination controls.

We have made a number of recommendations to federal lead and support agencies to improve such interagency exercises and follow-up evaluations, including the dissemination of evaluation results across agencies.[16]

VA Has Improved Inventory Management of Medical Stockpiles

VA has improved the internal controls and inventory management of several medical supply stockpiles it maintains for OEP and CDC to address previously identified deficiencies. VA is responsible for the purchase, storage, and quality control of thousands of stockpile supply items. It maintains stockpiles at several sites around the country for immediate use by federal agency teams staffed with specially trained doctors, nurses, other health care providers, and emergency personnel whose mission is to decontaminate and treat victims of chemical and biological terrorist attacks. In 1999, we found that VA lacked the internal controls to ensure that the stockpiled medical supplies and pharmaceuticals were current, accounted for, and available for use.[17] However, our recent work shows that VA has taken significant corrective actions in response to our recommendations that have resulted in reducing inventory discrepancy rates and improved accountability.[18]

At the same time, we have recommended additional steps that, VA, in concert with OEP and CDC, should take to further tighten the security of the nation's stockpiles. These include finalizing and implementing approved operating plans and ensuring compliance with these plans through periodic quality reviews. VA supports these recommendations and is taking action with OEP and CDC to implement them.

[16]See GAO-01-822.

[17]*Combating Terrorism: Chemical and Biological Supplies Are Poorly Managed* (GAO/HEHS/AIMD-00-36, Oct. 29, 1999).

[18]*Combating Terrorism: Accountability Over Medical Supplies Needs Further Improvement* (GAO-01-463, Mar. 30, 2001).

Considering VA's Strengths and Limitations Important in Planning for Homeland Security

VA has significant capabilities related to its four health care missions that have potential applicability for the purpose of homeland security. At the same time, it is clear that some of these capabilities would need to be strengthened. How best to employ and enhance this potential will be determined as part of a larger effort currently underway to develop a national homeland security strategy. As the Comptroller General recently noted, this broad strategy will require partnership with the Congress, the executive branch, state and local governments, and the private sector to minimize confusion, duplication of effort, and ineffective alignment of resources with strategic goals. It will also require a systematic approach that includes, among other elements, ensuring the nation's ability to respond to and mitigate the consequences of an attack.

In this regard, VA has a substantial medical infrastructure of 163 hospitals and more than 800 outpatient clinics strategically located throughout the United States, including the largest pharmaceutical and medical supply procurement systems in the world and a nationwide register of skilled VA medical personnel. In addition, VA operates a network of 140 treatment programs for post-traumatic stress disorder and is recognized as the leading expert on diagnosing and treating this disorder.

VA holds other substantial health system assets. For example, the agency has well-established relationships with 85 percent of the nation's medical schools. According to VA, more than half of the nation's medical students and a third of all medical residents receive some of their training at VA facilities. In addition, more than 40 other types of health care professionals, including specialists in medical toxicology and occupational and environmental medicine, receive training at VA facilities every year. In recent years, VA expanded physician training slots in disciplines associated with WMD preparedness.

In 1998, several government agencies, including VA, contributed to a presidential report to the Congress on federal, state, and local preparations and capability to handle medical emergencies resulting from WMD incidents.[19] The report outlined both strengths and weaknesses in regard to VA's emergency response capabilities. The report noted the potential for VA to augment the resources of state and local responders

[19]The report, *Preparations for a National Response to Medical Emergencies Arising from Terrorists' Use of Weapons of Mass Destruction*, was required by the Veterans Benefits Act of 1997 (P.L. 105-114), and submitted by the President to the Congress in July 1998.

because more than 80 percent of VA hospital emergency plans are included in the local community emergency response plan. However, the report also noted that

- VA hospitals do not have the capability to process and treat mass casualties resulting from WMD incidents.
- VA hospitals and most private sector medical facilities are better prepared for treating injuries resulting from chemical exposure than those resulting from biological agents or radiological material.
- VA hospitals, like community hospitals, lack decontamination equipment, routine training to treat mass casualties, and adequate on-hand medical supplies.

Currently, VA's budget authority does not include funds to address these shortcomings.

Concluding Observations

Myriad federal efforts are underway to strengthen the nation's ability to prevent and mitigate the consequences of terrorism. Consideration of what future role VA may assume in coordination with its federal partners in consequence management is an important element. Currently, the agency, in a supporting role, makes a significant contribution to the emergency preparedness response activities carried out by lead federal agencies. Expanding this role in response to stepped up homeland security efforts may be deemed beneficial but would require an analysis of the potential impact on the agency's health care missions, the resource implications for VA's budget, and the merits of enhancing VA's capabilities relative to other federal alternatives.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other Members of the committee may have.

Contact and Acknowledgments

For more information regarding this testimony, please contact me at (202) 512-7101. Stephen L. Caldwell, Hannah F. Fein, Carolyn R. Kirby, and Paul Rades also made key contributions to this statement.

Related GAO Products

Bioterrorism: Public Health and Medical Preparedness (GAO-02-141T, Oct. 9, 2001).

Bioterrorism: Federal Research and Preparedness Activities (GAO-01-915, Sept. 28, 2001).

Combating Terrorism: Selected Challenges and Related Recommendations (GAO-01-822, Sept. 20, 2001).

Homeland Security: A Framework for Addressing the Nation's Efforts (GAO-01-1158T, Sept. 21, 2001).

Combating Terrorism: Accountability Over Medical Supplies Needs Further Improvement (GAO-01-463, Mar. 30, 2001).

Combating Terrorism: Federal Response Teams Provide Varied Capabilities; Opportunities Remain to Improve Coordination (GAO/01-14, Nov. 30, 2000).

Combating Terrorism: Chemical and Biological Medical Supplies Are Poorly Managed (GAO/HEHS/AIMD-00-36, Oct. 29, 1999).

Combating Terrorism: Analysis of Federal Counterterrorist Exercise (GAO/NSIAD-99-157BR, June 25, 1999).

(290134)

GAO Reports Related to Terrorism and the Department of Veterans Affairs

Report Number	Title and Date
CROSS-CUTTING ISSUES	
GAO-01-822	*Combating Terrorism: Selected Challenges and Related Recommendations* (September 20, 2001)
GAO-01-1158T	*Homeland Security: A Framework for Addressing the Nation's Efforts* (September 21, 2001)
FEDERAL RESPONSE CAPABILITIES	
GAO-01-14	*Combating Terrorism: Federal Response Teams Provide Varied Capabilities; Opportunities Remain to Improve Coordination* (November 30, 2000)
GAO-01-666T	*Combating Terrorism: Accountability Over Medical Supplies Needs Further Improvement* (May 1, 2001)
GAO-01-463	*Combating Terrorism: Accountability Over Medical Supplies Needs Further Improvement* (March 30, 2001)
GAO/T-HEHS/AIMD-00-59	*Combating Terrorism: Chemical and Biological Medical Supplies Are Poorly Managed* (March 8, 2000)
GAO/HEHS/AIMD-00-36	*Combating Terrorism: Chemical and Biological Medical Supplies Are Poorly Managed* (October 29, 1999)
GAO/T-NSIAD-99-112	*Combating Terrorism: Observations on Biological Terrorism and Public Health Initiatives* (March 16, 1999)
COUNTERING COMPUTER-BASED THREATS	
GAO/AIMD-00-5	*Information Systems: The Status of Computer Security at the Department of Veterans Affairs* (October 4, 1999)

Statement of
The Honorable Anthony J. Principi
Secretary of Veterans Affairs
Before the
House Committee on Veterans' Affairs
on VA's Ability to Respond to
Department of Defense Contingencies and National Emergencies

October 15, 2001

Mr. Chairman, I thank you for the opportunity to testify before the committee on VA's preparedness to perform its missions under the conditions of military conflict abroad and terrorist attacks at home. I am accompanied by Dr. Frances Murphy, VA's Deputy Under Secretary for Health; Mr. James Farsetta, Director of the VA New York/New Jersey Healthcare System; and Mr. John J. Donnellan, Director of the VA New York Harbor Healthcare System.

My testimony will cover four significant areas:
-- how VA responded on, and in the days following, September 11;
-- VA's emergency response missions;
-- the challenges facing VA; and
-- the actions we are taking in response to those challenges.

Mr. Chairman, I will take this opportunity to again thank all VA employees for their efforts – whether they have been directly involved or have been a part of local VA and community efforts – in responding to the needs of victims and their families in New York, Washington, and Pennsylvania. I particularly want to commend VA staff in the immediate areas for their efforts to continue serving veterans in very difficult circumstances and beyond this – to support community family and victim assistance efforts in New York, New Jersey, and at the Pentagon.

VA operates the largest integrated national health care system in the country and with our 1200 sites nationwide, provides direct care benefits and memorial services in every state. We expect that this national resource will be called on to provide significant assistance should mass casualty situations arise. We have responded well in this circumstance and are prepared to provide assistance to the Department of Defense should the need arise. We are reexamining our plans and will be taking steps to strengthen them. We also stand ready to assist Governor Ridge and our other federal partners in the weeks ahead as they

strengthen the Nation's ability to prevent and respond to any future terrorist attack.

VA's Response to the Events of September 11

Veterans Health Administration

VA reacted very quickly to the events of September 11, 2001. Immediately following the second aircraft crash into the World Trade Center, the VA Continuity of Operations Plan (COOP) was activated. Alternate sites, which serve as command centers and give VA leadership the ability to manage a crisis in the event VA's headquarters is closed down, were operational and key personnel were deployed within a few hours.

While staff in the Central Office assured the continuity of operations, the Veterans Integrated Service Networks (VISN) 3 and 5 command centers were activated. VISN 4 provided support to the response following the downed aircraft in Pennsylvania. VA staff supported the special security mission during the President's address to the Nation.

In New York, VA was dealing with the greatest national tragedy to touch our shores in a very immediate way, caring for patients, managing emergent situations, heightening security, deploying staff, sharing inventory, assuring continuous communications, all very close to ground zero. It should be noted that in New York nearly every person in the VA family has been affected in some personal way by the tragedy. Some VA staff work so close to where the World Trade Centers stood that they watched the entire catastrophe unfold before their eyes. Some staff had loved ones and close friends in the towers who haven't come home.

While the wounded were few, they were significant, and VA facilities in New York provided much needed supplies to the emergency workers and the National Guard to help them carry out their jobs in the immediate aftermath. VA continues to provide medical support to 3,000 members of the National Guard who are providing security to the city and its critical infrastructure. The Network's centralized kitchen and laundry operations worked miracles in keeping food and clean linens stocked at all of our medical centers in New York and New Jersey, fighting bridge and tunnel closures, rigorous inspection stops and using VA Police escorts to get around town and into the suburbs. Whereas many businesses and hospitals in the city were without telephone communications, our team had telephones continuously up and working.

Since the tragedy, VA outreach teams have been staffing family and victim assistance centers around the city and in New Jersey. We are now gearing up for the emotional and traumatic impact this event is likely to generate in the weeks and months ahead. The mental health team across the network is reaching out to those who are at risk.

As a part of VA's support of civilian emergencies under the Federal Response Plan, two VA critical care burn nurses were deployed to Cornell Medical Center Burn Unit and four critical care burn nurses were deployed to the Washington Hospital Center Burn Unit in Washington, DC to augment their staffs.

On the Saturday following the terrorist attacks, staff from VA's National Center for PTSD arrived in Virginia to assist DoD in its relief efforts at the Pentagon. They provided education for counselors and debriefing and psychoeducational support for relief staff that included Red Cross personnel and DoD Casualty Assistance Officers. Among the tools they created for assisting the relief workers were a Debriefing Facilitators Manual, an evaluation questionnaire for Casualty Assistance Officers, and a computerized self-assessment for the Army Community Support Center staff.

Within days following the event, VA broadcast the Department of Defense-sponsored series on "Medical Management of Biological and Chemical Casualties", throughout the VA system using the VA's Knowledge Satellite Network. In addition, a nationwide satellite videoconference on "Medical Response to Chemical and Biological Agent Exposure" will be broadcast to VA facilities on October 16, 2001, followed by "Medical Response to Radiological Agent Exposure" in November.

Veterans Benefit Administration

The Veterans Benefits Administration (VBA) has had an active role in administering benefits to veterans and their families affected by the events of September 11. The New York Regional Office (NYRO) has been very involved in helping the survivors and family members affected by the World Trade Center disaster, while the Washington Regional Office (WRO) and personnel from VBA Headquarters have been supporting the Department of Defense in providing assistance to family members of the victims of the attack on the Pentagon.

On September 17, VBA established an information, assistance, and on-site processing unit at DoD's Family Assistance Center. The Washington Regional Office, along with VA headquarters staff, are providing the coverage for this unit and VA's Insurance Center in Philadelphia and each of the benefits programs within VBA are supporting them.

The New York Regional Office (NYRO) established a team of employees who are providing help at the New York City Family Assistance Center, located at Pier 94. Vocational Rehabilitation and Employment, Loan Guaranty, and Veterans Benefits and Services Divisions developed alternate plans to provide counseling, to close home loans, and to interview veterans at off-site locations. Telephone

calls about benefits issues were rerouted to other Regional Offices until the NYRO toll-free service was restored.

In an effort to ensure control and efficient, effective service to the survivors of this terrible tragedy we issued a letter to each of our field stations outlining procedures for handling all claims related to the attack. All claims processing for this initiative has been centralized to our Compensation and Pension Service at Headquarters.

We have also established a toll-free telephone number for the survivors, families of the victims, and DoD Casualty Assistance Officers to obtain information about benefits and services offered by VA. They are being notified of this special number in a letter that VBA is sending to each of the affected families. In addition, VA's web site offers information on benefits and services available to the survivors.

We have streamlined the claims process as much as possible in an effort to be as supportive as possible of the families at this difficult time. Working with DoD, we have obtained direct online access to the Defense Eligibility and Entitlement Records System (DEERS) to obtain data on dependents allowing us to conduct on-site claims processing. We are faxing claims for Servicemembers Group Life Insurance (SGLI) directly to the Office of SGLI in Newark where the claims are processed within 24 hours. We have also implemented similar procedures for processing burial claims and headstone or marker applications.

I am pleased to say that both DoD and the families have indicated appreciation for the support and services we have been able to offer in this very difficult time.

National Cemetery Administration

The National Cemetery Administration (NCA) was quick to respond to the events of September 11, 2001. After news of the terrorist attacks was received and the alternate site was activated, the NCA Continuity Of Operations (COOP) team was there to participate fully in guaranteeing that VA was able to continue meeting its missions.

As long as the COOP was activated, NCA was an active participant in the One VA effort to guarantee that key functions were carried out. For NCA, this included making decisions concerning burials for victims of the attacks. NCA remained sensitive to the needs of their families during this crisis, making accommodations wherever possible. All VA national cemeteries were directed to treat all VA burials resulting from this tragedy as high priority, and to honor requests for weekend burials and to extend hours, if necessary.

All national cemeteries remained operational with the exception of Ft. Rosecrans and Barrancas National Cemeteries, which, because of the attacks, were temporarily closed for burials. This was a result of the proximity of the cemeteries to military bases with restricted access. This interruption in service lasted only a short time and all burials scheduled before the attacks were successfully rescheduled and completed.

It was reported that there had been cancellations of military funeral honors by the Department of Defense. Cemetery Directors were urged to seek alternate honors approaches, including the use of cemetery representatives and/or other employees or additional Veteran Service Organization assistance if possible.

NCA has provided or scheduled burials for 15 victims in its national cemeteries, with three additional requests having been made but services not yet scheduled. We immediately provided Presidential Memorial Certificates (PMC) to the families of over 75 active-duty personnel or veterans killed on September 11. PMCs bear the President's signature and commemorate a person's honorable service to the Nation. NCA has begun to provide a headstone or marker for several victims. In those cases where remains are unrecoverable, we will be able to provide a memorial marker in lieu of an actual burial.

NCA will continue to meet the burial needs of the victims of this horrendous act in a compassionate manner.

In short, VA's response to the attacks was swift, orderly, and effective. And that response is consistent with VA's history of being there in times of great need.

