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EBOLA IN THE HOMELAND: THE IMPORTANCE OF EFFECTIVE INTERNATIONAL, FEDERAL, STATE AND LOCAL COORDINATION

U.S. HOUSE OF REPRESENTATIVES, COMMITTEE ON HOMELAND SECURITY

ONE HUNDRED THIRTEENTH CONGRESS, SECOND SESSION

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Committee on
HOMELAND SECURITY
Chairman Michael McCaul

Opening Statement

October 10, 2014

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**Statement of Chairman Michael McCaul (R-Texas)
Committee on Homeland Security**

**“Ebola in the Homeland: The Importance of Effective International, Federal, State and Local
Coordination”**

Remarks as Prepared

We are here today to discuss the threat to the U.S. homeland from the Ebola virus and what is being done to stop the spread of this terrible disease. The crisis is unfolding at an alarming pace. Thousands have died in Africa and thousands more have been infected, including four selfless Americans working in Liberia who have been flown home for treatment. Now the virus has begun to spread to other parts of the world, and the American people are rightfully concerned. They are concerned because the Ebola virus is an unseen threat, and it is only a plane-flight away from our shores. We’ve witnessed that with the recent case here in Dallas—the first fatality from Ebola in the United States.

But we must be sure to confront this crisis with the facts. Blind panic won’t help us stop this disease from spreading, and fear-mongering will only make it harder to do so. That is why we are here today: to ask the American people’s questions and get answers from our experts. Americans are seeking assurance that our federal, state, and local officials are doing everything in their power to keep this virus out of the United States.

Already, there has been a vigorous international, federal, state, and local response. We hope to hear more today about exactly what has been done—and what needs to be done going forward. Two weeks ago, Thomas Eric Duncan traveled here from Liberia by way of the Brussels and Dulles airports, fell ill, and presented himself for treatment at Texas Health Presbyterian Hospital here in Dallas. Mr. Duncan’s diagnosis set in motion an extensive public health operation involving federal, state, and local officials to identify and assess any individuals with whom he may have had contact, a process called “contact-tracing.”

That contact-tracing effort continues today, and our prayers are with everyone who is currently being monitored as part of this incident. We are thankful that, to date, there have been no additional cases of Ebola stemming from this case. Contact-tracing is time consuming and difficult, but it is one of the few ways to contain the disease. Containment also requires swift, coordinated action. In this Committee’s hearings and investigation on the Boston Marathon bombings, we heard testimony about the importance of the “incident command system.”

The system is a vital tool for making sure first-responders at all levels engage quickly and decisively, rather than argue over who is in charge. The importance of such a response mechanism was highlighted in the 9/11 Commission report, and it has since saved countless lives. I was encouraged to learn officials here in Texas instituted this structure. Today, state and federal officials are co-located in the Dallas County Emergency Operations Center, enabling vital information sharing and coordination.

To be clear, the situation here at home is far different than what is happening in West Africa. We have a strong public health infrastructure in place, particularly here in Texas, which enables us to work to contain this virus more effectively. But Dallas is not the only area that must remain vigilant. We need to ensure that state and local responders nationwide are prepared to move quickly if the virus is detected anywhere else within our borders. Hospitals are recognizing this and have made nearly 190 inquiries with the CDC about cases they believed could be Ebola. Thankfully, testing was only warranted in about 24 of those cases, and only one case was confirmed as Ebola.

Public health and medical personnel must remain vigilant, ensure all hospital personnel are informed, follow protocols to identify this virus, and take appropriate quarantine measures. We must reinforce the importance of taking travel histories and sharing that information with all relevant personnel. Protecting the homeland from the Ebola virus also requires us to put measures in place out our airports. I am pleased the President announced earlier this week additional entry screening efforts are being launched. Beginning tomorrow, enhanced screening measures will be activated at JFK airport and soon after at Dulles, O'Hare, Newark, and Atlanta. These airports receive more than 94% of all travelers from Liberia, Sierra Leone, and Guinea. I look forward to hearing more about these enhanced screening efforts from our witnesses. The Department of Homeland Security has been actively involved in the response, and I commend Secretary Jeh Johnson for his leadership in bringing federal resources to the fight.

