

**Summary of Remarks by  
Rear Admiral Craig Vanderwagen  
Assistant Secretary for Preparedness and Response  
Pandemic All-Hazards Preparedness Act  
Stakeholders Meeting  
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Most everybody in this room had some influence on how PAHPA developed, and it's right that we talk about it now. How will we make this work to benefit the American people?" Because all of us are committed to the mission of a nation prepared to prevent, respond to and recover from the public health and medical effects of disasters, whether they're natural or manmade. When you look at our strategic plan, you'll see that foursquare, front and center, that's what we're about, and I think that's what this group is really about.

How to empower communities, where they could manage the system to the best effect, is vitally important because in public health, we believe that the community-level direction is the best in dealing with public health and medical issues. Because who knows the behavior, the culture, the desire, the priorities of the community better than the people who actually live in that community.

First let me brag a little bit about some of the stuff that we've done in the last 10 months, and at the end of this, I'm going to say, "But there's much more to be done, and we need you to tell us how to take those next set of steps together with you." We are 10 months old.

We're committed to mitigating the public health, medical and human services effects of disasters. We believe that we must deliver value to those we serve, principally individuals, families and communities. Our Governmental partners are important clients as well, but we all must be able to carry out the critical mission of delivering services for individuals, families and communities. That's *who* we're here to serve.

To fulfill this commitment, we must:

- Empower leadership at the community level; promote strategic partnerships across multiple jurisdictions at multiple levels, and across both the public and private sector. What an opportunity.
- Educate public health and healthcare professionals and scientists to ensure that they have the knowledge, the skills and the training to perform their roles effectively, and we have many partners in this room, whether it's the schools of veterinary medicine, whether it's the schools of public health who work on those very issues.
- Empower the public and foster a culture of resiliency that's built on acceptance of responsibility at all levels. One of the best things that happened in Louisiana was once we got the parking lot dried off at the University Hospital in New Orleans, and we were able to stand up a tent hospital so that the docs and the nurses and the hospital staff could actually provide care for their own people, *that's* when we began to turn a corner in terms of that community feeling that they could deal with the challenge, that they could stand back up and be empowered and be resilient and survive this. That's our goal.
- Enhance preparedness and response infrastructure so that it's scalable, it's agile, it's adaptable, but built on a foundation of continuous improvement. For those of us in the medical world, we deal with that obligation every day. If I'm not willing to accept that I can improve, I'm not serving my patients well. And we do that in the public health

world, and in the response and preparedness world, we have to bring that same evidence-based willingness to challenge ourselves for improvement on a daily basis.

The Act has really broad implications for Health and Human Services Preparedness and Response. It reauthorized our preparedness activities, but it also made a number of significant changes that established our office and required us to do new things, including:

- Transfer the Emergency System for Advanced Registration of Volunteer Health Professionals, the National Disaster Medical System, and the Hospital Preparedness Program from the Department of Homeland Security to HHS.
- Establish the Biomedical Advanced Research and Development Authority. BARDA had a narrower role because under BioShield, we were only in the acquisition business, and it's a real challenge to get people across the Valley of Death. BARDA gave us new authorities to engage in advanced development to help bring those countermeasures from the research world into a more prepared product that could achieve licensure to demonstrate safety and efficacy. The jump from science to a licensable product that we can actually use, only about five percent of those products really make it.
- Develop a National Strategy for Health Security. Every four years, we will assess what the demands are, what our assets are, and where we're going to go collectively so that we have a sense of here's where we're trying to get to, here's what we're trying to achieve. Our colleagues at CDC have exerted great leadership in health promotion and disease prevention. Is that part of a National Health Security Strategy? How do we bring that into the picture and assure that whatever we do in health security meshes up effectively with the leadership that already exists, that many of you work on day in and day out in terms of chronic disease mitigation, in terms of trying to promote the health and well-being of our population. Or in the strategy are we simply talking about such things as medical countermeasures and delivery platforms for those countermeasures at the community level?
- Conduct a joint HHS, Homeland Security, DOD and VA review of NDMS. One phase is already completed, and evaluation of our medical surge capacity is underway.
- Appoint a director for at-risk individuals. One of the things we learned in Katrina was that there were many at-risk populations that had not been fully identified and plans pre-scripted ahead of time as to how we're going to manage them, but you know what? In 2006, for the full 107 nursing homes below I-10, between Mississippi and Texas, we knew for every patient in those 107 nursing homes how they were going to get evacuated – there was a seat in an identified vehicle to get them out of there, and where they were going to go. We didn't have that in 2005. That at-risk population needs to have special focus, and we've identified an individual to deal with that set of issues and coordinate them.
- Improve the readiness of the Commissioned Corps. We now have five RDF, rapid deployment force, teams, made up of 130 to 150 or so individuals, we can deploy. They're trained and they're ready to go.
- Establish a near real-time nationwide electronic situational awareness capability. We've now put money out, talked to the poison control centers to bring their databases, which are significant, into the mix, and add to our understanding of what's going on. There are best practices and models that exist in the states that we need to document and disseminate that show how to bring together emergency room data, public health department information, information from poison control centers and other sources into a coherent understanding of what the situation looks like.
- Build and maintain a civilian Medical Reserve Corps.