VA's History of Disaster Response

We are proud of our history of responsiveness to local and national disasters. The list is too long to include all our efforts, but just within the past 12 years, we have compiled a notable record of service in times of crisis. For example:

In 1989, as aftershocks of the October 17 earthquake continued to rock Northern California, VA opened the doors of its San Francisco and Martinez Medical Centers to supplement local emergency medical activities. Employees of the San Francisco VAMC staffed a mobile health-screen clinic that was deployed to area homeless shelters, and VA personnel were on hand at 17 federal disaster centers in the area.

When Hurricane Hugo struck Puerto Rico and the Eastern U.S. in 1989, VA facilities took direct hits, but their preparations enabled them to recover quickly and get to the business of helping their neighbors with services and shelter.

VA was ready in Florida in 1992 after Hurricane Andrew, and we quickly deployed to serve veterans and their communities stunned by that overwhelming disaster.

Even before the waters of the devastating 1993 Midwest floods receded, VA was helping veterans cope with the damage by instituting fast-response, one-day approval and processing of home-loan insurance issues, and delaying payment dates to allow veterans to recover from the disaster. We did this even though our own offices were flooded and many of our employees were working from home.

VA's Emergency Response Mission

The preceding are vivid examples of the manner in which VA responds to emergencies. The primary responsibilities and authorities governing VA's emergency management efforts include:

- VA and Department of Defense Contingency Hospital System, Public Law 97-174, May 1982, requires VA to serve as the primary contingency back-up to the Department of Defense medical services.

- National Disaster Medical System (NDMS) was established in 1984 by agreement between Department of Defense, Department of Health and Human Services, VA, and Federal Emergency Management Agency. It operates to provide capability for treating large numbers of patients who are injured in a major peacetime disaster within the continental United States, or to treat casualties resulting from a conventional military conflict overseas.

- Federal Response Plan, (updated 1999) implemented Public Law 93-288, the Robert T. Stafford Disaster Relief and Assistance Act as amended, and

established the architecture for a systematic, coordinated, and effective Federal response to a disaster or emergency situation.

- Executive Order 12656, Assignment of Emergency Preparedness Responsibilities, November 1988, charged VA to plan for emergency health care services for VA beneficiaries in VA medical facilities, active duty personnel, and, as resources permit, to civilians in communities affected by national security emergencies and for mortuary services for eligible veterans and to advise on methods for interment of the dead during national security emergencies.

- Federal Radiological Emergency Response Plan (FRERP) (May 1, 1996) established and organized an integrated capability for coordinated response by Federal agencies to peacetime radiological emergencies. VA's Medical Emergency Radiological Response Team (MERRT) is a federal resource available to respond to radiological emergencies.

- Presidential Decision Directive – 62, Combating Terrorism, May 1998, tasked U.S. Public Health Service (USPHS), working with VA, to ensure that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide and to train medical personnel in NDMS hospitals.

- Presidential Decision Directive – 63, Critical Infrastructure Protection (May 22, 1998) tasks VA to develop and implement plans to protect its infrastructure, including facilities, information systems, telecommunications systems, equipment and the organizations necessary to accomplish our mission to provide benefits and services to veterans.

- Presidential Decision Directive – 67, Continuity of Operations (October 21, 1998) tasks all Federal Departments and Agencies, including VA to ensure

that their critical functions and operations continue under all circumstances and a wide range of possible threats.

VA works closely with the Federal Emergency Management Agency to ensure compliance with the Continuity of Government and Continuity of Operations requirements in Presidential Decision Directive 67, titled *Enduring Constitutional Government and Continuity of Government Operations*.

VA also supports the Department of Health and Human Services in its mission of providing health and medical response following disasters, including terrorist incidents. In this regard, VA has significant medical assets that could assist the Nation should mass casualties occur. VA operates the Nation's largest integrated health care system; treating almost four million patients per year in hospitals and clinics in every state and Puerto Rico; and employing over 14,000 physicians and 37,000 registered nurses. As a partner in the National Disaster Medical System, VA is involved in planning, coordination, training and exercises to prepare for a variety of catastrophic events.

VA also provides support to the primary departments and agencies identified in Presidential Decision Directive 62, titled *Protection against Unconventional Threats to the Homeland and Americans Overseas*. Our Veterans Health Administration supports HHS's Office of Emergency Preparedness in ensuring that adequate stockpiles of antidotes and other necessary pharmaceuticals are maintained nationwide. Four pharmaceutical caches are available for immediate deployment with a HHS National Medical Response Team in the event of an actual weapons of mass destruction incident. We also maintain a fifth cache that is placed on-site at special high-risk national events, such as the Presidential Inauguration. VA also procures pharmaceuticals for the Centers for Disease Control and the Prevention National Pharmaceutical Stockpile Program.

VA is known worldwide as the authority in treatment of stress reactions and post traumatic stress disorder (PTSD). A vast number of highly skilled mental health staff are available for continuing response to the victims of the September 11 terrorist attacks and to respond to future events that psychologically traumatize our citizens.

VA has recently developed a nationwide registry of VA employees who volunteer and are trained to respond to disasters. In the future this registry will provide an inventory of personnel with skills and experience that can be matched to response requirements for both internal (VA) and external emergencies.
VHA is developing a national policy and plan for training and equipping our facilities and staffs to manage victims of a WMD incident. A Technical Advisory Committee (TAC) of both VA and non-VA experts was established in early 2000 to advise VA on WMD issues. The plan will include specific precautionary and response measures to be implemented at all VA facilities. We expect to establish a national policy and initiate system wide implementation before the end of 2001.

Public Law 97-174 authorized VA to furnish health care services to members of the armed forces during a war or national emergency. VA and DoD have established contingency plans whereby facilities of the VA healthcare system would provide the principal medical support to the military healthcare system for active duty military personnel when DoD does not have adequate medical resources under its own jurisdiction to meet medical contingencies.
These plans are reviewed and updated annually. This annual review is shared with DoD and a subsequent report is provided to Congress. VA also completes quarterly bed reporting exercises to ensure that procedures are familiar to staff and are ready for implementation on short notice should contingency support become necessary.

Emergency Preparedness Working Group

Although VA has plans in place to meet our critical emergency response missions, we know that there are new threats to America that we must address, and address quickly and effectively.

Given that this new threat is real and potent, I immediately formed a senior-level working group to undertake an assessment of the ability of the VA in its entirety to manage a multi-scenario crisis. This group assessed our ability to carry out our missions in case of a biological, chemical or radiological weapons attack. It also examined our capacity for reconstituting our ability to fulfill our missions, if need be.

This assessment has identified some deficiencies and opportunities to improve our ability to carry out all of our missions in today's environment. The challenges we face do not outweigh our overall strengths, and they do not compromise our primary mission to care for the nation's 25 million veterans. But they do represent challenges we must, and will, deal with quickly and appropriately.

In the following, I will outline some of the challenges that the working group has identified. However, in order to deny terrorists any sort of roadmap, I will avoid mentioning specifics at a public hearing. I will certainly be available to discuss such details with members and staff of this Committee after the hearing.

We are now facing the potential of having to respond to terrorists' attacks in the U.S., of providing contingency support to DoD, as well as continuing to care for our patients. Here are examples of our findings:

1. Some regions of VA's health care system would be hard-pressed if they were required to treat military and civilian casualties of chemical or biological agents in addition to carrying out their primary mission of providing health care to veterans.

2. VA needs to enhance its medical preparedness to respond to casualties from chemical and biological agents by providing training to its health care workers on decontamination procedures, and on diagnosis and treatment of chemical, biological and radiation injuries. VA medical centers are likely to play a crucial role in the initial response to an attack in their area. Yet their inventories of equipment and pharmaceuticals may not be adequate to address medical needs in the critical first hours of an attack, especially one involving chemical agents. As a result, VA Medical Centers need substantial upgrades to their personal protection gear, equipment, and training.

3. A call-up of Reserve or National Guard units, or a crisis causing staff to be unable to report to work, could result in a significant medical staffing shortage. This is part of the concern raised by Congressman Evans.

4. A major terrorist attack, especially one involving chemical or biological agents, would require a greater amount of post-traumatic stress counseling for military personnel, veterans, their families, VA employees – notably VA medical professionals and support staffs – and civilians. Long deployments of VA mental health staff could also have an impact on our ability to treat veterans.

5. VA's security forces need to be enhanced in numbers and training, both to manage a domestic crisis requiring medical care, and to protect our veteran patients, key personnel, facilities, and systems.

6. As this committee is well aware, we need to do a far better job securing our information and data bases from cyber-terrorism and to ensure that our key data centers are protected and their data back-up systems fully tested.

7. VBA is dependent on the Department of the Treasury to complete our payment process and issue payments. We need a back-up plan and process in the event that this link is inoperable.

8. Our National Cemetery Administration needs a comprehensive back-up plan to address increased interment workload in the event of an emergency.

9. VA needs to strengthen its communications protocols and its coordination efforts with the Department of Defense.

10. There is a need for a more robust VA headquarters Operations Center, for a stronger emergency operations command and control structure, and for a better-defined plan for mobilizing personnel to relocation sites.

11. We must periodically test our ability to respond to any terrorist attack through more training and periodic exercises.

12. Finally, and most importantly, we need to educate our employees and veterans on the realities of chemical and biological agents and how best to protect themselves.

New Actions Being Taken

VA has already begun to meet these challenges. As mentioned above, I immediately formed a working group to conduct a quick, but thorough, review of our readiness. Based on their findings, I have already authorized the following three actions:

First, as you are aware, the VA has the foremost source of medical care assets in the federal government and the largest integrated medical system in the nation. We are enhancing our emergency operations center to keep that system

functioning fully in the event of a crisis of any nature. I have ordered this center to institute daily, around-the-clock coverage, with secure data and voice communications links, to closely monitor VA's operational status, and to track the location of essential personnel for mobilization in the event of a crisis. We will also be improving our information technology capability system-wide.

Second, to make sure that we can respond fully in the event of a crisis, I have directed that an immediate review be made of the working group's many recommendations, that those requiring immediate action be identified, and that a fast-track decision be adopted to implement them. VA wants to ensure that it can continue its mission of caring for the nation's veterans, while supporting DoD in case of heavy casualties on battlefields abroad, and supporting FEMA, HHS and CDC and state and local authorities in case of casualties at home. We safeguard, maintain and deliver stockpiles for HHS and CDC and have emergency teams available on call in case of an emergency, particularly one involving biological, chemical or radiological weapons.

We will fully support Governor Ridge in fulfilling the mission of providing for homeland security, even as we continue to serve our nation's veterans. Above and beyond close coordination with the Homeland Security Council, we will continue to support DoD, HHS, CDC, FEMA, and state and local authorities in responding to future threats to our homeland.

VA's Future Role

Mr. Chairman, beyond the measures I have discussed today, VA will, no doubt, be a vital force in America's ability to meet tomorrow's challenges. I envision a VA that participates even more proactively in helping our communities maintain a high-degree of readiness in the event of natural disasters or terrorism on our homeland. Our primary mission will always be to serve America's veterans with honor, to acknowledge their sacrifices on our behalf, and to be there for them as

they were there for America. In any discussion of homeland defense, I want to assure the Nation's 25 million veterans that we will stand tall with our federal, state, and local colleagues to protect them, their families, and their communities.

The challenges we have defined in our preparedness assessment will also help us develop emergency response training and medical education opportunities that we can share with our civilian health professionals across America. As you know VA Medical Centers are often allied with medical schools and I believe these partnerships – enhanced by our lessons learned -- will help tomorrow's health care professionals meet the challenges we have talked about today.

Mr. Chairman, that concludes my statement. Thank you.

My colleagues and I would be pleased to respond to your questions.

Testimony
Before the Committee on Veterans Affairs
House of Representatives

The Role of HHS's Office of Emergency Preparedness in the Federal Response Plan

Statement of
Claude A. Allen
Deputy Secretary,
Department of Health and Human Services

For Release on Delivery
Expected at 2:00 pm
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Mr. Chairman and Members of the Committee, I am Claude A. Allen, Deputy Secretary of the Department of Health and Human Services (HHS). I am pleased to be here today to discuss the role of HHS's Office of Emergency Preparedness (OEP) in the Federal Response Plan.

The nation watched in disbelief, on the morning of September 11th, as American Airlines flight #11 crashed into the North Tower of the World Trade Center. As we all know, shortly thereafter, United Airlines flight #175 crashed into its twin building. Within minutes, we had activated our Department's Emergency Operations Center (EOC), knowing that our Department and our National Disaster Medical System (NDMS) partners in the Department of Veterans Affairs (VA), the Department of Defense (DoD), and the Federal Emergency Management Agency (FEMA) might be called upon to assist New York City in its response.

By the end of that tragic morning, with the almost simultaneous crashes of American Airlines flight #77 into the Pentagon, the crash of United Airlines flight #93 in Pennsylvania and the collapse of the World Trade Center buildings, Secretary Thompson had ordered activation of the entire NDMS, including notification of all of its 7,000 volunteer health workers and 2,000 hospitals. Verbal mission assignments were being obtained from FEMA, and teams were beginning to prepare to move during that day to staging areas around New York City and within Washington, D.C. It is a day that witnessed heroic actions, rapid responses, and profound grief.

HHS Preparedness and Response

The broad goals of a national response to an emergency, including acts of terrorism, or any epidemic involving a large population, are to detect the problem, control the epidemic's spread and treat the victims. At HHS, our efforts are focused on improving the nation's public health surveillance network to quickly detect and identify the biological agent that has been released; strengthening the capacities for medical response, especially at the local level; expanding the stockpile of pharmaceuticals for use if needed; expanding research on disease agents that might be released; developing new and more rapid methods for identifying biological agents and improved treatments and vaccines; improving information and communications systems; and preventing bioterrorism by regulation of the shipment of hazardous biological agents or toxins. HHS has also worked to forge new partnerships with organizations related to national security.

We are striving at HHS to strengthen our readiness and response, and our ability to respond has been greatly improved over the last several years. The system is not perfect, however, and we must continue to accelerate our preparedness efforts.

As you know, much of the initial burden and responsibility for providing an effective response by medical and public health professionals to a terrorist attack rests with local governments, which would receive supplemental support from state and federal agencies. However, if a disaster or disease outbreak reaches any significant magnitude, such as what

other federal resources, to assist in providing the needed services to ensure the continued health and well being of disaster victims.

The National Disaster Medical System is the vehicle for providing resources for meeting the medical and mental health service requirements of ESF #8, including forensic services. Begun in 1984, NDMS is a partnership between HHS, VA, DoD, FEMA, state and local governments, and the private sector. The System has three components: direct medical care; patient evacuation; and the non-federal hospital bed system. NDMS was created as a nationwide medical response system to supplement state and local medical resources during disasters and emergencies, to provide back-up medical support to the military and VA health care systems during an overseas conventional conflict, and to promote development of community-based disaster medical systems. The availability of beds in over 2,000 civilian hospitals is coordinated by VA and DoD Federal Coordinating Centers. The NDMS medical response component is comprised of over 7,000 private sector medical and support personnel organized into approximately 70 Disaster Medical Assistance Teams, Disaster Mortuary Operational Response Teams, and speciality teams across the Nation.

Disaster Response Teams

Our primary response capability is organized in teams such as Disaster Medical Assistance Teams (DMATs), specialty medical teams (such as those that would provide burn and pediatric care), and Disaster Mortuary Teams (DMORTs). Our 27 level-1 DMATs can be federalized and ready to deploy within hours and can be self-sufficient on the scene for 72 hours.

This means that they carry their own water, portable generators, pharmaceuticals and medical supplies, cots, tents, communications and other mission-essential equipment. These teams have been sent to many areas in the aftermath of disasters in support of FEMA-coordinated relief activities. In addition, staff from OEP and our regional emergency coordinators also go to the disaster sites to manage the team activities and ensure that they can operate effectively.

OEP's National Medical Response Teams (NMRTs) can provide medical treatment after a chemical or biological terrorist event. Each one is fully deployable to incident sites anywhere in the country with a cache of specialized pharmaceuticals to treat up to 5,000 victims of chemical exposures. The teams have specialized personal protective equipment, detection devices and patient decontamination capability.

Our mortuary teams can assist local medical examiner offices during disasters, or in the aftermath of airline and other transportation accidents, when called in by the National Transportation Safety Board and the Federal Bureau of Investigation.