We must also closely monitor the situation overseas and continue our global response efforts. I have spoken with the President's Homeland Security Advisor Lisa Monaco numerous times to ensure our government is doing all that is necessary. We recently discussed exit screening procedures that have been put in place in Liberia, Sierra Leone, and Guinea by CDC-trained personnel. In the past two months, this screening has stopped 77 travelers with Ebola-like symptoms or contact history from boarding planes, out of a total of 36,000 individuals screened. None of those 77, that we are aware of, has been diagnosed with Ebola. While there have been many positive aspects of this response, there have also been missteps.

For instance, here in Dallas Mr. Duncan's travel history was not communicated to all relevant medical personnel when he first sought treatment, which led to his release from the hospital and the potential that additional people were exposed to the virus. There were also problems removing hazardous biomedical waste from the apartment where Mr. Duncan's family was quarantined. The soiled materials remained in the home with the quarantined individuals for days after the Ebola diagnosis was confirmed.

We must learn from these missteps, and ensure the proper procedures are established and followed should another case arise in the United States. Going forward, we must consider all policy options for stopping the spread of this horrific disease. I have heard many ideas directly from my fellow Texans—everything from stopping inbound flights from specific countries to additional screenings at home and abroad. We hope our witnesses will discuss options that are being considered and the tradeoffs we may have to confront.

We also have to ensure unnecessary government red tape does not slow down the response. I urge the Senate to follow the lead of the House and approve the Pentagon's request to transfer additional resources to the fight. The Defense Department is seeking to move \$750 million toward response efforts, and we should move swiftly to satisfy that request.

Now is not the time for politics. Congress has been loathe to get much done this session, and if there has ever been a time to come together and put pettiness aside, it is now. We must get this right and make sure that federal protocols are put in place and communicated to our local and state leaders when a situation this critical occurs.

My hope today is we won't focus on gotcha politics, instead hearing from our panels and focusing on a solutions based hearing. We are in the same boat. And we need to work hard to make sure that our Nation is protected from this threat. I want to thank the Ranking Member for being here in my home state of Texas in a show of support for this shared goal.

Before we begin, I also want to commend the first responders, medical personnel, and public health officials who have responded courageously to the case here in Dallas. Most importantly, our thoughts and prayers are with the victims and families affected by this crisis. I look forward to hearing from our distinguished panel of witnesses today on the recent response efforts and what more can be done to keep America safe.

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House Committee on Homeland Security

Ebola and the Homeland: The Importance of Effective International, Federal, State and Local
Coordination

October 10, 2014

Statement of Toby Merlin

Director, Division of Preparedness and Emerging Infections, National Center for Emerging and
Zoonotic Infectious Diseases, Centers for Disease Control and Prevention

Good afternoon Chairman McCaul, members of the Committee, and members of the Texas Delegation. Thank you for the opportunity to testify before you today and for your ongoing support for the Centers for Disease Control and Prevention's (CDC) work in global health. I am Dr. Toby Merlin, Director of CDC's Division of Preparedness and Emerging Infections. I appreciate the opportunity to be here today to discuss the epidemic of Ebola in West Africa, as well as the work the CDC is doing to manage the global consequences of this epidemic in the wake of the first diagnosed case here in the United States two weeks ago, which ultimately and tragically, has become the first death from Ebola in the United States.

From the time the situation in West Africa escalated from an outbreak to an epidemic, we have anticipated that a traveler could arrive in the United States with the disease. We have been preparing for this possibility by working closely with our state and local partners and with clinicians and health care facilities so that any imported case could be quickly contained. This occurrence underscores the need to carefully follow the protocols that have been developed, to work closely across levels of government, and to continue our urgent effort to address the epidemic in West Africa, which remains the biggest risk to the United States.

As we work to learn from the recent case in Dallas and continue the public health response there, we remain confident that Ebola is not a significant public health threat to the United States. It is not transmitted easily, and it does not spread from people who are not ill, and cultural norms that contribute to the spread of the disease in Africa – such as burial customs – are not a factor in the United States. We know how to stop Ebola with strict infection control practices which are already in widespread use in American hospitals, and the United States is leading the international effort to stop it at the source in Africa. CDC is committing significant resources both on the ground in West Africa and through our Emergency Operations Center here at home.

