



Testimony

of

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Before the

Subcommittee on Emergency Preparedness, Committee on Homeland Security

U. S. House of Representatives

On

**Taking Measure of Countermeasures (Part 2)
A Review of Efforts to Protect the Homeland Through Distribution
and Dispensing of Medical Countermeasures**

**Thursday, May 12, 2011, 1:00 pm
311 Cannon House Office Building
Washington, D.C.**

Good afternoon Chairman Bilirakis, Ranking Member Richardson, and Members of the Subcommittee. Thank you for inviting me here today to testify on New York City's efforts to prepare for the rapid distribution and dispensing of medical countermeasures in the event of a public health emergency. My name is David Starr and I serve as the Director of Countermeasures Response in the Office of Emergency Preparedness and Response at the NYC Department of Health and Mental Hygiene. I have been privileged to be involved in NYC's emergency medical countermeasure planning for more than five years. I currently supervise operational planning for the receipt and distribution of Strategic National Stockpile (SNS) assets and the opening of emergency dispensing sites citywide, development of emergency staffing plans to support such an operation – including the expansion of New York City's Medical Reserve Corps (MRC) – and special projects to supplement current dispensing plans. Our goals remain consistent: to maximize the speed and efficacy of distribution and dispensing operations and to increase access to countermeasures by the general public.

Over the last decade, New York City has worked hard to develop robust plans for the receipt of SNS assets and their further distribution and dispensing to the public. Currently, two receiving warehouses stand ready to receive and distribute SNS assets within hours of notification. We are linked to the two sites with a state-of-the-art warehouse management system, enabling us to both monitor and direct warehouse operations remotely. We have identified close to 200 facilities citywide that could be used as "Points of Dispensing" or PODs – temporary dispensing sites set up at the time of an emergency. Each POD is designed to dispense oral medications to approximately 40,000 people in less than 48 hours. Setting up and running these PODs would present enormous logistical challenges.

We are working hard to overcome the challenges. In New York City, each POD is operated with pre-trained leadership teams of 6 and about 90 additional staff who receive "Just-in-Time" training. If NYC were to open all PODs for a citywide emergency dispensing operation, we would need approximately 1,200 leadership staff and 20,000 general staff for the first shift. To support the leadership staffing needs of such an operation, we have trained over 1,500 City employees as potential POD leadership team members. We continue to build that number by identifying and training additional staff. For general staff, NYC plans include accessing the city's substantial workforce of nearly 300,000 individuals, and engaging volunteers from various organizations to respond. The New York City Medical Reserve Corps is another source of staff for PODs, and consists of more than 9,000 pre-credentialed and pre-registered health care professionals who have volunteered their services during emergencies.

We have also developed our capacity to provide critical supplies and medication to hospitals and primary care centers after the initial 72 hours, and we have reviewed plans for these healthcare facilities to dispense medication to their staff and patients. We maintain a local cache of medications for our first responders, whose agencies maintain internal plans for dispensing these medications to their own employees.

Admittedly, these plans and protocols are merely words and ideas until implemented in exercises and real-life responses. The response to the H1N1 influenza outbreak in 2009 allowed us to put into practice many of our plans and protocols. Within days of its emergence in a Queens high school, New York City received antiviral medications and respirators from the SNS. Our ability to mobilize quickly was proven when the SNS notified our staff of inbound assets at approximately 1:00 a.m. on Monday, April 27th and our receiving warehouse was ready as the first trucks arrived around 5:00 a.m. As the response in the fall unfolded, our operational capacity was further tested. New York City planned an ambitious school-based vaccination program, as well as the largest POD operation in recent history. Our warehouse quickly set up a parallel vaccine distribution operation, expanding their refrigerated vaccine processing area, purchasing additional vaccine supplies and training select staff on vaccine handling. New York City then directed the receipt, repackaging, and delivery of more than 1,800 orders of vaccine and supplies to schools – at the peak, making 90 deliveries per day, including 15 priority deliveries before 9:00 am. Through this emergency school-based vaccination program, we provided an estimated 202,000 flu vaccinations to children across the City.

In addition, New York City mobilized several thousand city employees and Medical Reserve Core volunteers for POD operations in 29 sites over five weekends. The vast majority of these employees were trained “Just in Time” per our current protocols. We vaccinated close to 50,000 New Yorkers in these PODs, and in one site on the Upper East Side, almost 6,000 people were vaccinated within two days. The response from the public at this site – even from those who waited an hour in a cold rain – was overwhelmingly positive. However, even the valuable H1N1 experience did not reach the threshold we set for ourselves for a citywide dispensing effort.

These operations allowed us to test our distribution and dispensing site selection, staffing, command and control and training protocols and a substantial number of changes to existing plans resulted from this experience. We have altered our process for selecting POD sites to assure selected sites are most suitable to support the operation and we made selection criteria more stringent. In addition, we have conducted population-density analysis to achieve optimal coverage among our selected sites. We have revamped our training program and are conducting drills to test these new protocols. We know that we must not stop with these accomplishments. Opening 200 temporary sites across an urban area the size, density and diversity of New York City is fraught with obstacles, and while we attempt to identify and mitigate these obstacles, we are constantly seeking innovative solutions to maximize dispensing speed and increase access to needed countermeasures.