In the last few years, OEP has deployed to New York, Florida, Texas, Louisiana, Alabama, Mississippi, the Virgin Islands and Puerto Rico in the aftermath of hurricanes and tropical storms. Our mortuary teams and management support teams have deployed to Rhode Island, Pennsylvania and California to assist local coroner offices after airline crashes. And we have supported local and federal efforts during special events such as World Trade Organization meetings, NATO 50th Anniversary events, Democratic and Republican National Conventions,

Presidential inaugural events, and State of the Union Addresses in Washington, D.C. Most recently, OEP and NDMS have deployed to Texas to respond to the health and medical needs caused by Tropical Storm Allison, and to New York, Pennsylvania and Virginia in the aftermath of the horrors of September 11, 2001.

NDMS Agency Partnerships

HHS, through OEP, manages and provides medical and mental health services, and mortuary services during disasters, and DoD has the lead responsibility for patient evacuation activities. DoD and VA share responsibility for definitive care activities, including managing a network of about 2,000 non-federal hospitals to ensure that hospital beds can be made available through a system of Federal Coordinating Centers (FCC). In addition, the VA provides other needed medical support during disasters. During the response to Tropical Storm Allison, the VA provided additional staffing to our Emergency Operations Center, dozens of additional medical and nursing personnel at the scene, and opened its VA hospital in Houston to receive patients when a majority of the hospitals in the Houston area were flooded and not able to receive patients. Currently, the VA is actively involved with us in New York City and in Washington, D.C. They have provided staff for our ESF #8 EOC, area managers to assist our Management Support Team in New York, mental health experts and crisis counselors, and nurses to treat burn patients both in New York and Washington.

The VA is partnering with OEP on other activities as well. The VA is one of the largest purchasers of pharmaceuticals and medical supplies. Capitalizing on this buying power, OEP

and VA have entered into an agreement under which the VA manages and stores the four National Medical Response Team specialized pharmaceutical caches. The VA has purchased all of the pharmaceuticals and supplies, rotates the stock, maintains the inventory, ensures the security of the caches and ensures that the caches are ready for deployment. Additionally, during FY 2001, OEP provided funds to the VA to begin to develop plans and curricula to train NDMS hospital personnel to respond to WMD events.

Other OEP Activities

OEP is working on a number of fronts to assist local areas hospitals, and medical practitioners to effectively deal with the effects of terrorist acts. HHS is taking the necessary steps to prepare our Nation for the health effects of terrorism, recognizing that should a chemical, nuclear, or bombing terrorist event occur, our cities and local metropolitan areas would bear the brunt of coping with its effects. In addition, we realized that the local medical communities would be faced with severe problems, including overload of hospital emergency rooms, medical personnel injured while responding, and potential contamination of emergency rooms or entire hospitals. Consequently, in FY 1995, HHS began developing the first prototype Metropolitan Medical Response System (MMRS). These systems, managed by local governments, are capable of providing triage and patient decontamination, population-based pharmaceutical prophylaxis and necessary medical care. In fact, the health care capacity issues that they are addressing are important regardless of the cause of mass casualties - for example, earthquakes, disease pandemics or terrorist events. To date, OEP has contracted with 97 of the Nation's largest

metropolitan areas for MMRS development, and plans to initiate an additional 25 contracts during this fiscal year.

In FY 1999, Congress appropriated funds for OEP to renovate and modernize the Noble Army Hospital at Ft. McClellan, AL, in order for the hospital to be used to train doctors, nurses, paramedics and emergency medical technicians to recognize and treat patients with chemical exposures. The Noble Training Center is working with universities, medical centers, and other federal agencies to train medical practitioners, emergency room staff, hospital administrators, medical first responders, and others to ensure that our citizens receive the best possible medical care after a WMD event. Working with CDC and the VA, a training program was developed for pharmacists working with distribution of the National Pharmaceutical Stockpile.

Conclusion

The Department of Health and Human Services is committed to ensuring the health and medical care of our citizens. We are prepared to mobilize quickly the health care professionals required to respond to a disaster anywhere in the U.S. and its territories and to assist local medical response systems in dealing with extraordinary situations, including meeting the unique challenge of responding to the health and medical effects of terrorism. The Departments of Veterans Affairs and Defense are critical partners in these efforts.

Mr. Chairman, that concludes my prepared remarks. I would be pleased to answer any questions you may have.

STATEMENT OF

DAVID S.C. CHU

UNDER SECRETARY OF DEFENSE

(PERSONNEL AND READINESS)

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

U. S. HOUSE OF REPRESENTATIVES

OCTOBER 15, 2001

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United States House of Representatives

Introduction

Mr. Chairman, I am pleased to be invited here today to present to you and the members of the Committee the Department of Defense's views on the Department of Veterans Affairs' (VA's) role as principal backup to the Department of Defense in the event of war or national emergency. The Department of Defense places enormous value on all of its sharing partnerships with the Department of Veterans Affairs. Since the outset of the sharing program which was established under the 1982 legislation, "Department of Veterans Affairs and Department of Defense Health Resources Sharing and Emergency Operations Act" , DoD has subscribed to the promise for improved economies of operation that health resources sharing has held.

In addition to promoting greater peacetime sharing of health care resources between VA and DoD, this vital legislation authorized the VA to serve as the principal health care backup to DoD in the event of war or national emergency. The military medical departments' primary mission is to support their combat forces in war and in peacetime to maintain and sustain their well-being in the accomplishment of National Military Objectives. The military medical mission is "to provide top quality health services, whenever needed, and to support military operations." Subsequently, military medical readiness is defined as all actions and preparation necessary to respond effectively and rapidly to the entire spectrum of potential military operations—from major regional conflicts, to smaller scale contingency operations, to humanitarian support missions. Military readiness involves both active and Reserve forces, and is accomplished through a strategy that seamlessly ensures a health and fit force, prevention of casualties from operational threats, and responsive combat casualty care and management. The Military Health System

(MHS) must fully integrate its military medical readiness mission with its beneficiary mission to provide quality, cost-effective medical services and support to military families, retirees and their families worldwide. Through the conduct of the MHS beneficiary mission, readiness is promoted in the military medical departments through the maintaining of a fit force; continuous surveillance of health risks pre-, during and post-deployment; the provision of clinical training for medical providers; enhancing recruiting and retention of quality service members; and otherwise fostering quality of life for military families by ensuring access to a worldclass health care system.

The Military Health System (MHS) consists of 76 hospitals and more than 400 medical clinics worldwide serving an eligible population of 8.3 million. Our medical units are capable of deploying as part of our Armed Forces to provide the preventive and resuscitative care that our troops may require in the conduct of operational contingencies. We emphasize the maintenance of a healthy, hyper-fit force prepared for the rigors of these contingencies, and the prevention of injury and illness. We identify potential hazardous exposures, track immunizations, and record health encounters with information systems designed to provide a continuous life-cycle surveillance that supports the health and fitness of the fighting force.

Concurrently, we provide a comprehensive healthcare delivery system for our service members, retirees, survivors, and family members. This system not only provides a training platform to maintain the technical skills of military clinicians, but also ensures our ability to directly influence the quality of care we deliver to our beneficiaries. Our primary responsibility is to provide medical support for our deployed forces, but those capabilities are inextricably linked

to our hospital and clinic operations. A robust healthcare delivery system is a strategic lynchpin that ensures a healthy and fit force for National Command Authority-directed contingencies, and provides the medical architecture capable of providing combat health support in missions ranging from humanitarian civic assistance to high intensity conflict.

The U.S. military has a history of successfully providing support and assistance to domestic civil authorities during emergencies and other instances of national concern. Examples you may recall include the military's response to natural disasters within the United States, such as hurricanes and earthquakes. The task of supporting civil authorities in a time of crisis is not a new responsibility for either DoD or military medicine.

The military health system continues to leverage the wartime capabilities of the men and women in our Armed Forces for domestic consequence management in support of the civil authorities. I am very proud of the efforts of our military medical team in response to the events of September 11th. The hospital ship USNS Comfort was dispatched within 48 hours to New York City with Navy medical personnel from the National Naval Medical Center. The Army's Dilorenzo clinic staff at the Pentagon was among the first responders to the attack on the Pentagon. Additionally, Walter Reed Army Medical Center immediately dispatched three trauma teams, a preventive medicine team and two combat stress teams to respond to the Pentagon crisis.

In response to the 1982 law authorizing a new contingency role for the VA, a Memorandum of Understanding (MOU) was executed between the Secretary of Defense and the Administrator

of Veterans Affairs (presently the Secretary of Veterans Affairs), specifying each agency's responsibilities under the law. Plans have been developed and are jointly reviewed and updated every year by VA and DoD. The VA/DoD Contingency Hospital System is outlined in the Veterans Health Administration Handbook 0320.1 of May 1, 1997.

The VA/DoD Contingency Hospital System is activated by the VA after the Secretary of Defense determines that DoD needs VA medical care resources because of a military conflict or another type of national emergency. The Secretary of Defense notifies the Secretary of Veterans Affairs, in writing, of any need for medical care contingency support. The Secretary of Veterans Affairs commits VA to provide support and communicates this commitment to the Secretary of Defense in writing. Through the VA/DoD Contingency Hospital System, DoD receives periodic estimates of VA contingency bed availability.

The Commander-in-Chief (CINC), US Joint Forces Command (JTFCOM) has overall responsibility to ensure integrated CONUS medical operations. Consequently, CINC JTFCOM has in place the Integrated CONUS Medical Operations Plan (ICMOP) that coordinates all CONUS medical assets in support of DoD casualties. ICMOP is supported by the VA/DoD Contingency Hospital System Plan.

One important objective of the overall planning effort is to assess VA's contingency bed capacity. Accordingly, VA medical centers assess 13 specific bed categories (that include highly specialized beds) required by DoD. These assessments take into account the impact on local operations of VA employees subject to mobilization, since long-standing VA policy is that no

employee is unavailable for active military duty in a national emergency by reason of his/her position or assignment.

The VA and DoD bed contingency plans are also supplemented by the National Disaster Medical System. This robust bed expansion capability will be activated subsequent to a war or national emergency requiring more than the combined resources of the DoD and VA. This joint Federal, State, and local mutual assistance organization provides for a coordinated medical response in time of war, national emergency, or major domestic disaster resulting in a mass casualty situation. Patients are evacuated to designated locations throughout the United States for care that cannot be provided locally. They are placed in a national network of hospitals that have agreed to accept patients in the event of a major disaster. DoD is a primary Federal agency responsible for administering the NDMS. Other agencies sharing responsibilities with DoD include the Department of Health and Human Services (DHHS), FEMA, and the VA. NDMS may be activated by the Assistant Secretary of Defense for Health Affairs in support of military contingencies when casualties exceed the combined capabilities of the VA/DoD Contingency Care System. The Assistant Secretary of Health (DHHS) may activate NDMS in response to a domestic crisis or disaster. Under the latter circumstances, DoD components, when authorized, will participate in relief operations to the extent compatible with U.S. national security interests.

The success of this joint venture was aptly demonstrated immediately following the September 11th attack on the World Trade Center Towers and the Pentagon. In anticipation of receiving casualties, The Secretary of Health and Human Services activated NDMS whereupon both VA and DoD began to report bed availability to the Global Patient Movement Requirements

Center (GPMRC) located at Scott Air Force Base, Illinois. There were however no casualties evacuated as a result of this tragedy, as local resources were able to handle health care commitments.

In summary, Mr. Chairman, the events of September 11th have highlighted the importance of a coordinated federal response to national disasters. While each of us must ensure that our health care system is capable of meeting the demands of our respective missions, we recognize the vital role the Department of Veterans Affairs plays in providing backup to the Department of Defense in the event of war or national emergency.

TESTIMONY OF DR. SUE BAILEY
HEALTH VENTURES, LLC
FORMER ASSISTANT SECRETARY OF DEFENSE
FOR HEALTH AFFAIRS
BEFORE THE
UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

OCTOBER 15, 2001

Chairman Smith and Members of the Committee, thank you for inviting me to this hearing and allowing me to testify.

In my role as Assistant Secretary of Defense for Health Affairs I was responsible for the Military Health System and was the principal advisor to the Secretary of Defense on issues of health and force protection, including chemical and biological warfare. This included assuring that the facilities and equipment available for the care of the active personnel and their dependents was of the highest quality available and was capable of meeting wartime and peacetime requirements.

Key aspects of meeting wartime and peacetime requirements are DoD's Integrated CONUS Medical Operations Plan (ICMOP), which coordinates DoD's CONUS medical resources; The VA/DoD Contingency Hospital System, which makes VA medical resources available to support DoD needs; and the National Disaster Medical System (NDMS), which supplements the war or national emergency needs of the combined resources of the VA and the DoD. Importantly, both the Assistant Secretary of Defense for Health Affairs and the Assistant Secretary of the Department of

Health and Human Services may activate the NDMS. During the recent attacks on 11 September, the Secretary of HHS did in fact activate the NDMS and the VA and DoD reported bed availability. While the low number of casualties allowed local medical facilities to cope with the patients generated, we cannot assume that future national emergencies would play out similarly. Clearly, in the wake of 11 September attacks, the domestic aspects of VA and DoD participation in the NDMS take on new relevance. Moreover, I believe there is much we can do to leverage the superb private and public health resources of this country in order to improve the quality and capacity of our response.

While there are differences in the VA and DoD health systems that are the result of their missions, these differences do not mean that the military and Veterans' Administration medical systems cannot be powerful assets to protect our citizens and defend our homeland. On the contrary, the experience, facilities, equipment and personnel of these agencies are essential to an effective civilian response program.

The tragic events of September 11th and the subsequent anthrax exposures in Florida and New York have dramatically illustrated the vulnerabilities of our society to terrorist attacks. Most experts agree that the likelihood of a large-scale bio-terrorist attack is small. Fortunately, biologic and chemical agents are not easily weaponized or disseminated and they are difficult, dangerous and expensive to produce in quantities that would create mass casualties. This does not mean that there is not a threat. On the contrary, the threat is

real but overall the risk is small when compared to other types of potential terrorist attacks.

While the risks are small, the potential consequences of a successful attack could be devastating. In one exercise known as "Dark Winter" federal and private officials simulated an attack on a major US city with smallpox. It ended in chaos and demonstrated our inability to contain a bioterrorist attack involving an infectious pathogen. Furthermore, the economic consequences can be equally devastating with estimates as high as $26 billion dollars per 100,000 persons exposed. These studies clearly justify the costs associated with a greatly enhanced and coordinated emergency preparedness program that calls upon the considerable combined assets of our private hospital system and the DoD/VA national system.

The World Health Organization (WHO) has identified Anthrax, Smallpox, Plague, and Botulism as the agents against which nations should step up surveillance and response efforts. While the lists of possible biologic and chemical weapons that U.S federal agencies maintain vary, most include Smallpox, Anthrax, and Sarin, principally due to either their availability, biologic stability, or potential for weaponization.

Scenarios such as "Dark Winter", and potential large-scale national emergencies that recent events call upon us to consider, point up that medical emergency preparedness and homeland defense require collaborative efforts involving careful planning between Federal, State and local governments. Despite the success of existing systems to respond in

recent emergencies, it is easy to imagine resources being over-whelmed by even a medium scale weapon of mass destruction attack on our homeland. Clearly, current systems could be inadequate to manage significant events. A coordinated surveillance, identification, containment, communication, and response system will be necessary to minimize the effects of a biologic, chemical or conventional mass casualty incident. Essential facets of such a system would include:

- Adequate communications support between headquarters and field offices and on-site systems.
- Integrated communications among detection units, laboratories, first responders, health care facilities, and federal agencies.
- Adequate detection equipment and enhanced laboratory capacities.
- Coordinated nation-wide medical surveillance for near real-time trend analysis.
- Accelerated specialized training of health care providers, first responders, and other personnel.
- Increased protection for first responders and facilities.
- Ensured access to stockpiled medications and vaccines.
- Decontamination facilities at all hospitals.
- Enhanced surge/bed capacity and alternative/mobile medical facilities.
- Improved bed status and patient-tracking reporting systems.