We have been constantly monitoring our response in the United States, and will continue to do so. The CDC and the U.S. Customs & Border Protection (CBP) in the Department of Homeland Security (DHS) announced this week that we will begin new layers of entry screening at five U.S. airports that receive over 94 percent of travelers from the Ebola-affected nations of Guinea, Liberia, and Sierra Leone. New York's JFK International Airport will begin the new screening October 11. In the 12 months ending July 2014, JFK received nearly half of all travelers from those three West African nations. The enhanced entry screening will also be implemented at Washington-Dulles, Newark, Chicago-O'Hare, and Atlanta international airports.

This is a whole of Government response, with agencies across the United States Government committing human and financial resources. Across HHS, CDC is actively partnering with the Office of Global Affairs, the Office of the Assistant Secretary for Preparedness and Response, the National Institutes of Health, and the Food and Drug Administration to coordinate and respond to this epidemic. Also, CDC has embedded technical staff in the USAID-led DART team in West Africa. Additionally, staff, logistical support, and resources from the Department of Defense (DoD) are already being deployed to rapidly scale up our efforts to include constructing Ebola treatment units and training health

care workers. We are working closely with our international partners to scale up the response to the levels needed to stop this epidemic.

Ebola is a severe, often fatal, viral hemorrhagic fever. The first Ebola virus was detected in 1976 in what is now the Democratic Republic of Congo. Since then, outbreaks have appeared sporadically. The current epidemic in Guinea, Liberia, and Sierra Leone is the first time an outbreak has been recognized in West Africa, the first ever Ebola epidemic, and the biggest and most complex Ebola challenge the world has ever faced. We have seen cases imported into Nigeria and Senegal from the initially-affected areas and we have also seen in Nigeria and Senegal that proven practices such as contact tracing can contribute to managing Ebola and preventing a small number of cases from growing into a larger outbreak.

Ebola has symptoms similar to many other illnesses, including fever, chills, weakness and body aches. Gastrointestinal symptoms such as vomiting and diarrhea are common and profound, with fluid losses on average of 5-7 liters in 24 hours over a five day period. These fluid losses can result in life-threatening electrolyte losses. In approximately half of cases there is hemorrhage-- serious internal and external bleeding. There are two things that are very important to understand about how Ebola spreads. First, the current evidence suggests human-to-human transmission of Ebola only happens from people who are symptomatic-- not from people who have been exposed to, but are not ill with the disease. Second, everything we have seen in our decades of experience with Ebola indicates that Ebola is not spread by casual contact; Ebola is spread through direct contact with bodily fluids of someone who is sick with, or has died from Ebola, or exposure to objects such as needles that have been contaminated. While the illness has an average 8-10 day incubation period (though it may be as short as two days and as long as 21 days), we recommend monitoring for fever and signs of symptoms for the full 21 days. Again, we do not believe people are contagious during that incubation period, when they have no symptoms. Evidence does not suggest Ebola is spread through the air. Catching Ebola is the result of

exposure to bodily fluids, which we are seeing occur in West Africa, for example, in hospitals in weaker health care systems and in some African burial practices. Getting Ebola requires exposure to bodily fluids of someone who is ill from – or has died from – Ebola.

The earliest recorded cases in the current epidemic were reported in March of this year. Following an initial response that seemed to slow the early outbreak for a time, cases flared again due to weak systems of health care and public health and because of challenges health workers faced in dealing with communities where critical disease-control measures were in conflict with cultural norms. As of last week, the epidemic surpassed 7,900 cumulative reported cases, including nearly 3,800 documented deaths, though we believe these numbers may be substantially under-reported. The effort to control the epidemic in some places is complicated by fear of the disease and distrust of outsiders. Security is tenuous and unstable, especially in remote isolated rural areas. There have been instances where public health teams could not do their jobs because of security concerns.

Many of the health systems in the affected countries in West Africa are weak or have collapsed entirely, and do not reach into rural areas. Health care workers may be too few in number or may not reliably be present at facilities, and those facilities may have limited capacity. Health care workers are at greater risk of Ebola due to conditions they are working in and we must work to reduce that risk. Poor infection control in routine health care, along with local traditions such as public funerals and cultural mourning customs including preparing bodies of the deceased for burial, make efforts to contain the illness more difficult. Furthermore, the porous land borders among countries and remoteness of many villages have greatly complicated control efforts. The secondary effects now include the collapse of the underlying health care systems resulting for example, in an inability to treat malaria, diarrheal disease, or to safely deliver a child, as well as non-health impacts such as economic and political instability and increased isolation in these areas of Africa. These impacts are intensifying, and not only signal a growing humanitarian crisis, but also have direct impacts on our ability to respond to the Ebola epidemic itself.