- Develop a curriculum and training program for public health medical response.

Let me quickly recount a few things. We've stood up at ASPR. We have not only an organizational chart, the requisite bureaucratic boxology, but you will see that our strategic plan, built around a Balanced Scorecard, focuses on our stakeholders, focuses on how we will learn and grow, how we will align our resources with the goals. That plan is in place, and we're tracking our activity against that plan.

BARDA has stood up. We transferred NDMS. ESAR-VHP, the Hospital Preparedness Program. We completed a joint review of NDMS, at least the first phase of it. We expanded the Medical Reserve Corps. It now includes 705 units for 140,000 volunteers.

We developed active-duty and regular corps and active reserve corps readiness policies.

In the area of countermeasures, we made major strides this year, in addition to standing up BARDA – a draft BARDA strategic plan and an implementation plan were issued, and we're very close to getting a BARDA director.

ASPR has embarked on a Public Health Emergency Medical Countermeasures Enterprise, an important phenomenon. It brings together the senior leadership of the Department that have responsibility for various elements in the development and delivery of countermeasures. NIH conducts a great deal of research. How do we focus that research and target it against identified threats? FDA has a role in working with our industry partners to assure that we have high-quality, effective, safe and licensable countermeasures. CDC has the large responsibility for stockpiling and delivering those countermeasures to communities in times of need. And, of course, you at the State and county level have the really heavy lift of assuring that there are delivery platforms at the community level that will get those countermeasures to the people. We formed a board that's composed of the Director of NIH, the Director of CDC, the Director of FDA, myself, Homeland Security and DOD to assure that we think through the various investments that we make in countermeasures, that we have delivery platforms, that we aren't buying a countermeasure we can't get to the people. It is a way for us to focus on these requirements, and to assure that we're making the best commitments and investments we possibly can to support you at the community level with countermeasures that are safe, effective and targeted to the threats that you're potentially going to have to face.

We've had two BARDA stakeholder meetings, reaching out to industry. We had an industry day so that folks could show us some of their innovations and their developments. The National Biodefense Science Board activities are underway, and the first meeting is December 17th and 18th here in DC. There are significant issues where their expertise will be useful to us in formulating appropriate policy and direction.

These efforts have yielded concrete results, and we need to help the policymakers here in Washington understand the concrete results that you all are implementing and making happen at the ground level.

- In North Carolina – 87 pandemic exercises last year in North Carolina alone. They have 85 counties and 84 of them played. So that takes care of a big chunk of it, but the point is, they are taking it seriously and they're implementing it, like many of you are.
- Eighty-five percent of the awardees have used seasonal vaccine clinics to exercise mass prophylaxis plans. Last weekend, my middle son participated in a drive-by immunization program in Howard County, up the road here, one of the suburban Washington counties employing it as a means to test-drive how they're going to deal with mass immunization.

- Eighty-three percent of awardees participated in tabletop exercises of non-pharmaceutical interventions to contain pan-flu.
- Ninety-seven percent of awardees have submitted pandemic influenza ops plans. They're in development. They're in action.