It is vital that the resources of the VA and DOD Systems be included in these efforts so that in the event the National Disaster Medical System is activated, the full capacity of the nation medical resources may be brought to

bear. This is entirely consistent with Public Law 97-174, which authorizes the Veterans' Administration to be the site of back-up medical care in the event of war or national emergency. Thus the Veterans' Administration hospitals, equipment and personnel can and should play an integral part of planning by the federal, state and local governments as they develop contingency plans for homeland defense.

Mr. Chairman, I am very proud to have served our Armed Forces as Assistant Secretary of Defense and honored to be asked to testify today. I would be happy to answer any questions the Committee may have. Thank you.

American Red Cross

James Krueger
Executive Vice President
American Red Cross

WRITTEN STATEMENT

Weapons of Mass Destruction Hearing
October 11, 2001

Mr. Chairman, Members of the Veterans Affairs Committee, I am Jim Krueger, Executive Vice President of the American Red Cross. On behalf of the Red Cross, I am honored to be here today to share with you the Red Cross response to the horrific events of September 11th and our interaction with the Veterans Administration in times of national emergency.

This terrible tragedy has touched all of us in a permanent way. America's spirit, our liberty and national security have been attacked. Yet we have seen firsthand the resilience and dignity of our countrymen. As Dr. Bernadine Healy, president and CEO of the American Red Cross has said, "What has taken place is extraordinary, and we must respond in an extraordinary way. The American Red Cross has a tremendous responsibility – to live up to the inspiration and memory of those lost. It is with great humility and pride that we carry out this noble obligation to serve the American people at this time of great need."

The Red Cross is an essential partner with federal response agencies during disasters by Congressional charter and by statute. Our primary focus is on the human needs of those affected, and we respond to both the physical and emotional devastation experienced by people during and after a disaster. Our duty yesterday, today and tomorrow is to serve humanity with dignity, valor, and compassion.

Evolving to meet the public's needs and expectations, the American Red Cross has unique capabilities and expertise, derived through more than 100 years of experience with disasters and public health challenges. One hundred years ago, we could not have imagined the devastation wrought by the recent terrorist attacks. Unimaginable as it may seem, terrorism on U.S. soil has become an appalling fact of life. The last time that such devastation occurred in this country was during the Civil War, and out of the chaos of that war came the American Red Cross.

With a presence in almost every community, Red Cross employees and volunteers are among the first on the scene of a disaster, and work closely with local and state first responders. Immediately following a disaster, before a presidential declaration is made

triggering federal response and resources, the Red Cross is on site sheltering and feeding victims, their families, those fleeing the affected area, and first responders.
The Red Cross has systems and infrastructure in place, which support our nationwide capability to help prepare for and respond to disasters of every kind, quickly and routinely. We can mobilize a network of trained staff and volunteers in communities throughout the nation, experts in logistics, nursing, mental health, communication, and sheltering. Most importantly, the public trusts us. The American Red Cross is a trusted, independent organization that can serve as a vital link between all levels of government and the American public during an event of this magnitude.

MANDATED RESPONSIBILITIES OF AMERICAN RED CROSS

Congressional Charter
We derive our authority from our Congressional Charter of 1905. This covenant directs us to carry out humanitarian service to victims of war, and a "system of national and international relief ...and apply that system in mitigating the suffering caused by pestilence, famine, fire, floods, and other great national calamities, and to devise and carry out measures for preventing those calamities." We are also entrusted to serve "...in accordance with military authorities as a medium of communication between the people of the United States and the armed forces..." With the recent deployment of troops, the Red Cross Armed Forces Services has over 200 American Red Cross staff deployed worldwide, assisting our men and women in uniform.

The charter defines the role of the American Red Cross as an auxiliary to the United States government in the fulfillment of the Geneva Conventions to protect victims of conflict. The terrorist attacks of September were acts of war, which trigger our work under the Conventions to inform the public about international humanitarian law. Our focus is on the moral and legal obligation to exercise humanitarian restraint within our own communities following this great trauma.

Federal Response Plan
The Red Cross has obligations under the Federal Response Plan, codified by the "Robert T. Stafford Disaster Relief and Emergency Assistance Act" (Public Law 93-288, as amended). We have lead responsibility for Emergency Support Function #6 (ESF #6), Mass Care. We meet the needs of disaster victims by providing food, shelter, clothing, and by operating a family linking system to report on the status of those affected and to reunite them with their families.

To assist us in carrying out this role, the Federal Response Plan designates eight federal agencies as "support agencies" including the Departments of Agriculture, Defense, Health and Human Services, Housing and Urban Development, Veterans Affairs, and the General Services Administration, U.S. Postal Service and FEMA.

The Red Cross also supports the Department of Health and Human Services, the lead agency for "Health and Medical Services" (ESF #8), and FEMA as the lead agency for "Information and Planning" (ESF #5).

Aviation Disaster Act

The Red Cross also has obligations to provide valuable services in the event of aviation disasters. These obligations are codified by the "Aviation Disaster Family Assistance Act of 1996" (Public Law 104-264). We have primary responsibility for coordinating the emotional care and support of the families of passengers involved in aviation disasters. This includes mental health and counseling services, meeting with families who have traveled to the location of the disaster, and to periodically contact families after such a disaster until assistance is no longer needed. We also have a solemn responsibility in that we are to arrange a suitable memorial service following such a tragedy.

AMERICAN RED CROSS RESPONSE TO SEPTEBER 11TH ATTACKS

We have never faced a disaster of this size, scope or intensity. In New York City, at the Pentagon, and in Pennsylvania nearly 20,000 dedicated disaster relief volunteers have been working tirelessly providing humanitarian assistance. The American Red Cross has provided safe refuge for over 4,000 people in 76 shelters, served 1.6 million meals to survivors, emergency personnel and stranded travelers. And the American Red Cross has helped 30,000 people by providing crisis, grief and spiritual counseling.

Following the terrorist attacks of September 11, 2001, the American Red Cross has launched an unprecedented relief effort that calls upon virtually every line of service – Blood, Disaster, International, Chapter Services, and the Armed Forces Emergency Services. In each instance, we focus on the needs of the people we serve: the rescue workers, those lost, their families, those in hospitals and those mourning in communities everywhere. That has led us to embark on services under our mission never before taken.

Immediately following the attacks, the American Red Cross:

- Dispatched expert trained Aviation Incident Response (AIR) teams to the plane crash sites and Boston, Newark, Los Angeles and San Francisco to support rescue workers and anyone present by offering food, beverages and a comfortable place to rest as well as offering grieving and spiritual counseling.

- Ensured the adequacy of our inventory of blood, contacted hospitals and public health officials in New York City, Washington, DC and Pennsylvania to have ready lifesaving blood, and moved blood to the perimeter from other parts of the country so that it would be readily available wherever needed. We also mobilized albumin and tissue for burn victims.

- There has been an enormous outpouring of Americans wishing to give blood as a way to help, giving a piece of themselves. The Red Cross expanded blood collection, storage and freezing capacity so that we did not have to turn generous blood donors away and so that we could build and maintain a large, readily deployable liquid inventory of blood and grow our frozen supply. We have radically increased our national blood inventories from 2-3 days to 10 days or more through this effort, which has made us stronger than ever before in blood readiness.

- Within a week the American Red Cross initiated a financial gift program for families who lost someone as a result of this tragedy, to help with near term financial needs such as food, clothing, utilities, transportation, mortgage or rent payments, funeral and related expenses, and other time sensitive and uncovered expenses. This gift is being provided in the form of a tax-free grant.

- Our Armed Forces Services are expanding their work as our troops are being mobilized, an established American Red Cross role for over a century. As active duty military, Guardsmen and Reservists are separated from their families, the American Red Cross will provide around-the-clock worldwide emergency communication services, confidential counseling, access to financial assistance for military families in crisis, family support and other assistance.

- Our chapter network has been activated to support communities by providing needed services. All of America is grieving and we have embarked on nationwide grieving and healing outreach programs in our chapters. Our chapters are promoting the humanitarian principles of the Red Cross, including neutrality, unity, universality and encouraging tolerance. Our international services are working with families of foreign nationals who were lost in this tragedy by linking their families through their local national Red Cross and Red Crescent Society and assisting with travel and logistics.

- To help the many thousands of people in New York City struggling to recover from the devastation caused by the terrorist attacks, the American Red Cross has set up three warehouses stocked with needed supplies such as food, cleaning materials, batteries and more. Called "canteens," these facilities will help many people obtain needed supplies and whatever goods they need to aid their recovery.

COLLABORATION WITH VETERANS ADMINISTRATION

As a support agency to the Red Cross for Emergency Support Function #6, Mass Care, the Veterans Administration has provided important support for counseling services. Following a disaster, no matter if at the local, state or federal level, Veterans Administration counselors and members of the VA Chaplain Service have helped provide grief counseling and spiritual care under the auspices of Red Cross Disaster Services. VA counselors are currently serving at the Family Assistance Center in New York City, a unique facility created to help families who lost loved ones in the World Trade Center buildings. It has become a safe haven for victims and their families as well as a place for people who lost their jobs and homes to seek assistance.

The need for emotional support in the wake of the largest disaster ever to strike the United States cannot be overstated. We are all grieving, from the families who lost loved ones to the hundreds of rescue and relief workers, to those who watched via television, this disaster has had an emotional impact on many. Mental health workers, grief counselors and spiritual care advisors such as those from the Veterans Administration are supporting grieving families at the Family Assistance Centers in New York City and the

Pentagon, and were with the families who came to grieve and remember loved ones at the crash site in Pennsylvania. They are available to listen to help rescue workers at Respite Centers, guide parents at Service Centers and shelters in helping their children through the trauma of losing their home, help workers face their fears of returning to high rise office buildings, and much more.

In addition to providing counselors and chaplains to support the work of the American Red Cross, the VA has agreed to make available facilities suitable for shelters and to provide medical supplies for use in these facilities. As we continue our planning for future WMD events, we will work with the Veterans Administration to identify how and when these facilities may be used, and other opportunities for collaboration.

AMERICAN RED CROSS RESPONSE TO HUMAN NEEDS FOLLOWING A WMD EVENT

Before September 11th, we knew that the American people would expect much from the Red Cross in the event of a terrorist attack. We knew it was a matter of when, not if. Our planning efforts had been underway for almost 2 years. The events of this past month have confirmed that we have an important role, and that as with all government and non-governmental entities responding to this disaster, additional planning, training and coordination is needed. This will be an ongoing effort. Our major planning and preparedness initiatives are described below. In many of these areas we will need partners, including the Veterans Administration.

Mobilize Expert Volunteers to Respond to People's Needs
Over the past century, the Red Cross has demonstrated its ability to mobilize expert volunteers during times of crisis. Red Cross must recruit and train volunteers with a wide range of expertise, such as employees of the Veterans Administration, to be ready to meet extraordinary demands.

- Red Cross Medical Reserve Corps - "Mercy Battalion": We will establish a corps of medical reservists (general practitioners, pediatricians, internists, respiratory therapists, physician assistants, pharmacists, phlebotomists and nurses) to be deployed from across the country. As envisioned, this corps will supplement the work of those medical professionals, primarily Emergency Medicine physicians, supporting the Department of Health and Human Services' National Disaster Medical System (NDMS). The Corps will enable the Red Cross to expand the basic health care provided in our shelters.

- Vaccination Capability: Biological terrorism could easily overwhelm the nation's public health infrastructure. The Red Cross can work with public health officials to assist with vaccinations by offering the people, facilities and assistance for rapid and large-scale emergency vaccinations. During last year alone we assisted with immunizations for nearly 100,000 people.

- National Pharmaceutical Stockpile: As requested by the Centers for Disease Control (CDC), the Red Cross is prepared to mobilize volunteers to break down and assist in dispensing the National Pharmaceutical Stockpile (NPS) strategically located throughout the country, so that these medications are ready when needed.
- Mental Health Issues: As the American Red Cross has seen in traumatic situations from Kosovo to the crash of Egypt Air 990, grief counseling and spiritual care are important elements of recovery. Even today, five years later, we are still counseling people in Oklahoma City. The Red Cross can mobilize more than 4,000 licensed, trained, practicing professionals in an emergency.

Provision of Food, Shelter and Basic Health Support

Our response and preparation regarding mass care depends upon the agent used - nuclear, chemical, radiological and high-yield explosive agents each carry unique response requirements. Biological weapons provide the greatest challenge in terms of shelter and containment since the attacks may not be successfully detected and identified until days after its release. Infection of thousands of civilians could require weeks to months of quarantines and martial law.

Large numbers of people will flee or be evacuated from areas impacted by an attack. Hospital facilities will be overwhelmed. The Red Cross will not only be asked to provide food, shelter and basic first aid to those displaced by the disaster, but to augment existing health care facilities which will devote resources to treat the most gravely injured. Hospital patients with less serious conditions and those in non-acute care settings will be moved to shelters to make room for the more seriously ill and injured. We will need trained medical professionals to observe for symptoms, administer medications and vaccines, and provide basic health care. Again, we will explore potential collaborations with the Veterans Administration to meet these needs.

CONCLUSION

The American Red Cross is an important private sector partner with Congress and the Executive Branch agencies in the development of a national strategy to prepare the nation to meet the human needs of those affected by WMD. We are an independent humanitarian organization with a history of trust and caring with the American public, as well as recognized leadership and effectiveness in responding to disasters domestically and internationally. We have demonstrated success in working well in public-private alliances and in coordinating activities with other organizations at the local, state and federal levels. Our more than 100 years of experience in helping people recover from disasters and coordinating relief will contribute to your leadership efforts to address this major national security issue.

Congress can rely on the American Red Cross to take a leadership role in addressing the human needs following catastrophic events. To coordinate and carry out this role, we need support from agencies such as the Veterans Administration. Thank you for inviting us to be part of this important hearing.

STATEMENT OF

ANNIE W. EVERETT

ACTING REGIONAL ADMINISTRATOR

NATIONAL CAPITAL REGION

U.S. GENERAL SERVICES ADMINISTRATION

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

OCTOBER 15, 2001

Chairman Smith and Members of the Committee, thank you for inviting the General Services Administration (GSA) to this hearing and for allowing me to testify. I am pleased to appear before you today to discuss with you the role and responsibilities of the General Services Administration in preparing for and responding to domestic disasters and national security emergencies.

GSA Role and Responsibilities

GSA is assigned specific domestic and national security emergency preparedness responsibilities under Executive Orders 12656 and 12472. The key responsibilities included are to:

- Provide rapid and efficient logistical support and telecommunications;
- Assist client agencies in their recovery;
- Provide support to those Federal agencies assisting victims of disaster or emergencies; and
- Ensure the continuity of GSA operations.

Specifically, Executive Orders 12656 and 12472 require GSA to:

- Ensure that Federally owned or managed domestic communications facilities and services meet the national security and emergency preparedness

requirements of the Federal civilian departments, agencies and entities;

- Develop national security emergency plans and procedures for the operation, maintenance, and protection of Federally-owned and occupied buildings managed by GSA;
- Have national security operating procedures for the control, acquisition, leasing, assignment and priority of occupancy of real property by the Federal government, and by State and local governments acting as agents of the Federal Government;
- Develop national security emergency operational plans and procedures for the use of public utility services by Federal Departments and agencies;
- Develop plans and operating procedures of government-wide supply programs to meet the requirements of Federal Departments and agencies during national security emergencies;
- Provide procedures for the use of excess and surplus real and personal property by Federal, state, and local governmental entities in national security emergencies;
- Develop plans, in coordination with the Federal Emergency Management Agency (FEMA), with respect to Federal buildings and installations, to minimize the effects of attack and establish shelter management organizations; and
- Create plans to assist Federal departments and agencies in the operation and maintenance of essential information processing facilities during a national security emergency.

These responsibilities are the same whether there are peace time or wartime emergencies. Unfortunately on September 11, 2001, GSA had our most challenging experience yet in carrying out these responsibilities.

GSA has also been asked to comment on its interaction with the Department of Veterans Affairs in times of national emergency. While the Department of

Veterans Affairs has responsibility for the acquisition of medical equipment and supplies pursuant to a delegation of procurement authority, GSA is available to provide whatever assistance the Department of Veterans Affairs or any other Federal agency may need to ensure the provision of medical equipment and supplies during national emergencies.