Fortunately, we know what we must do. In order to stop an Ebola outbreak, we must focus on three core activities: find active cases, respond appropriately, and prevent future cases. The use of real-time diagnostics is extremely important to identify new cases. We must support the strengthening of health systems and assist in training healthcare providers. Once active cases have been identified, we must support quality patient care in treatment centers, prevent further transmission through proper infection control practices, and protect healthcare workers. Epidemiologists must identify contacts of infected patients and follow up with them every day for 21 days, initiating testing and isolation if symptoms emerge. And, we must intensify our use of health communication tools to disseminate messages about effective prevention and risk reduction. These messages include recommendations to report suspected cases, to avoid close contact with sick people or the deceased, and to promote safe burial practices. In Africa, another message is to avoid bush meat and contact with bats, since “spillover events,” or transmission from animals to people, in Africa have been documented through these sources.

Many challenges remain. While we do know how to stop Ebola through meticulous case finding, isolation, and contact tracing, there is currently no cure or vaccine shown to be safe or effective for Ebola. We are working to strengthen the global response, which requires close collaboration with the World Health Organization (WHO) and additional assistance from our international partners. At CDC, we activated our Emergency Operations Center to respond to the initial outbreak, and are surging our response. As of last week, CDC has over 139 staff in West Africa, and over 1,000 staff in total have provided logistics, staffing, communication, analytics, management, and other support functions. CDC will continue to work with our partners across the United States Government and elsewhere to focus on key strategies of response:

- Effective incident management – CDC is supporting countries to establish national and sub-national Emergency Operations Centers (EOCs) by providing technical assistance and standard operating procedures and embedding staff with expertise in emergency operations. All three

West African countries at the center of the epidemic have now named and empowered an Incident Manager to lead efforts.

- Isolation and treatment facilities – It is imperative that we ramp up our efforts to provide adequate space to treat the number of people afflicted with this virus.
- Safe burial practices – Addressing local cultural norms on burial practices is one of the keys to stopping this epidemic. CDC is providing technical assistance for safe burials.
- Infection control throughout the health care system– Good infection control will greatly reduce the spread of Ebola and help control future outbreaks. CDC has a lead role in infection control training for health care workers and safe patient triage throughout the health care system, communities, and households.
- Communications – CDC will continue to work on building the public’s trust in health and government institutions by effectively communicating facts about the disease and how to contain it, particularly targeting communities that have presented challenges to date.

The public health response to Ebola rests on the same proven public health approaches that we employ for other outbreaks, and many of our experts are working in the affected countries to rapidly apply these approaches and build local capacity. These include strong surveillance and epidemiology, using real-time data to improve rapid response; case-finding and tracing of the contacts of Ebola patients to identify those with symptoms and monitor their status; and strong laboratory networks that allow rapid diagnosis.

The resources provided for the period of the Continuing Resolution will support our response and allow us to ramp up efforts to contain the spread of this virus. More than half of the funds are expected to directly support staff, travel, security and related expenses. A portion of the funds will be provided to the affected area to assist with basic public health infrastructure, such as laboratory and surveillance capacity, and improvements in outbreak management and infection control. Should other outbreaks

occur in this region, authorities will have the experience and capacity to respond without a massive external influx of aid, due to this investment. The remaining funds will be used for other aspects of strengthening the public health response such as laboratory supplies/equipment, and other urgent needs to enable a rapid and flexible response to an unprecedented global epidemic. CDC is working to identify our potential resource needs for the rest of the fiscal year, and possibly further, as we deal with this evolving situation. CDC will continue to coordinate activities directly with critical Federal partners, including the United States Agency for International Development (USAID), DoD, DHS, and non-governmental organizations. Over the past few weeks, we have seen progress, as the DoD has begun deploying assets to the area and laying the ground work to construct 17 Ebola treatment facilities, train local workers to staff the facilities, and move supplies into the area. In addition, USAID is working closely with non-governmental organizations to scale up efforts in all areas of the response. Currently, there are over 50 burial teams in all 15 counties of Liberia for the management of safe human remains. More than 70 organizations are providing Ebola education and awareness in Liberia, Guinea, and Sierra Leone. Organizations are also working to increase infection control practices in all health facilities to ensure functionality of the healthcare system. We continue to work with national governments, WHO, and USAID to provide for interim measures such as isolation in community settings with proper protections, and improvements to ensure the safe burial of those who have died from the virus.