But we have much work yet to do. I'm done bragging. Let's talk about what lies ahead.

What are we going to do with our schools? How do we take care of the school feeding programs if we're going to close down the schools? What do we do with those teachers? How do we keep kids engaged? These are real challenges and people have been working on those issues.

We need your participation in ESF-8, Emergency Support Function 8. Public health and medical services – we need to develop some more effective common concept of operations so that we know how we will interact, so that you understand what we can bring, and we understand what you have, and we can synchronize those things in times of need without a lot of posturing, maneuvering and failing.

We're planning on putting out for dialogue with our State and city colleagues at least a couple of our playbooks, our Concept of Operations – what trigger points we think are critical and important to think about, where our Federal colleagues from DOD, from the VA and others are willing to bring things. When that trigger goes off, they're going to bring this; we're going to bring that, and so on. We need to talk through those things together and understand what those assets look like, and understand what our limitations are going to be.

In addition, the development of the National Health Security Strategy is just beginning. We really have not moved on that because we believe that we must have you right there at the front-end to begin that process. What should the scope of that strategy look like? How can we make it manageable? If we take on everything under the sun, we're setting ourselves up for unreal expectations. That will compromise our resiliency because if we set up expectations and we can't meet them, then the community's sense of resiliency will be undermined. So we have to think this through together. You need to help us understand what's rational, what's real and how we can set the scope in an appropriate manner that we can achieve a measure of success. By achieving a measure of success, the belief that we have in ourselves and that our communities have in us will rise, and that will help in our resilience challenge. What should we include, what not to include in 2009? What should we leave for the next one? How can we best collaborate? I mean what are the processes that we need to put together to make this work?

Grants are clearly an area where we need your input. The consistency of performance measures is a critical and important value. But, can we define what preparedness looks like collectively in a way that allows us to move forward. It's sort of like “I know it when I see it” kind of thing, but how do we define it and then measure it, so that we can point out again, pointing back to our communities, the families, the individuals, “Here's what preparedness looks like, and we're achieving it.” And by achieving it, we're stronger.

Defining expenditures for public health preparedness, the Act requires that we talk about the maintenance of state-level funding. What does that mean? What do we count in that “maintenance of funding”? What is appropriate to count as matching? Now there are other templates and other grant programs, but are those the best templates for us to talk about in this particular set of grants. So there's much to talk about in that area.

Situational awareness is clearly an area where we all want to do better. A lot of great work has been done in some states. In 2006, Nebraska had six statewide exercises. What's their data system for capture? I'm not really sure. I know they're out there working. In North Carolina,

they've got hospital emergency room data merged with Public Health Department data merged with Poison Control Center data, so that Leah and Steve can look at and mark trends in a fairly comprehensive way. New Jersey has done a great job. They can tell you where the ambulances in that state are, if they're in motion, how fast they're moving and in what direction. Now that is concise understanding of where your assets are being deployed and how they're being deployed. That's a different kind of situational awareness. How do we bring those things together in a comprehensive package, looking at some of the best practices that you all in the states and in the communities have developed, and agree to that as a best practice? The literature support really isn't there in this arena like I'm used to in the medical arena. So we have to articulate that, lay out the evidence for some of those best practices and agree we're going to live with those best practices.

These and other issues really are the focus for the breakout sessions later this morning and this afternoon. You all have ideas. We want to hear those ideas. That's what consultation is about. It's the respect that you have ownership of this and meaningful ideas that we need to account for in the way we do our business. We want you to share constructive criticism. You heard me say that quality improvement, the buzz words that many of us in management have heard for years, quality improvement is a basic value for us, and if we don't hear constructive criticism, we're not going to improve. So we welcome it. We don't shy away from it. We won't duck. We won't walk away.

So we need to understand each other, we need to have our plans aligned to the degree that we can, but recognize that change is reality for all of us who work in this world. The consistency here is the mission. We are here to serve the people and to see a nation prepared to prevent, respond to and recover from the public health and medical effects of disasters, natural or manmade. That is the consistent piece that we all need to buy.