Response to Terrorist Attack

GSA associates have always been at their best in putting the agencies of the Federal Government back in business following natural disasters, such as hurricanes and earthquakes. In the immediate aftermath of the terrible terrorist attacks in New York City and the Washington, D.C. area, staff from across GSA upheld that tradition on a larger scale than ever before. In accordance with our Continuity of Operations (COOP) plans, GSA immediately activated our New York Region COOP. Our associates literally worked around the clock to produce logistical "miracles" within a matter of days.

In Lower Manhattan, many buildings that had been leased by GSA for occupancy by Federal agencies were heavily damaged or destroyed. For example, one major World Trade Center low rise, located at the base of the Twin Towers and occupied by the U.S. Customs Service, was completely destroyed. In addition, six major Federally-owned GSA buildings in Lower Manhattan were closed due to loss of power, loss of telecommunications and their proximity to the World Trade Center.

In the Washington, D.C. area, officials at the Department of Defense (DOD) asked GSA to locate, make ready for occupancy and totally equip nearly 850,000 square feet of space. These facilities were needed to provide a place for DOD employees to relocate from many areas within the Pentagon.

The results were extraordinary. By September 17th, six of GSA's Lower Manhattan Federally-owned buildings were reopened for essential personnel of the tenant agencies. By the same date, GSA had negotiated 14 leases totaling approximately 1.3 million square feet of space in New York City and New Jersey. This includes space acquired to house FEMA operations and several displaced agencies. An additional 9 sites (for a total of approximately 700,000 square feet) are being acquired for other tenant agencies that have been displaced or need additional space as a result of the tragic events of September 11th. Remarkably, by September 17th, GSA had also located, outfitted, and prepared for occupancy 850,000 square feet for DOD in Northern Virginia. Shortening a process that usually takes months in either the private or public sector to a few days, GSA was assisting DOD to begin moving in on September 17th.

Also, Officers from the Federal Protective Service immediately began helping evacuate the buildings in New York City and helping people to safety. Within two hours of the first collision, GSA had set up an emergency command center in New York to begin providing affected agencies with the supplies and services needed to restore operations.

Beyond providing space and furniture, and coordinating with the private sector for the replacement of destroyed telecommunications lines and switches, GSA labored extensively to provide many other items and support, including:

- hundreds of vehicles,
- security services,
- computers and servers,
- protective equipment and masks for the rescue workers,
- hauling equipment and tractors, and
- and a full range of many other services for our customer agencies, as well as the FEMA.

In total, GSA has been called upon to provide nearly 3 million square feet of replacement and new space in New York, New Jersey, and Virginia, along with furniture, telecommunications systems, computers and all of the other items that are needed in today's office environment.

When GSA briefed representatives of all the agencies being supported in New York, our representatives received widespread praise and the warm applause of heartfelt appreciation. The DOD summed up GSA's ability to anticipate its needs by stating that "GSA is 4 ½ hours ahead of anything that we can think of". In my opinion, Mr. Chairman, the GSA associates who produced those results are heroes in every sense of the word. I am proud of them.

Mr. Chairman, this concludes my statement. I will be glad to answer any questions that you or the Committee members may have.

STATEMENT OF

BRUCE P. BAUGHMAN

DIRECTOR

PLANNING AND READINESS DIVISION

READINESS, RESPONSE, AND RECOVERY DIRECTORATE

FEDERAL EMERGENCY MANAGEMENT AGENCY

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

OCTOBER 15, 2001

Introduction

Good morning, Mr. Chairman and Members of the Subcommittee. I am Bruce Baughman, Director of the Planning and Readiness Division, Readiness, Response, and Recovery Directorate, of the Federal Emergency Management Agency (FEMA). Director Allbaugh regrets that he is unable to be here with you today. It is a pleasure for me to represent him at this hearing on the role of the Department of Veterans Affairs in emergency response. My remarks will be brief. I will describe how FEMA works with other agencies under the Federal Response Plan framework and where the Department of Veterans Affairs – the VA – fits within that framework.

FEMA and the Federal Response Plan Community

The FEMA mission is to reduce the loss of life and property and protect our nation's critical infrastructure from all types of hazards. However, we are a relatively small agency; we do not "own" all the resources needed to fulfill that mission. Our success depends on our ability to organize and lead a community of local, State, and Federal agencies and volunteer organizations. We promote the ability of individuals, families, businesses, voluntary organizations, local governments, and States to manage the vast majority of emergencies in this country on their own. Under the auspices of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, we also provide a management framework and funding to bring the Federal Government's resources to bear when State and local governments need help with emergency or disaster situations, or when these situations involve a primarily Federal responsibility.

The heart of our response framework is the Federal Response Plan. The Federal Response Plan reflects the labors of interagency planning and coordination groups that meet as required in Washington and all ten FEMA Regions to develop our capabilities to respond ***as a team.*** This team includes 26 Federal departments and agencies and the American Red Cross, all signatories to the plan. The plan organizes departments and agencies into interagency functions based on the authorities and expertise of the members and the needs of our counterparts at the State and local level.

Currently, there are 12 of these "Emergency Support Functions": Transportation, Communications, Public Works and Engineering, Firefighting, Information and Planning, Mass Care, Resource Support, Health and Medical Services, Urban Search and Rescue, Hazardous Materials, Food, and Energy. Each has a primary agency – the agency with the most authority and expertise in that area – and supporting agencies that can provide additional relevant capabilities.

Since 1992, this Federal Response Plan framework has proven effective time and time again, for managing major disasters and emergencies regardless of cause – including the recent terrorist attacks.

FEMA's principal role under the Federal Response Plan is to manage the allocation of Federal resources to assist State and local governments. Where there is a valid need, we try to find the best way to provide the right resource to the right place at the right time. The Federal Government is not *always* the best source – there may be resources available commercially in the area or from a neighboring State government. When the Federal Government is the best source, a department or agency may be able to provide what is needed under its own authority and with its own resources. If not, FEMA issues a mission assignment and provides for reimbursing the costs associated with the mission. If a mission falls within the scope of an Emergency Support Function, FEMA assigns it to the primary agency for that function; the primary agency may then task its supporting agencies.

The Department of Veterans Affairs within the Federal Response Plan Framework

Since FEMA's concern is resource allocation, we want to have as large a pool of available resources as we can. We recognize that as one of the nation's largest healthcare providers, the Department of Veterans Affairs has substantial assets – including medical facilities, medical staff, and pharmaceuticals – and we are pleased to count the VA among the signatories to the Federal Response Plan. Within the Federal Response Plan framework, VA is a supporting agency under ESF #8, Health and Medical Services. The Department of Health and Human Services is the primary agency for ESF #8, and would subtask VA for health and medical missions as appropriate. I defer to both organizations to discuss their work under ESF #8 and the National Disaster Medical System in more detail.

I should note that VA's role in the Federal Response Plan does not end there. VA is also a supporting agency to the U.S. Army Corps of Engineers under ESF #3, Public Works and Engineering, committed to making its facilities engineering personnel available if needed. VA is a supporting agency to the American Red Cross under ESF #6, Mass Care, to provide medical supplies, food preparation, and facilities if needed to support shelter operations. VA can support the General Services Administration under ESF #7, Resource Support, with procurement and distribution, including technical assistance on procuring medical supplies and services. VA has made a commitment to supporting Federal Response Plan operations in whatever way they can, and we at FEMA appreciate it.

Conclusion

Mr. Chairman, that concludes my remarks. I would be pleased to answer any questions you or the Committee may have.

STATEMENT BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

FOR

THE COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

REGARDING

THE DVA'S ABILITY TO RESPOND TO DEPARTMENT OF DEFENSE CONTINGENCIES AND NATIONAL EMERGENCIES

OCTOBER 15, 2001

Mr. Chairman and Members of the Committee, on behalf of the more than 600,000 federal and District of Columbia employees represented by the American Federation of Government Employees, AFL-CIO (AFGE), I want to thank you for the opportunity to express our views and concerns today on the public health mission of the Department of Veterans Affairs. AFGE represents 135,000 Department of Veterans Affairs (DVA) workers across the nation, or about 75% of the rank and file employees in the agency.

After September 11th, we must reassess the role of government and the best way to defend our country from terrorism. In light of this, we must also reconsider our approach to the public health system in this country. We must acknowledge that the private sector does not always provide the answer to public problems. It provides excellent care to privately insured patients, but ignores millions who are uninsured. It encourages efficiency in health care management, but it also cuts back so-called "excess capacity." When we as a nation need to respond to events which may affect vast numbers of our citizens simultaneously, the lean, mean private sector will be incapable of responding to our nation's needs. For years, we have neglected public investment in health care assuming either that the private sector health care system would fulfill public needs, or assuming that national security threats would never translate into national threats to public health. Today, we know better and must do everything possible to reinvigorate this system.

The Federal Emergency Response Plan needs a public health care system to succeed. However, this system must have different values than a private business. The first concern of a private company is profit. That cannot be the only aim of a nation at war. We must focus first on our nation's safety and our citizens' health.

Unfortunately, in recent years DVA has embraced a private sector model of management. I come here to say that this is a mistake. Many DVA medical centers have reduced staff and supplies simply to reduce costs. As a result, they have little surge capacity to meet the demands of either war, terrorist attacks or epidemic illnesses. This short-sighted, bottom-line approach has decimated the DVA, and left our nation's public health system in a vulnerable position. The DVA's use of private contractors and reliance on private hospitals will not be adequate in a time of crisis. The DVA must maintain a higher level of capacity to respond to a crisis, even if it is "inefficient" in terms of how a business operates. Indeed, this capacity is a central part of the unique public health function of the DVA and military medical systems. They maintain capacity that would not be profitable for a private sector health care provider to maintain.

The DVA would play an important role in responding to any public health crisis. The keystone to this response is surge capacity. The DVA medical centers can address some of the need for space and supplies. The Veterans Health Administration offers an existing network of medical facilities in every state. It provides health care to veterans with approximately 173 medical centers and other facilities throughout the country. This is an invaluable resource as we prepare to respond to mass casualties. It provides an extant network to which surge capacity can and must be added.

The Drive to Privatize and Dismantle the DVA

There have been constant calls either to close DVA medical centers, merge DVA facilities with private hospitals or to contract out and/or privatize the services that they provide. DVA claims to have closed more than 52% of all its hospital beds, since 1994. AFGE estimates that DVA cut 1 in 6 of its nursing staff since the mid-1990s based upon an analysis of the agency's budget. DVA is seriously considering closing "excess" facilities as part of its capital assets management.

Through the "Federal Activities Inventory Reform Act" (the FAIR Act), the Office of Management and Budget developed regulations for agencies to use when implementing the law. The Bush Administration directed that five percent of all jobs listed on the FAIR Act inventory must be given to contractors or subjected to public-private competitions.

Late last month, the DVA issued its FAIR Act lists. It has categorized 161,065 Veterans Health Administration jobs as commercial, effectively putting that number of federal employees at the risk of losing their jobs to privatization. Additionally, 28% of DVA employees are veterans, according to the Office of Personnel Management's "Demographic Profile of the Federal Workforce." Few of these veterans will even the opportunity to compete in defense of their jobs. The Bush Administration will require the agency to compete or privatize a minimum of 9,300 of these workers. Many of these employees perform work that would be essential in the case of a massive public health crisis.

DVA considers all of its nursing staff, roughly 50,000 Registered Nurses, Licensed Practical Nurses, and Nursing Assistants, as performing work that could be turned over to the private sector. There are also 11,496 employees, mostly physicians, performing medical services for the DVA that can be privatized without even the opportunity to compete in defense of their jobs. The DVA has another 5,068 surgical service employees who could be privatized. Among psychiatry services personnel, the number is 5,470. Pathology and laboratory medicine services workers at DVA medical centers numbering 6,787 are on the block. These DVA employees provide clinical disease management and examine the development of a diseased condition. Other DVA specialties subject to arbitrary privatization without competition include, but are not limited to, the following: anesthesiology services, audiology and speech pathology services, biomedical engineering services, blind rehabilitation services, chaplain services, clinical ambulatory care services, dental services, dermatology services, diagnostic radiology services, dialysis services, domiciliary services, fire protection unit, medical and patient library services, medical media services, neurology services, nuclear medicine services, nursing services, optometry services, orthotics laboratories, pharmacy services, physical medicine and rehabilitation services, podiatry services, psychology services, radiation therapy services, readjustment counseling services, security services, social work services, and spinal cord injury services.

The DVA has a key role in mass care of civilians during emergencies. However, it is not capable of fulfilling this responsibility today. The path of privatization guarantees that the DVA will not be able to provide the needed surge capacity.

In an emergency, the DVA also plans to offer shelter and food preparation for masses affected by a medical or other disaster. However, the DVA lacks the resources to perform this work today. For example, it is reducing its infrastructure for food production by introducing the quick chill method. When quick chill is in place at a medical center, the facility no longer has the capacity to produce food unless it is in a particular microwavable form.

DVA facilities provide ideal locations to stockpile pharmaceutical and medical supplies. DVA medical centers exist throughout the country. In many less populated areas, the DVA could serve as an excellent resource to provide pharmaceuticals and medical supplies if needed. In September the DVA announced that many of these jobs will be subject to privatization again without even offering the employees an opportunity to compete to keep their jobs.

There is a demand for better laboratory capacity. The National Laboratory System (NLS) is an attempt to respond to threats to public health posed by bioterrorist attacks, infectious diseases, and other health problems. The DVA should join this attempt to improve the public health system. Because community facilities may be the front line for the detection of biological threats, the DVA should lead the efforts to coordinate the identification, monitoring, and cure of these threats to public health. Using the DVA would increase the number of clinical laboratories associated with public health departments around the country.

The Veteran Population

In the 1990s, most policy makers assumed that this nation would not need an infrastructure to care for aged veterans in the future. They believed that the passing of veterans from World War II and Vietnam would also end an era of large number of Americans who served in the armed forces. However, in a war on terrorism we will create new veterans and may continue to have civilians who are injured on the front lines of terrorist attacks. The future of the DVA and all its capital assets should be reevaluated in light of this change in outlook.

Conclusion

The DVA can play a critical role in responding to terrorist attacks or medical disasters, however, to do so it must abandon the HMO model and embrace the public health system ideal. As a corollary to this, the agency should create favorable working conditions for its staff. The DVA cannot retain a cadre of capable employees to meet today's new demands if these workers are constantly at risk of losing their jobs. In short, the agency must treat its staff with respect and dignity.

In closing, I ask you this: How will turning over nine thousand DVA jobs to private sector contractors, without any competition, increase our nation's ability to respond to a medical emergency? How will this increase surge capacity? Will this save lives? Or will it sacrifice them to the mindless allure of privatization?

Thank you for considering AFGE's views.

STATEMENT OF
JACQUELINE GARRICK, CSW, ACSW, CTS
DEPUTY DIRECTOR, HEALTH CARE
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
TO THE
U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
ON THE
VA RESPONSE TO THE SEPTEMBER 11, 2001 ATTACKS

OCTOBER 11, 2001

Mr. Chairman and Members of the Committee:

Thank you for the invitation to contribute The American Legion's observations and recommendations to this extremely important hearing. On September 11, many American Legion members were sitting in the Committee's hearing rooms awaiting the National Commander's testimony before a Joint Session of the Veterans' Affairs Committees. As the horrendous acts began to unfold, Americans stood in disbelief. Fortunately, many Federal agencies are prepared to address such disasters with aggressive, coordinated activities.

As a clinical social worker and Certified Trauma Specialist (CTS), I volunteered to provide counseling support at the Pentagon Family Assistance Center in the Sheraton Hotel in Crystal City, VA. The American Legion graciously allowed me to spend many working hours assisting at the Center. I worked with both the Department of Defense's (DoD) Behavioral Mental Health Team and a nonprofit group, the Tragedy Assistance Program for Survivors (TAPS). Together, these two programs provide much needed support services at the Center or in the Pentagon. The American Legion provided resource materials and made referrals for financial assistance and peer support. Additionally, The American Legion Auxiliary donated $10,000 to provide children's grief workbooks and other self-help materials for the survivors and their family members.