Though the most effective step we can take to protect the United States is to stop the epidemic where it is occurring, we are also taking strong steps to protect Americans here at home. The imported case of Ebola in Dallas, diagnosed on September 30th in a traveler from Liberia, required CDC and the Nation's public health system to implement rapid response protocols that have been developed in anticipation of such an event. Within hours of confirming that the patient had Ebola, CDC had a team of 10 people on the ground in Dallas to assist the capable teams from the Texas state health department and local

authorities. We have worked side-by-side with state and local officials to prevent infection of others. Together, we assessed all 114 individuals who might possibly have had contact with the patient. We narrowed down the contacts to 10 who may have been around the patient when he was infectious and 38 others with whom infection cannot be ruled out. These individuals will be tracked for 21 days for any signs of symptoms, and they will quickly be isolated if symptoms develop. We are also working to identify and learn lessons from the initial patient encounter and other events that complicated our response, and to apply them in any other responses. We are confident that our public health and health care systems can prevent an Ebola outbreak here, and that the authorities and investments provided by the Congress have put us in a strong position to protect Americans. To make sure the United States is prepared, as the epidemic in West Africa has intensified, CDC has done the following:

- Instituted layers of protection, starting in affected countries where our staff work intensively on airport exit screening, such as temperature scanning for outbound passengers.
- Provided guidance for airline personnel and for DHS Customs and Border Protection Officers on how to identify sick passengers and how to manage them. Though it was one of many false alarms, the recent incident with an inbound passenger to Newark, New Jersey shows how CDC's quarantine station at the airport worked with airline, DHS, airport, EMS, and hospital personnel to assess and manage a sick passenger, and to protect other passengers and the public.
- Developed guidance for monitoring and movement of people with possible exposures
- Along with partners in DHS and state and local health agencies, continually assessed and improved approaches to inbound passenger screening and management, and as the President announced on October 6th, CDC is working with DHS to enhance screening measures at United States airports.

- Worked with American hospitals to reinforce and strengthen infection controls, and CDC has provided checklists and instructions to all health care facilities to assess patients for travel history. We have also worked with state and local health departments to ensure that these practices are being followed.
- With state health departments, intensified training and outreach to build awareness since the Dallas case.
- Through the Laboratory Response Network (LRN), expanded lab capacity across the United States – in addition to CDC’s own world class laboratories, 14 LRN labs now have capacity for testing, ensuring that we have access to labs for timely assessment – and surge capacity in case it is needed.
- Developed response protocols for the evaluation, isolation and investigation of any incoming individuals with relevant symptoms.
- Extensively consulted to support evaluation and, when indicated, tested suspect cases. With heightened alert, we are receiving hundreds of inquiries for help in ruling out Ebola in travelers – a sign of how seriously airlines, border agents, and health care system workers are taking this situation. So far just over a dozen of these hundreds of suspect cases have required testing, and only one (the Dallas patient) has been positive.

Our top priority at CDC is to protect Americans from threats. We work 24/7 to do that. In the case of Ebola, we are doing that in many different ways here at home, but we also need to retain our focus on stopping the outbreak at its source, in Africa.

Working with our partners, we have been able to stop every prior Ebola outbreak, and we will stop this one. It will take meticulous work and we cannot take short cuts. It’s like fighting a forest fire: leave

behind one burning ember, one case undetected, and the epidemic could re-ignite. For example, in response to the case in Nigeria, 10 CDC staff and 40 top Nigerian epidemiologists rapidly deployed, identified, and followed 1,000 contacts for 21 days. Even with these resources, one case was missed, which resulted in a new cluster of cases in Port Harcourt. However, due to the meticulous work done in Nigeria, no new cases have been identified, and the outbreak appears to have been extinguished there.

Ending this epidemic will take time and continued, intensive effort. Before this outbreak began, we had proposed, in the FY 2015 President's Budget, an increase of \$45 million to strengthen lab networks that can rapidly diagnose Ebola and other threats, emergency operations centers that can swing into action at a moment's notice, and trained disease detectives who can find an emerging threat and stop it quickly. Building these capabilities around the globe is key to preventing this type of event elsewhere and ensuring countries are prepared to deal with the consequences of outbreaks in other countries. We must do more, and do it quickly, to strengthen global health security around the world, because we are all connected. Diseases can be unpredictable – such as H1N1 coming from Mexico, MERS emerging from the Middle East, or Ebola in West Africa, where it had never been recognized before – which is why we have to be prepared globally for anything nature can create that could threaten our global health security.