The greatest danger to our efforts is complacency; the hard work doesn't end. The federal government has worked to define target capabilities and benchmarks relative to countermeasure distribution and dispensing, and we meet and exceed those that have been defined. However, in the absence of a real-life catastrophic incident, the operational success of our plans is extremely difficult to predict. We don't have a textbook we can open, or a workbook or checklist to complete that tells us if we are truly prepared or not. Preparedness is not a binary concept, you are not either prepared or not prepared, it's a continuum that must be nurtured with constant attention, creativity, and predictable

financial support. However, I can say with assuredness that in the arena of countermeasure distribution and dispensing, we are far more prepared than we were a decade ago, or even three years ago. Maintaining these achievements and continuing our progress requires constant vigilance.

When terrorism, or H5N1, or H1N1 is in the news, federal resources increase. However, once the threat dims, interest and resources dwindle as well. After 9/11, everyone was a New Yorker, and there was no debate about the increased threat faced by New Yorkers and other urban areas. In 2004, Cities Readiness Initiative (CRI) funding in the Public Health Emergency Preparedness grant was provided to prepare major US cities and metropolitan areas to effectively respond to a large scale bioterrorist event by building capacity to dispense antibiotics to their entire identified population within 48 hours.

New York City initially received \$5.1million in 2004 as one of 21 cities in the country considered at highest risk. In the following years, the number of CRI cities increased to 72. The Cities Readiness Initiative became everybody's readiness initiative, but without additional resources, many of the highest risk cities saw a decrease in support. In 2008, New York City's CRI grant was cut by 25%, and has remained at that level since.

New York City has also experienced decreases in overall Public Health Emergency Preparedness (PHEP) grant funding as well – approximately 26% since 2002; the Administration's budget for FY 2012 proposes another cut in funding for PHEP State and Local Capacity. While the Center for Disease Control has developed a pilot risk-based funding pool for FY 2011, this additional funding for New York City is – in current proposals – partly offset by a 4% cut in our basic grant. Furthermore, we have been informed that current proposals are not final, and levels are expected to decrease even more. In regard to the new risk-based funding, on a per capita basis, New York City, despite its obvious high risk, ranks 13th out the 18 jurisdictions to be awarded risk funding. Although we have long supported risk-based funding, we are also concerned that the uncertainty of continuation of this funding stream and the large cut in program funding would leave us with a much larger overall funding gap in FY 2012 and beyond.

Stable federal funding is absolutely necessary for state and local responders to increase and maintain levels of preparedness. As we undertake new initiatives and maintain our state of readiness, there is a cost. We pay contingency fees to various private partners to build operational capacity and integrate response planning. We pay to identify, survey and map POD sites. We pay for modeling and other scientific analyses to improve our plan elements. We pay for transportation redundancy to deliver countermeasures to our citizens. We pay to maintain a robust warehouse management system, and for climate monitoring systems that operate in all sites where we store pharmaceuticals. We pay for the annual training of POD leadership staff. We continually strive to identify gaps, holes, and weaknesses in our plans and often pay to fill, patch, and reinforce them. Most of all, we pay for essential staff, including the highly dedicated individuals in public health that help to build and maintain our preparedness. Simply put, if preparedness funds continue to decline, our City's ability to sustain its preparedness infrastructure will be jeopardized.

There are also many operational issues that need additional attention – as we have communicated to the various federal agencies we depend on for guidance and support. We continue to push for the pre-positioning of a limited quantity of federal countermeasures in local warehouses to speed the opening of the first PODs to the public. We have advocated for the relaxation of the terms of the Emergency Use Authorization that the FDA will require for the legal dispensing of countermeasures in an emergency. And while our plans center primarily on the rapid dispensing of oral medications, we are moving forward with planning for the dispensing of the additional days of antibiotics needed by an exposed population following a widespread anthrax attack, as well as the administration of the three-dose course of anthrax vaccine as recommended by the CDC. There is great need for more guidance in regard to these matters, and we continue to push for clarity.

The structure of our funding is also confusing and sometimes encourages duplication of effort. We continue to use, to the best of our ability, funds from many different sources including the PHEP grant from CDC, the hospital preparedness grant from the office of Assistant Secretary for Preparedness and Response/HHS and the UASI grant from Department of Homeland Security-. However, each of these funding streams has unique characteristics and requirements. We understand that a perfect synergy may not be possible, but some effort to align requirements, timelines and deliverables could significantly reduce the administrative burden that draws resources from efforts to improve public health preparedness.

Fortunately, we benefit from having federal partners that are willing to listen, and there has been marked improvement over the years. We've seen our federal partners consider options to speed the initial delivery of countermeasures to our warehouses, and a willingness to entertain different models of Emergency Use Authorizations that would help states and local jurisdictions dispense countermeasures legally in the first hours of an emergency.

We are also grateful for the continued interest of Congress and the work of Chairman King and this Committee. Thank you for your support of our efforts to protect our citizens, and for the opportunity to comment today.

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