The American Legion also re-instituted its Family Support Network to assist Reservists and members of the National Guard federalized to respond to this national emergency. During the Persian Gulf War, the Family Support Network provided much needed assistance to family members in local communities across the country. Services included such activities as childcare assistance, automobile maintenance, home repairs, and financial assistance provided by local members of The American Legion family. Over a half million dollars in grants were provided to the families of activated servicemembers during the Persian Gulf War. The American Legion renews this commitment to assist the citizen soldiers, sailors, airmen, Marines, and their families for the duration of this crisis.

Through this first-hand involvement, I witnessed the role of the Department of Veterans Affairs (VA) in responding to this tragic event. The Veterans Benefits Administration, Veterans

Health Administration and the National Cemetery Administration were mobilized to assist in answering questions, providing mental health services, filing for benefits, and assisting with burial arrangements. VA also worked with Federal Emergency Management Agency (FEMA), the Office of Crime Victims (OCV), American Airlines and the American Red Cross.

VA's National Center for Post-Traumatic Stress Disorder (PTSD) sent six team members from the Palo Alto Education Division to the Pentagon Family Assistance Center within days of the attack. After consulting with previous DoD contacts and obtaining permission from VA, the Division Director decided to drive, virtually non-stop across country, to respond to the disaster. For more than two weeks, this team provided psychological support and education to the recovery workers and family members at two separate locations.

At the Pentagon Family Assistance Center, VA's team provided:

- Psycho-education for counselors in support of families of missing or deceased.
- Debriefing of support staff, counselors, and other agencies (including Red Cross, FEMA, and DoD).
- Psycho-education and debriefing to Casualty Assistance Officers (CAO), who are charged with providing case management to the families of the deceased.
- Educational materials regarding disaster response for victims and helpers.
- Facilitator's guide for behavioral and emotional support debriefing for use by DoD counselors.
- Consultation with operation and mental health leadership in a long-term disaster response plan.
- Family support.
- Program evaluation questionnaire for CAOs to assess preparedness, effectiveness, and utilization of resources while providing services for family members of deceased victims.

At the US Army Community and Family Support Center Command Group in Alexandria, Virginia, VA's team provided:

- Psycho-education regarding human response to disaster and utilization of psychological first aid.
- Psycho-educational materials.
- Counseling to Pentagon employees.
- A survey for staff to use as self-assessment in response to the disaster.

The reputation and consultation services of the National Center are recognized throughout the world. The National Center provides more than simply long-term care for combat veterans suffering from PTSD, but also includes Acute Stress Disorder and Disaster Mental Health. This group published a guidebook that serves as the model for Pentagon relief efforts. The National Center for PTSD's recent performance demonstrates the valuable role of VA in response to such disaster. The presence of the National Center for PTSD was greatly appreciated by representatives of DoD, FEMA, Red Cross, OCV, TAPS, and the other responding organizations.

Initially, DoD did not plan to include VA in the recovery efforts. The plan used in responding to this disaster was from the National Transportation Safety Board (NTSB) model, which does not include VA. **The American Legion strongly recommends that VA be added to NTSB's list.** Under the Aviation Disaster Family Assistance Act of 1996, the Chairman of the NTSB may request the assistance of:

- American Red Cross
- Department of State
- Department of Health and Human Services
- Department of Justice and the Federal Bureau of Investigation
- Federal Emergency Management Agency
- Department of Defense

The National Center for PTSD has an ongoing agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA) to respond to disasters. In New York, the National Center coordinated efforts with Federal, state, and city officials. They continue to work with the New York Fire Department in planning the next phase of mental health services to be offered.

The National Center for PTSD provides resource materials on the immediate affects of trauma on survivors, families, rescue workers, and children through their website. As of last week, this website received approximately 50,000 hits daily. The National Center expects to continue to play a major role in providing consultation, education, and research information in this post-disaster response.

There seems to be a need for an internal VA response and coordination protocol in the event of a national emergency. **The American Legion recommends that the National Center for PTSD serve as the lead agent in coordinating such a protocol.** Since there are 206 Vet Centers around the country that can be activated to provide counseling in local communities, the Readjustment Counseling Services is another valuable resource in helping to provide disaster relief.

The VA/DoD Health Resources Sharing and Emergency Operations Act of 1982 gives VA the mission as primary backup for DoD and FEMA in the event of a disaster or armed conflict. The National Disaster Medical System Federal Coordinating Center Guide identifies plans and coordination protocols for local exercises and responsibilities that include VA. However, according to the key assumptions in the VA Strategic Plan 2001-2006, "The United States will not engage in any major global or regional conflict during the period of this plan." Yet, the same plan lists as an objective, "Improve nation's response in the event of a national emergency or natural disaster by providing timely and effective contingency medical support and other services."

The American Legion remains concerned over this assumption. Currently, VA lacks the resources to fully staff the additional inpatient beds, if needed. VA must carry out a Continuity of Operation plan that includes annual tests, training, and exercises; preparation of alternate operating facilities; and identification of designated emergency planners. The American Legion believes the number of VA and DoD sharing agreements will increase over the next few years.

The American Legion recommends that VA should prepare a report on its emergency preparedness plans to treat mass casualties resulting from a national emergency.

In conclusion, The American Legion is truly touched by the outpouring of national support for the victims and their families. As a nation, Americans have come together to use their sense of humanity to best counter terrorism. Federal and organizational bureaucracies, that often seemed territorial and to act in isolation, overcame those barriers to provide much needed comfort and services to victims and families.

The National Center for PTSD will be issuing a more detailed report on its involvement in the response to this tragic event. The results of this report should help establish the framework for future national emergency contingency plans. VA must certainly be listed as a Federal agency that responds with NTSB. There should be on going communication and liaison activities between VA, DoD and FEMA in accordance with VA's mission to act as a backup to these Federal agencies. The American Legion requests that a new assessment and re-evaluation of VA's strategic plan be completed to determine if it has not underestimated the potential need for bed space and emergency medical care.

Mr. Chairman, that concludes this statement.

Non Commissioned Officers Association of the United States of America
225 N. Washington • Alexandria, Va. 22314 • Telephone (703) 549-0311

STATEMENT

OF

RICHARD C. SCHNEIDER
DIRECTOR OF VETERANS AND STATE AFFAIRS

Submitted to

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

ON

VA's Ability to Respond to DoD Contingencies and National Emergencies

October 15, 2001

Chartered by the United States Congress

DISCLOSURE OF FEDERAL GRANTS AND CONTRACTS

The Non Commissioned Officer Association of the USA (NCOA) does not currently receive, nor has the Association ever received, any federal money for grants or contracts. All of the Association's activities and services are accomplished completely free of any federal funding.

INTRODUCTION

Mr. Chairman and distinguished Members of the Committee:

The Non Commissioned Officers Association of the USA (NCOA) believes your review of the Department of Veterans Affairs Ability to Respond to DoD Contingencies and National Emergencies is extremely relevant in view the September 11th Terrorist Attack on America. The days that have passed since September 11th have sensitized the American people to man made disasters beyond comprehension.

NCOA is appreciative of the opportunity to submit its perspective for the record on VA's ability to respond to DoD operations and National Emergencies.

The Association's membership is exclusive in its representation of enlisted personnel of Active, Reserve, and Guard Service Components, the USCG, military retirees and veterans. The significant ratio of enlisted personnel to military officers who have served in the Armed Forces quickly translates to the fact that the majority of veterans who would benefit from VA medical care in this eventuality would be current or former enlisted Soldiers, Sailors, Marines, Airmen, and members of the Coast Guard. NCOA is strongly committed to the issue of preparedness of the VA to meet readiness obligations to ensure the war fighting and sustainability of military forces. Likewise, the Association believes that the Department of Veterans Affairs is uniquely qualified and should be on the front line in the preparation, management and execution of any and all National Emergencies.

Today, the sons and daughters of America serving in the Armed Forces, the United States Coast Guard, and all Reserve, or Guard Components prepare again to answer the clarion call to duty. The call to duty has already placed many in harm's way and will require sacrifice and place hardship on all service members and their families alike.

BACKGROUND

The Nation was thrust into a new concept war on September 11th when terrorists attacked America and its citizens targeting civilian locations. The terrorists' acts of aggression and destruction have indelibly redefined the concept of war for the world in the 21st Century. The people of America supported the President in his declaration of war on terrorists and any country that offers them safe harbor. Hence the "call up" of Reserve and Guard personnel as military forces are being deployed to counter the worldwide threat including locations in cities, shipping corridors and airports in the United States. NCOA communicated its steadfast support to The President in his determination to seek justice for all victims of terrorism. A copy of the correspondence from NCOA to the President is attached.

News reporting and continuous live coverage of the events in New York, Washington DC, and Pennsylvania has vividly communicated the nation's response to the unfolding events. That all Americans have been sensitized is evident by people responding with financial

contributions, providing food and clothing, and expressing personal grief for unknown citizens who were victims of the terrorist attacks.

The Nation has been further sensitized or perhaps traumatized to the terrorist reality by both the President and Federal Bureau of Investigation warnings that additional terrorist activities are to be expected. Citizens have received the message to remain vigilant to strangers, activities, and things that appear out of the ordinary. Concurrently, the President has encouraged people to return to "normal" activities, continue with vacation plans, not to hesitate to fly, take planned shopping trips, and help America in a period of time characterized by:

- A continued threat to life and property
- Declining economy
- Job losses and high unemployment
- Citizens traumatized by events
- Perception of America becoming an armed camp
- Ongoing news and talk show hosts running commentaries on terrorism
- Sense of foreboding and doom

Additionally, a Presidential Executive Order established the Office of Homeland Security and chartered a Homeland Security Council to develop and coordinate a comprehensive national strategy to strengthen protections against terrorist threats or attacks in the United States. Citizens are advised that this new function will coordinate federal, state, and local counter-terrorism efforts.

COMMENT AND RECOMMENDATIONS:

1. Emergency Medical Back Up to the DoD

The Office of Emergency Medical Preparedness, VAMC Martinsburg, WV serves as the point of contact for DoD Contingencies and is involved in the planning and preparedness for VA medical services required to support the DoD Mission. That office has access to information, classified and unclassified, and likewise communication capabilities to actively exercise its role in support of DoD contingencies to manage the medical care and distribution of military wounded.

Planning and Communication are key to providing the required hospital beds and distribution of patients for needed medical expertise. The migration of the Veteran Health Administration medical delivery system from an inpatient to an outpatient primary care system raises the ageless questions that are continuously reviewed and must always be confronted when military forces are placed in harm's way:

Are there sufficient VA bed spaces, medical staff, and equipment to convert unused wards for mass casualties?

Are there air transportation hubs and ground-access areas available in the needed communities for the movement of patients?

How will mobilization impact availability of either VA medical staff or contract physicians/nurses?

Will any needed medical specialty capability be lost due to military deployment?

Are medical vehicles available in the required communities to transport mass casualties?

The communication capability that exists between the VA and its health care facilities can provide 7 x 24 real time information for VA and VHA leadership to make decisions to aggressively respond to DoD requirements.

Recommendations:

Continued leadership review of the Office of Emergency Medical Preparedness and its planning function.

Ensure adequate funds are budgeted to stockpile medical equipment and supplies, and upgrades for redundant processes to include alternate VA command and control facilities, communication technology, and medical hot sites.

Ensure highest level of technology and back up systems for communication with DoD and air transport centers.

Ensure medical triage information for the correct distribution of mass casualties to treatment centers where specialty service is available.

Actively participate in planning exercises with the military to ensure a current and viable DoD contingency mission.

2. VA Ability to Respond to National Emergencies:

VA has historically responded well to all types of natural disasters in America.

The terrorist attack on America raised significant issues for America and the Department of Veterans Affairs. Initially described as a terrorist war, the national role of VA in the immediate aftermath of the crisis appeared to be in question and perhaps even nonexistent. Internally, the Department of Veterans Affairs communicated leadership direction and involvement of local VA Medical Centers and Vet Center personnel in the adjacent areas of the disasters. It also aggressively directed the immediate involvement of the Veterans Benefits Administration to facilitate the death and burial benefits of veteran victims.

Lacking in the immediate aftermath of the September 11th event was the programmatic role of the Federal Agencies. Most notably missing was the Department of Veterans Affairs as

the Nation's premier health care provider in response to such disasters. It appeared that DoD, The Department of Health and Human Services, FEMA and other agencies had their roles being defined and action directed in response as events unfolded on September 11. In fact, the Governors of the impacted states (New York, Virginia, Pennsylvania and the Mayor of the District of Columbia) were actively involved in the process.

That the Secretary, Department of Health and Human Services had an aggressive leadership role seems inexplicable when you consider the Department as a health care policymaker lacking resources to be an emergency health care provider. Undoubtedly, there is an obvious role for HHS in such emergencies but certainly not as an agency capable of delivering health care services or to provide intervention for those suffering from post-traumatic stress.

The Department of Veterans Affairs in the past years has dealt with the concept of terrorism as it relates to medical care. In fact, in the week prior to September 11, the Secretary of Veterans Affairs responded to a General Accounting Office report on a matter dealing with terrorism. That response was related to one of six (6) such GAO reports relating to the readiness of federal agencies relative to terrorism in the preceding two years. VA had already begun to train its medical personnel on intervention and care techniques to terrorism involving casualties resulting from the utilization of chemical, biological, or nuclear agents.

The President's immediate appointment of a new Cabinet Office as Office of Homeland Security and charter of a Homeland Security Council was an excellent action in response to what has become known as the Terrorist War on America. NCOA regrets however that the formal statements sanctioning this new office and council did not reflect the Secretary of Veterans Affairs as a named participant in this initiative. The chartering statements allow for the appointment of others determined to be possibly appropriate for inclusion in this initiative. The Association believes only the Veterans Health Administration of the Department of Veterans Affairs has the nationwide medical delivery service able to respond to either provide direct care or augment community resources in response to future terrorist actions.

Recommendations:

NOTED: That the Secretary of Veterans Affairs has already sanctioned a departmental disaster preparedness work group and that a tentative report is already being reviewed.

That VA be assigned a national leadership role in assignments of the Office of Homeland Security and Homeland Security Council for the formulation of policy, planning, and implementation for the coordinated federal delivery of community heath care services in response to terrorist activities.

That resources be budgeted for the VA to stockpile caches of medical equipment, pharmaceuticals, and supplies to respond to nationwide terrorist activities. Likewise, that VA's budget include provision for protective clothing, equipment, communication technologies, decontamination and facility modifications to provide control for the care of victims of nuclear, biological, or chemical attacks.

VA should be considered a national resource in the training of community medical personnel in their preparation to management contingencies related to terrorism. Federal leadership and involvement by a number of agencies in such programs is key to a successful unified community response to an actual event.

VA health care professionals should be a part of DoD mass casualty exercises. It is readily apparent that the joined medical response to terrorism of DoD and VA would best serve America. Further, VHA could provide the continuity of such responses should existing military medical resources be deployed or otherwise not available.

CONCLUSION

Thank you Mr. Chairman and members of the House Veterans Committee for recognizing the need to address this special subject dealing with VA's ability to exercise its DoD Contingency Mission and the role of the Department in responding to national emergencies.

NCOA believes that the Secretary of Veterans Affairs and the diverse program resources of that Department must be a part of any national program that responds to major natural disasters or emergencies. It is inconceivable that a federal agency the scope and size of the Department of Veterans Affairs would not be at the national planning table ensuring the readiness of America to respond to any such event.

Thank you.

BIOGRAPHY

of

Richard C. Schneider
Director of Veterans and State Affairs

Mr. Schneider is the National Director of State/Veterans Affairs, Non Commissioned Officers Association of the United States of America. His responsibilities include executive management of all NCOA programs that support America's veterans. These include service transition, employment, benefit rights and adjudication processes. He directs 473 NCOA Veteran Service Officers located in the United States and overseas. Additionally, he provides legislative focus for 46 NCOA State Legislative Coordinators, which represent NCOA in State Legislative Affairs. Mr. Schneider concurrently serves as the Executive Director of the NCOA National Defense Foundation. In this capacity, he is responsible for the Association's Voter Registration Program including the operation of the National Voter Registration and Information Center in cooperation with the Department of Defense. He also manages NCOA Operation Appreciation, which provides grants to benefit hospitalized veterans and other association determined humanitarian outreaches.