Investments in strengthening health systems in West Africa have been very challenging due to the low capacity of the systems. However, all of the donor partners agree that adequately strengthening the public health infrastructure in West Africa could allow such outbreaks to be detected earlier and contained. This Ebola epidemic shows that any vulnerability could have widespread impact if not stopped at the source.

In February, the United States Government joined with partner governments, WHO and other multilateral organizations, and non-governmental actors to launch the Global Health Security Agenda (GHSA). Over the next five years, the United States has committed to working with over forty partner countries (with a combined population of at least four billion people) to improve their ability to prevent, detect, and effectively respond to infectious disease threats - whether naturally occurring or caused by accidental or intentional release of pathogens. As part of this Agenda, the President's FY 2015 Budget includes \$45 million for CDC to accelerate progress in detection, prevention, and response, and we appreciate your support for this investment. We are working to evaluate the needs to strengthen the Ebola-affected nations and neighboring ones most at risk, and are asking that GHSA partners make specific commitments to establish capacity in West African countries in two or three years to prevent, detect and rapidly respond to infectious disease threats. The economic cost of large public health emergencies can be tremendous – the 2003 Severe Acute Respiratory Syndrome epidemic, known as SARS, disrupted travel, trade, and the workplace and cost to the Asia-Pacific region alone \$40 billion. Resources provided for the Global Health Security Agenda can improve detection, prevention, and response and can potentially reduce some of the direct and indirect costs of infectious diseases.

Improving these capabilities for each nation improves health security for all nations. Stopping outbreaks where they occur is the most effective and least expensive way to protect people's health. While this tragic epidemic reminds us that there is still much to be done, we know that sustained commitment and the application of the best evidence and practices will lead us to a safer, healthier world. With a focused effort, and increased vigilance at home, we can stop this epidemic, protect Americans, and leave behind a strong system in West Africa and elsewhere to prevent Ebola and other health threats in the future.

Thank you again for the opportunity to appear before you today. I appreciate your attention to this terrible epidemic and I look forward to answering your questions.

Statement for the Record

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And

**John Wagner
Acting Assistant Commissioner
Office of Field Operations
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U.S. Department of Homeland Security**

Before

**The U.S. House of Representatives
Committee on Homeland Security**

For a Field Hearing in Dallas, Texas, On

***“Ebola in the Homeland: The Importance of Effective International, Federal, State and Local
Coordination”***

October 10, 2014

Chairman McCaul, Ranking Member Thompson, distinguished members of the Committee, and the Texas Delegation, we appreciate the opportunity to submit this statement on the U.S. Customs and Border Protection’s (CBP) and the Office of Health Affairs’ (OHA) roles in the Federal government’s Ebola response.

The 2014 Ebola epidemic is the largest in history with devastating impacts in multiple West African countries – the hardest hit being Liberia, Sierra Leone, and Guinea. In the midst of this public health event, it is important to remember that the Centers for Disease Control and Prevention (CDC) has stated that the risk of a widespread Ebola outbreak in the United States is very low. OHA and CBP, as part of the Department of Homeland Security’s (DHS) overall strategy, are engaged on a daily basis with DHS interagency partners to prepare for and respond to Ebola and other potential threats to public health.

As you know, DHS is responsible for securing our nation’s borders and assisting the Department of Health and Human Services (HHS) in safeguarding the American public from communicable diseases that threaten to traverse our borders. In doing so, DHS is committed to ensuring that our responses to the Ebola epidemic are conducted consistent with established civil rights and civil liberties protections. OHA is at the intersection of homeland security and public health, better

known as health security. OHA provides medical and health expertise to DHS components and senior leadership, and is helping to coordinate with Components and provide them with medical advice regarding the Department's efforts in preparing for and responding to Ebola. In today's remarks, we will provide an overview of the Department's efforts to protect the American people from Ebola, and CBP's specific efforts within ports of entry to identify and respond to travelers who may pose a threat to public health.