Mr. Schneider was born in New Jersey. He was raised in the Garden State attending elementary and secondary schools in Lyndhurst. He has a Bachelor of Science from the University of Southern Colorado (1972) and a Master of Arts from the University of Northern Colorado (1974).

He served in the United States Air Force from August 1957 to September 1990. Mr. Schneider retired in the grade of Chief Master Sergeant. He held significant assignments in management and personnel planning throughout his military career. His military decorations include the Legion of Merit, the Meritorious Service Medal with two Oak Leaf Clusters and the Air Force Commendation Medal with four Oak Leaf Clusters.

He is currently the Secretary, Board of Directors, Pentagon Federal Credit Union, Alexandria, VA. He also is currently the Chairman of the Board, Financial Technologies, Inc., Chantilly, VA.

Mr. Schneider is married to the former Anne Ferguson of Prestwick, Ayrshire, Scotland. They have four children: three daughters, Kristin, Leslie, and Fiona; and a son, Richard.

NCOA

Non Commissioned Officers Association of the United States of America

225 N. Washington • Alexandria, Va. 22314 • Telephone (703) 549-0311

September 12, 2001

The President
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Mr. President:

The Non Commissioned Officers Association of the United States of America strongly supports your leadership as Commander-in-Chief in the resolution of the terrorist attacks against America. Today, those organizations which participated in Tuesday's cowardly acts of terrorism against this land and its people along with those nations which harbor(ed) them know with certainty that America is united in its quest for justice.

We mourn with all free people the senseless loss of life of our fellow citizens and comrades-in-arms. This Association knows first hand the suffering and anguish inflicted upon countless families of those lost or wounded in an act of war. NCOA is resolute that this national tragedy and its impact on all citizens and their families are not forgotten and that all responsible are held accountable for their despicable act.

NCOA pledges with its motto "Strength in Unity" that determination of support, encouragement, and steadfast loyalty as you lead America in the turbulent days ahead. Our prayers are with you for strength and wisdom as you lead our country and its people through their most difficult days.

God bless you and God bless America!

Semper Fidelis,

David W. Sommers

David W. Sommers
President

Cc: Members of Congress

Chartered by the United States Congress

STATEMENT OF THE

PARALYZED VETERANS OF AMERICA

FOR THE RECORD OF THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

HEARING REGARDING

VA's ABILITY TO RESPOND TO DEPARTMENT OF DEFENSE

CONTINGENCIES AND NATIONAL EMERGENCIES

OCTOBER 11, 2001

Public Law 97-174, the "Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," currently part of 38 U.S.C. § 8111A, states that the Department of Veterans Affairs (VA) is the principal medical care backup for military health care "[d]uring and immediately following a period of war, or a period of national emergency declared by the President or the Congress that involves the use of the Armed Forces in armed conflict[.]" 38 U.S.C. § 8111A. This is one of the four primary missions of the VA.

On September 18, 2001, in response to the terrorist attacks on September 11, 2001, the President signed into law an "Authorization for Use of Military Force" which constitutes specific statutory authorization within the meaning of section 5(b) of the War Powers Resolution. This resolution, P.L. 107-40, satisfies the statutory requirement that triggers the VA's responsibilities to serve as a backup to the Department of Defense (DOD).

A summary of the 1982 law, published by this Committee, stated that the law "recognizes the need for VA and DOD to participate in joint contingency planning. The measure establishes the formal role of the VA health care system as the primary backup to the DOD health care system for treatment of members of the U.S. Armed Forces engaged in armed conflict during a period of war or national emergency declared by the President or the Congress."

In a 1986 hearing conducted by this Committee to ascertain the implementation of the 1982 law, the Assistant Secretary of Defense for Health Affairs testified that the "VA was directed to serve as the primary backup to the DOD in the event of a war or national emergency. The two Departments have made great strides in designing a VA backup system to our contingency system at DOD. Today the system stands ready to provide 32,506 contingency beds for use by DOD in the event of a war or a national crisis."

The VA's requirement to report to this Committee within 30 days of the declaration of war or national emergency as to the VA's "allocation of facilities and personnel in order to provide priority hospital care . . . to members of the Armed Forces" was repealed last year with the enactment of P.L. 106-419. PVA would be interested in ascertaining the number of contingency beds the VA would be able to make available consistent with the intent underlying the 1982 law to provide a priority to members of the Armed Forces "second only to the priority of service-connected veterans for care and treatment."

This priority is also contained in the regulations promulgated under this statutory authority. 38 C.F.R. 17.230 (a) reads:

> (a) Priority care to active duty personnel. The Secretary, during and/or immediately following a period of war or national emergency declared by the Congress or the President that involves the use of United States Armed Forces in armed conflict, is authorized to furnish hospital care, nursing home care, and medical services to members of the Armed Forces on active duty. The Secretary may give higher priority in the furnishing of such care and services in VA facilities to members of the Armed Forces on active duty than to any other group of persons eligible for such care and services with the exception of veterans with service-connected disabilities.

This national emergency entails not only a crisis abroad, but a crisis here at home. As the VA serves as a backup to our Armed forces, it also serves as a backup to, and an integral part of, our Nation's health care system. When terrorists struck New York City, the VA was there, caring for victims. In fact, the Government Accounting Office, in its January 2001 report entitled "Major Management Challenges and Program Risks" (GAO-01-255) characterizes the VA's role as the "primary backup to other federal agencies during national emergencies." The VA must be prepared, and provided with the resources it needs, to accomplish this comprehensive and vital mission.

We ask this Committee to ensure that the VA is an integral part of contingency plans established by the new Office of Homeland Security, headed by former Governor Tom Ridge, and task forces such as the Gilmore Commission (the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction).

We believe that if the VA is to meet these many responsibilities during this period of crisis then it must be assured of sufficient resources. We do not believe that the VA has the resources it will need for the upcoming fiscal year to adequately care for veterans. If the VA is to fulfill its mission it must be provided these resources. We further believe that this, once again, points out the importance of maintaining the integrity of the VA system and its ability to provide a full range of health care services.

We know this Committee will work closely with the Administration, your colleagues in Congress, and with veterans to safeguard the care provided to sick and disabled veterans and to realize the additional resources the VA will need to fully meet its obligations to serve as a backup to the DOD, other federal agencies, and the Nation, in this time of national emergency.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES

STATEMENT OF

PAUL A. HAYDEN, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

THE DEPARTMENT OF VETERANS AFFAIRS ABILITY TO RESPOND TO
DEPARTMENT OF DEFENSE CONTINGENCIES AND NATIONAL EMERGENCIES

WASHINGTON, DC OCTOBER 11, 2001

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States (VFW) and its Ladies Auxiliary, I would like to thank you for the opportunity to make a statement on such an important and timely topic.

First, we would like to commend the Department of Veterans Affairs (VA) for its role in the response to the domestic terrorist acts that shocked our nation last month. According to the Office of Emergency Preparedness' (OEP) Situation Report #25, released on October 3, 2001, the VA "is providing support to the city [New York] through its VA health care facilities..." of which the "VAMC Manhattan received and treated a total of 76 victims with an additional 17 treated at the VAMC Brooklyn, three at the VAMC in the Bronx and two at the Northport VAMC for a total of 98." Aside from the victims treated, the VA immediately deployed assistive personnel to New York City, Pennsylvania and Virginia.

In communicating with VFW Service Officers and members located near the affected areas, we are proud to report that we have not received one complaint about VA's ability to complete its primary mission to serve veterans. Again, the VA is to be commended for carrying an increased workload while maintaining a continuity of services to veterans.

The VFW believes that VA's authority to respond to Department of Defense (DOD) contingencies is well documented in PL 97-174, the *Veterans' Administration and Department of*

Defense Health Resources Sharing and Emergency Operations Act. This Act, codified in Title 38 U. S. C. § 8111A, and commonly referred to as VA's "fourth mission" states that VA will be the principal backup to DOD by furnishing health care services to active duty members of the Armed Forces in the event of war or national emergency "that involves the use of Armed Forces in armed conflict."

Further, Title 38 U. S. C. § 8110, dealing with the operation of VA medical facilities mandates the Secretary to "maintain a contingency capacity to assist the Department of Defense in time of war or national emergency."

VA's role to backup the military is clear. As the recent terrorist attacks have proven, however, national emergencies involve civilian casualties as well. Without doubt, PL 97-174, passed May 4, 1982, was based on the Cold War expectations that we would suffer mass military casualties conducting a land campaign in Eastern Europe and/or on the Korean Peninsula. Additionally, our national security strategy at that time was based on nuclear weapons and the concept of Mutually Assured Destruction (MAD).

As this committee considers how VA can best carry out its mission in the future, we feel it is important to take into account how national security has changed since the collapse of the Soviet Union and the proliferation of Weapons of Mass Destruction (WMD), specifically nuclear, biological and chemical. Recent reports, such as the U. S. Commission on National Security for the 21st Century (Hart-Rudman Commission), have all recognized that the "U. S. will become increasingly vulnerable to hostile attack on the American homeland" as well as be called upon to provide frequent military intervention abroad. It is no longer *if* the terrorists strike, but *when*.

So the question arises, how does VA fit into this new environment? One new strategy proposed for national security is homeland protection based on prevention, protection, and response. Common sense dictates that the VA, as the nation's largest health care network, will provide support under the response category. In fact, they already do.

We believe it was VA's role as a federal-level partner with the Federal Emergency Management Agency (FEMA) and the National Disaster Medical System (NDMS) that allowed it to respond to the civilian casualties so efficiently and effectively in the hours and days following the attack.

As one of 28 signatories to the Federal Response Plan (FRP) managed by FEMA, VA already has in place an inter-agency understanding that they will act as a support agency on 4 of 12 Emergency Support Functions (ESF) that FEMA uses to coordinate federal efforts to counteract the consequences of a national disaster. For example, VA's authority to treat the 98 victims it received in its New York Medical Centers was based on its support role in ESF #8, Health and Medical Services. Aside from Health and Medical Services, VA has a support role in ESF #3, Public Works and Engineering, ESF #6, Mass Care, and ESF #7, Resource Support.

VA's participation with FRP is more or less a *de facto* fifth mission and the VFW feels that it provides the most logical paradigm for VA's future response strategies and tactics in time of national emergency.

It is essential to point out that we are not advocating additional VA capacity for civilians. We, however, are mindful that DOD has been downsizing its medical facilities' beds for years and recent testimony before the Senate Appropriations Subcommittee on Labor, HHS and Education on the threat of biological terrorism has only highlighted the fragile state of the nation's public health system's ability to deal with multiple simultaneous disasters from WMD. The Senate testimony articulated that "financial problems have also transformed the health care industry in recent years, sharply reducing the number of available hospital beds and the size of the nursing staff and largely eliminating 'surge' capacity, or the ability to treat a sudden influx of patients resulting from a major disaster."

The same problems that threaten the public health system are the same ones that have been emphasized in past testimony to this committee regarding the VA health care system. Everyone is aware that the VA has been steadily transforming its health care system from inpatient to outpatient care for nearly a decade and the nursing shortage problem is nationwide. In addition, years of flatline budgeting have seriously eroded VA's ability to provide care to its primary constituency, the veteran. The lack of a "surge" capacity in the public health arena only underscores the need for one at the federal level.

There is no other federal hospital system, other than VA, that can be expected to handle the overflow of patients from the public, private and DOD health systems resulting from a national emergency or act of war. Given the aforementioned testimony the potential for military and civilian casualties flooding the VA system and disrupting service to veterans is real. For

example, what if there had been 6,000 wounded survivors instead of 6,000 fatalities as a result of the terrorist's actions in New York City?

Therefore, the VFW firmly believes that VA's goals during a national emergency should be twofold. First, VA must work to maintain services to veterans, as they aptly demonstrated they could do in New York and Virginia, while providing backup to DOD and FEMA. Second, given a scenario where they are overwhelmed in their support roles of handling civilian and military casualties, and the situation dictates that traditional veteran services must be reduced or even suspended, they must work diligently to return civilians to the public and private health care providers, where possible, to ensure room for DOD personnel as well as for veterans whose services were interrupted.

In order for VA to successfully respond to DOD contingencies and national emergencies, they must be properly prepared. Continued participation in local, state, and federal disaster training and the implementation of the FRP is the key to that preparedness. In addition, Congress, when using the power of the purse, must be mindful of VA's missions during acts of war and national emergencies. How can the VA be expected to carry out these support missions when it is struggling to carry out its primary mission of caring for the veteran?

We are hopeful that this discussion will assist in producing sound policy. Again, we are thankful for the chance to participate. This concludes my testimony and I would be happy to answer any questions you or the members of this committee may have.

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Statement of

VIETNAM VETERANS OF AMERICA

Submitted for the Record

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Before the

House Committee on Veterans' Affairs

Regarding

The VA's Emergency Preparedness Posture and Related Issues

October 15, 2001

Vietnam Veterans of America **October 15, 2001**
Statement for the Record, HVAC
VA's Emergency Preparedness Status

Chairman Smith, Ranking Member Evans, and other distinguished members of the Committee, Vietnam Veterans of America (VVA) is pleased to have this opportunity to provide our comments for the record on our concerns regarding the Department of Veterans Affairs (VA) preparedness to deal with a national emergency, including wartime contingencies. Because the VA is required to provide medical back up to the Defense Department in such emergencies, we believe it appropriate to briefly review the state of DoD's performance in this are over the last decade.

Operations Desert Shield and Desert Storm revealed many problems in the U.S. armed forces' ability to mobilize and deploy available medical personnel. This included inadequate data in the personnel information systems used to identify doctors and nurses for active duty assignments as well as a lack of peacetime training to prepare doctors and nurses for their wartime roles.[1] DoD attempted to address this after Congress authorized a demonstration project for training military doctors in civilian trauma centers in 1996, but the program's relatively small scope and DoD's dalliance in getting the program underway meant that as of early 1998 only four surgeons had completed the program.[2]

In a broader 1992 report on the ability of DoD, VA, and the National Disaster Medical System (NDMS) to handle wartime casualties, GAO made a number of observations that to VVA appear to still be valid nearly a decade later:

- DoD did not know enough about the qualifications or readiness of medical reservists
- The number of beds available in DoD, VA, and NDMS hospitals was overstated
- DoD lacked effective plans to develop additional specialty care, such as burn treatment
- Some communities do not have adequate plans to receive and transport casualties
- Casualty tracking systems were inadequate
- VAMC's had not planned for follow up care of beneficiaries displaced from those centers

All of these shortfalls have a common theme: they are capacity driven.

Throughout 2001, VVA has testified before this and other Congressional committee's regarding our deep concerns over the loss of capacity in the VA health care system to treat veterans with special needs: the seriously mentally ill, homeless veterans, blinded veterans, veterans suffering from spinal cord injuries, and veterans exposed to toxic substances. Should our country be forced into large-scale ground combat operations in Southwest Asia as part of a larger counterterrorism campaign, it is inevitable that we will see an influx of casualties requiring these kind of specialized services. Just as inevitably, DoD will turn to the VA for assistance in treating and subsequently caring for and compensating these veterans, particularly given the downsizing of the services' medical organizations in the wake of Desert Storm. Our

[1] *Operation Desert Storm: Full Army Medical Capability Not Achieved*, GAO/NSIAD-92-175. August 18, 1992.
[2] *Medical Readiness: Efforts are Underway for DoD Training in Civilian Trauma Centers*, GAO/NSIAD-98-75, April 1998.

view is that the VA is fundamentally unprepared to cope with this new crisis for at least two key reasons.

The first is the aforementioned reductions in the VA's capacity to treat veterans with specialized needs.

As we testified before the full committee earlier this year, since fiscal year 1996, VA's spending on Post-traumatic Stress Disorder (PTSD) treatment programs has declined by over 8% even as the number of patients in need of services has increased by over 20%. VA's ability to provide inpatient or residential PTSD care has been virtually eliminated. If one counts medical inflation, then PTSD program resources have declined by more than 30%. Likewise, programs for the seriously mentally ill have suffered a major reduction in capacity—a roughly 10% loss in resources against a nearly 10% increase in the number of patients. Veterans who should have been treated for PTSD on an inpatient basis are now dealt with infrequently and through outpatient programs that are inadequately staffed, under funded, and unevenly allocated nationally. Existing seriously mentally ill veterans are now wandering our streets, without proper treatment or hope for recovery. This is but one example of the overall diminishment of VHA capacity due to the continued starving VA of vitally needed funds.

Given these types of resource deficits, VVA believes that there is no way that the VA will be able to treat a new influx of veterans suffering from PTSD or other mental disorders brought on by combat in the wilds of Afghanistan or elsewhere in Southwest Asia. Bluntly stated, this is a mental health treatment disaster waiting to happen, particularly since VA cannot even properly deal with the patients they have now!

Substance abuse programs have also been ravaged. Despite a roughly 12% decline in the number of veterans seeking treatment, total resources declined by an astonishing 37%, amounting to a net reduction in services of 25%, not accounting for medical inflation. Even allowing medical inflation at only 8% per year (the private sector has been averaging over 10%), the sum total of reduction in substance abuse services is more than 60%! We note that the medical inflation rate we have quoted is our minimum estimate of its impact on the VA system; the real impact in reduction in services is likely much greater.

American servicemembers deployed to Afghanistan or any adjacent countries can count on fighting in a "drug rich" environment, as the following excerpt from the October 3, 2001 edition of the *Washington Post* makes clear:

> "According to the State Department, the Taliban controls 96 percent of the territory where poppies are cultivated in Afghanistan. It promotes this activity to finance arms purchases and military operations. Although congressional sources said it is not clear that bin Laden benefits directly from drug money, McCaffrey said he is sure there is a "direct personal relationship" between the Taliban and al Qaeda, the international terrorist network led by bin Laden. He said much of the treasury initially accumulated by bin Laden came

from selling heroin in Europe."[3]

Having financed their international mayhem through drug sales, we can rest assured that bin Laden and his Taliban allies will use their drug network to attempt to get as many deployed American military personnel as possible addicted to opiates or hashish. We must also be alive to the possibility that American forces worldwide may become the target of terrorist-financed drug addiction efforts. Given the virtual collapse in the VA's inpatient drug treatment program, VVA sees no way that the Veterans Health Administration could cope with a significant influx of new hard drug users attempting to get clean.

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996, explicitly requires the VA to "maintain its capacity to provide for the specialized treatment and rehabilitation of disabled veterans within distinct programs or facilities dedicated to the specialized needs of those veterans." Instead, PTSD, substance abuse, mental illness, and homeless programs within the VA have virtually imploded due to inadequate funding. Under these conditions, how can anyone expect the VA's specialized services to be able to cope with a new generation of combat veterans?

Our organization has estimated that it will take a bare minimum of $3 billion—over and above additional funds to offset past medical inflation—to begin to restore VA health care programs to their pre-1996 level. Much more would be required if large numbers of new Southwest Asia veterans enter the system.

Another major problem impacting the VA's ability to meet its wartime mission requirement is the VA's proposed Capital Asset Realignment for Enhanced Services (CARES) process.

Ostensibly, CARES is designed to allow the VA to rationalize its medical infrastructure by closing or consolidating facilities while shifting to an emphasis on outpatient treatment. In July 2001, VHA Undersecretary Garthwaite issued his preliminary recommendations for the first CARES-driven restructuring, in this case for VISN 12, which serves northern Illinois, Wisconsin, and parts of Michigan. Our analysis of this proposed restructuring highlights not only the impact it will have on the existing veteran population but on any future veterans created by the administration's counterterrorism campaign.

The CARES options selected by VA for the Northern and Central markets of VISN 12 stipulate that there would be no routine contracting for medical services in the more remote submarkets. Given the fact that there is no VAMC in the region between Iron Mountain and Tomah, VVA finds it incomprehensible that the VA would select options that do not *mandate* medical service contracting for the nearly 100,000 veterans who live in these two markets.

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[3] *Scrambling to Get on Board ...The New Battlefield*, The Washington Post online, Wednesday, October 3, 2001.

Not only are we concerned about the ability of veteran in rural areas to get access to quality, full-spectrum medical services, we are also deeply concerned about the lack of hospital access for veterans living in the Green Bay-Appleton-Manitowoc triangle. Veterans from these areas would have to drive 50+ miles to get full-spectrum medical services under the proposed plans—a totally unacceptable situation. One can only imagine the problems these veterans will face if they are displaced from the VA health care system by competition from more recently wounded veterans from Operation ENDURING FREEDOM.

Moreover, we are also deeply concerned that the Tomah VAMC's complete lack of surgical, SCI, and blind rehab beds will leave affected veterans in central and western Wisconsin without access to these services unless VA enters into appropriate contracting agreements with local providers. Given the VA's own acknowledgement that veterans from ***outside*** VISN 12 have been seeking access to VISN 12's already inadequate specialized services, we are quite certain that the 34 blind rehab beds at Hines VAMC are inadequate to serve the existing veteran population, to say nothing of potential ENDURING FREEDOM veterans.

Regarding the availability of private sector medical services within the VISN, BAH noted that

> *"This analysis suggests that the vacancy rate of private sector community hospitals could be as high as 43 percent, therefore suggesting there is excess capacity in the private sector with the potential for the VA to buy services." (p. 2-19)*

Of the 116 community hospitals in Wisconsin, VVA is quite certain that there are several hospitals the VA could contract with to ensure that veterans with specialized needs have access to the services they require, and that veterans in need of more routine care do not spend hours on the road in search of health care, particularly if they are displaced by ENDURING FREEDOM veterans seeking the same services. Based on previous GAO testimony and the observations of our members and service representatives in the field, we know that the problems described above are present throughout the entire VHA.

Moreover, the notional DoD-VA sharing agreement in the VISN 12 CARES proposal underscores another serious problem: the fundamentally different nature of the patients the two agencies treat.

Clinically, veterans are generally older and in poorer health than their active duty counterparts. Accordingly, their medical needs are in many ways fundamentally different. Secondly, we are concerned that any DoD-VA sharing agreement would be dominated by DoD, which has a far larger budget and a greatly increased role and status in the wake of the World Trade Center and Pentagon terror attacks this month. Our fear is that DoD's needs will take priority over those of the VA and the veteran population it serves, to the detriment of the health of the veteran population.

We would withdraw our objection to these proposed sharing arrangements ***only*** if the Congress and the VA guarantee veterans access to health care through adequate, readily accessible private health care providers. Even with such contracting arrangements, however, one fundamental problem would remain: most private sector clinicians have even ***less*** understanding of the special needs and circumstances involved in treating veterans than do VA or DoD clinicians. What DoD, VA, and the Congress must come to recognize is that if our country wants to ensure that it has an adequate pool of health care providers trained in ***veterans health problems***, it must create the medical education infrastructure to recruit and train such providers ***now***.

Additionally, we are extremely concerned about the impact of the current Guard and Reserve mobilization will have on the VA. How many VA doctors, nurses, and support personnel are also in the Guard and Reserve? Who will backfill those who've been called up? In the Washington metro area alone, VVA has already heard of cases where mobilized VA personnel have been pulling double shifts—one at the VA, the other at their mobilization center/station. Tired medical professionals can make deadly mistakes in high-stress situations. How many potential additional casualties will we create by overworking and under-strength VA medical staff? The committee must have answers to these questions immediately, and corrective action must swiftly follow.

Another major area of concern for VVA is the VA's ability to deal with some of the more serious diseases that are endemic to Afghanistan, particularly Crimean Congo hemorrhagic fever (CCHF), which is fatal is roughly 35% of cases. As the disease is tick-borne, troops bivouacked in the field will be most vulnerable to infection; hospital workers are also at considerable risk. Obviously, next to a direct biological warfare attack, CCHF represents the most serious health threat for U.S. troops deploying to the region.

Moreover, less life-threatening but still serious endemic disease threats will also confront American forces in this theater of operations. Specifically, we are concerned about "sandfly fever," which can cause severe flu like symptoms that can last for up to a week. Last week, the *Washington Post* reported on the results of a 1996 study in which U.S. and Pakistani physicians measured the antibody response to various diseases in three different groups of Pakistani military personnel. The researchers found that 27%-70% of the study subjects had antibodies to sandfly fever virus, strongly suggesting that American military personnel face a serious medical hazard from this endemic disease.

How many VA physicians have experience in dealing with CCHF or sandfly fever? It bears mentioning that initially, DoD and VA health screeners missed the presence of *leishmania tropica* among a small group of Desert Storm veterans. Serious questions remain about the adequacy of VA's screening and treatment efforts for these kind of diseases. This committee should demand that both DoD and VA show what measures they have in place to deal with these extremely serious health threats, and especially to track infected personnel in a longitudinal study to determine the long-term health risks of such exposures.

Significantly more money is needed in veterans health care beginning now, and not next year after further layoffs and hiring freezes have even further diminished the capacity of VHA, and hence the capacity of the VA to fulfill the vital mission of contributing to the national security of the United States.

It is critical that the VA and the Congress recognize that this new war we face will affect not only veterans but their family members as well. How well equipped is the VA to provide counseling and other services to family members affected by this crisis? Given the state of the VA as we have outlined it above, we are fairly certain that aid to spouses or survivors is relatively low on VA's list of priorities.

Another factor this committee must consider is how well the VA is prepared to help deal with a civilian mass casualty scenario like the one that occurred in New York City. How quickly would VA medical establishments be able to provide trauma or other emergency support to local hospitals in major cities should those hospitals be overrun with civilian casualties? We suspect the answer would not be reassuring, particularly since the total number of inpatient VA beds has declined from 53,000 in FY 95to only 22,000 in FY 2000 (the last year for which figures are available).

Finally, the committee must review the VA's physical security measures and the integrity of its employee identification process. How easy is it for unauthorized persons to obtain official VA credentials? How easy is it for unauthorized persons to gain access to the uniforms and equipment used by VA contractors, and thus gain access to VA facilities? These questions need immediate answers.

VVA and this committee share a common goal: ensuring that all veterans have access to quality health care services. Unfortunately, years of neglect and inadequate resources have left the VA incapable of meeting its current obligations to existing veterans, much less the capacity to deal with significant numbers of ENDURING FREEDOM veterans. We applaud Secretary Principi and this committee for their efforts to secure additional resources for the VA. We would respectfully suggest, however, that the VA must move immediately to comply with PL 104-262 by seeking sufficient resources from the Congress to restore and maintain capacity within the VA health care system. The VA's top organizational priority must be a recentralization of the specialized services, followed by the implementation of stringent accountability measures for senior managers within the VHA. Just as Secretary Principi acted decisively in dealing with the recent fraud scandal within the VBA, so too must he act decisively to restore the VHA's capacity to treat both current and future veterans.

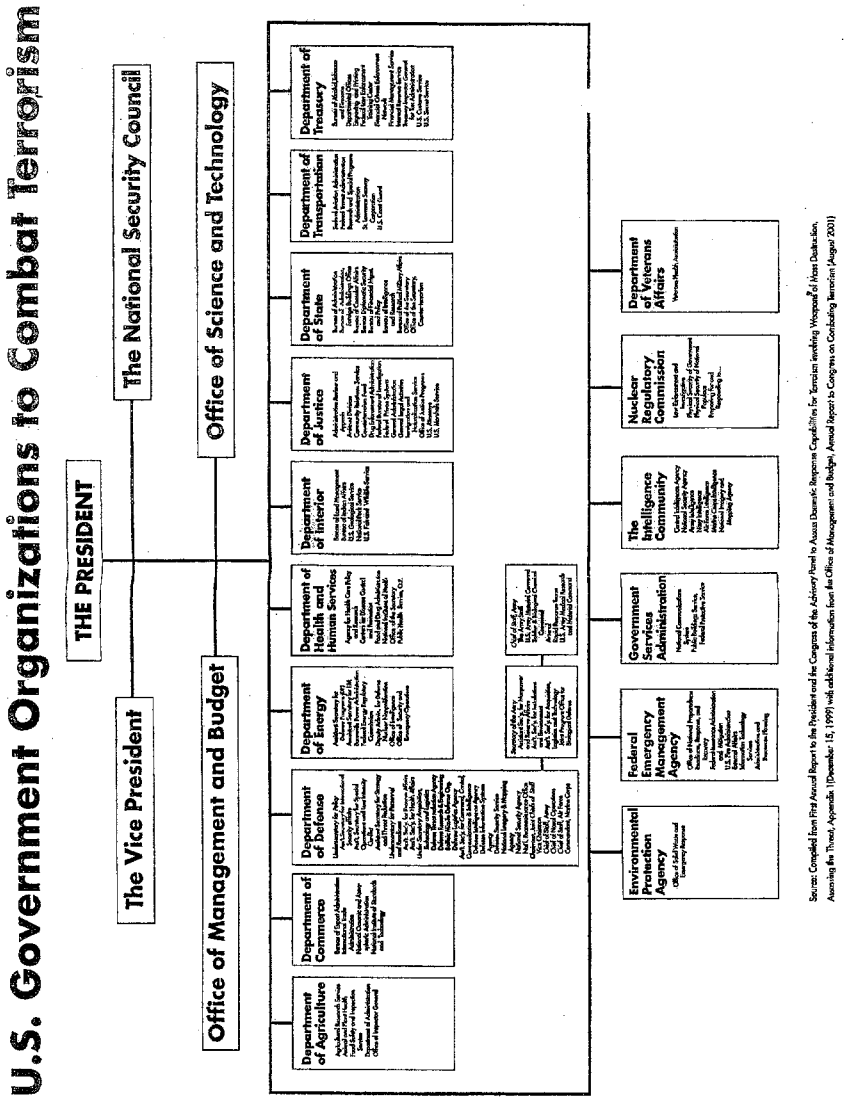
Vietnam Veterans of America sincerely appreciates the opportunity to present our views on these extremely important issues, and we look forward to working with you, Mr. Chairman, and your distinguished colleagues on this Committee to address and resolve these and other important matters of concern to our nation's veterans.

occurred on September 11th, local resources could be overwhelmed and the federal government may be required to provide protective and responsive measures for the affected populations.

Office of Emergency Preparedness Role in Federal Response

Within my Department, the Office of Emergency Preparedness is the primary agency responding to requests for assistance and resources. OEP's main function is to manage the National Disaster Medical System (NDMS) as well as the Public Health Service Commissioned Corps Readiness Force, which could be called into action depending upon the severity of the event. One of OEP's missions is to manage and coordinate, on behalf of HHS, the federal health, medical, and health related social service response and recovery to major emergencies, federally declared disasters and terrorist acts. OEP directs and manages Emergency Support Function #8 (health and medical services) of the Federal Response Plan. This includes coordinating the activities of 12 other federal departments nationwide, including the Departments of Veterans Affairs, Defense, Transportation, Energy, and Agriculture, the Environmental Protection Agency, and others.

When there is a disaster, FEMA, as the Nation's consequence management and response coordinator, tasks HHS to provide critical services, such as health and medical care; preventive health services; mental health care; veterinary services; mortuary activities; and any other public health or medical service that may be needed in the affected area. OEP, as the Secretary's action agent, will direct NDMS, the Public Health Service's Commissioned Corps Readiness Force, and



Source: Compiled from First Annual Report to the President and the Congress of the Advisory Panel to Assess Domestic Response Capabilities for Terrorism involving Weapons of Mass Destruction, Assessing the Threat, Appendix II (December 15, 1999) with additional information from the Office of Management and Budget, Annual Report to Congress on Combating Terrorism (August 2001)

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN SMITH TO DR. CHU, UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS)

Question: I do have one final question I would like to pose to Dr. Chu. After the attacks in New York, thousands of National Guardsmen were activated by the governor, as you well know. The VA agreed to provide health care to all of those troops even though they had not been federalized. Should this arrangement be made formal and authorized in advance? Do we need to go back to the drawing board on that?

Answer: In my testimony, I emphasized the great success of both our systems in responding to the horrible events of September 11, 2001. In my view, there is ample legislative authority for each of our health care systems to tailor the delivery of care to meet the unique medical needs of such events. We are required by law to conduct a joint annual review of our contingency plans and update them, as necessary. These periodic reassessments enable us to apply any lessons learned from situations, such as last September's, to our future planning and modify our operational relationships where appropriate.