As the Nation's unified border security agency, CBP is responsible for securing our Nation's borders while facilitating the flow of legitimate international travel and trade that is so vital to our Nation's economy. Within this broad responsibility, CBP's priority mission remains to prevent terrorists and terrorist weapons from entering the United States. CBP also plays an important role in limiting the introduction, transmission, and spread of serious communicable diseases from foreign countries.

The President has been focused every day on this response and has stated to his senior health, homeland security, and national security advisors that the epidemic in West Africa is a top national security priority, and that we will continue to do everything necessary to address it. Because of the steps we have taken, the President reiterated that he is confident that the chances of an outbreak in the United States are extraordinarily low.

Screening and Observation Protocols

CBP and the CDC have closely coordinated to develop policies, procedures, and protocols to identify travelers to the United States who may have a communicable disease, responding in a manner that minimizes risk to the public. These pre-existing procedures – applied in the land, sea, and air environments – have been utilized collaboratively by both agencies on a number of occasions with positive results.

As a standard part of every inspection, CBP officers observe all passengers as they arrive in the United States for overt signs of illness, and question travelers, as appropriate, at all U.S. ports of entry. CBP officers are trained in illness recognition by the CDC. Officers look for overt signs of illness and can obtain additional information from the travelers during the inspection interview. If a traveler is identified with overt signs of a communicable disease of public health significance, the traveler is isolated from the traveling public and referred to CDC's Regional Quarantine Officers or local public health for medical evaluation.

It is important to note that the CDC has worked closely with affected countries, and CBP has provided support and assistance, to ensure that all outbound travelers from the areas affected by the West Africa Ebola outbreak are screened for Ebola symptoms before departure. CDC provides "Do Not Board" recommendations to CBP and the Transportation Security Administration (TSA) regarding individuals who may be infected with a highly contagious disease, present a threat to public health, and should be prevented from traveling via commercial aircraft. TSA is performing vetting of all airline passengers coming to, departing from or flying within the U.S. to identify matches to the "Do Not Board" list and flag matched individuals' records in the Secure Flight system to prevent the issuance of a boarding pass. TSA is also

supporting CDC requirements to identify all passenger reservations on flights where it has been determined that one or more passengers present an Ebola risk, such as when passengers have traveled from the affected African areas and have exhibited Ebola symptoms.

Additional Ebola Screening Measures

Although we have recently seen the first cases of Ebola virus in the United States, the CDC believes that the U.S. clinical and public health systems will work effectively to prevent the spread of the Ebola virus. DHS has executed a number of measures to minimize the risk of those sick with Ebola entering the United States, and we take a layered approach to ensure there are varying points at which an ill individual could be identified. To this end, DHS is also focused on protecting the air traveling public and taking steps to ensure that travelers with communicable diseases like Ebola are identified, isolated, and quickly and safely referred to medical personnel.

On October 21, DHS announced travel restrictions in the form of additional screening and protective measures at our ports of entry for travelers from the three Ebola-affected countries in West Africa. As of October 22, all passengers arriving in the United States whose travel originated in Liberia, Sierra Leone, or Guinea are required to fly into one of five airports including New York John F. Kennedy; Washington Dulles; Newark; Chicago O'Hare; and Atlanta International Airport. DHS is working closely with the airlines to implement these restrictions with minimal travel disruption.

At these five airports, all travelers from the affected countries undergo enhanced screening measures consisting of targeted questions and a temperature check, through the use of non-contact thermal thermometers, seeking to determine whether the passengers are experiencing symptoms or may have been exposed to Ebola. Detailed contact information is also collected in the event the CDC needs to contact them in the future. If there is reason to believe a passenger has been exposed to Ebola, either through the questionnaire, temperature check, or overt symptoms, CBP refers the passenger to CDC for further evaluation. The CDC has surged staff to these airports to support this mission requirement.

In addition to these measures, CBP officers are asking all passengers traveling on a passport from Liberia, Sierra Leone, and Guinea, regardless of where they traveled from, whether they have been in one of the three countries in the prior 21 days. If the traveler has been in one of the three countries in the prior 21 days, he or she will be referred for additional screening and, if necessary, CDC or other medical personnel in the area will be contacted pursuant to existing protocols.

The U.S. Coast Guard is also monitoring vessels known to be inbound from Ebola-affected countries, and is providing information to the Captain of the Port, District, and CDC representatives.

The CDC maintains Federal jurisdiction to determine whether to isolate or quarantine potentially infected arrivals. DHS personnel may be called upon to support the enforcement of the CDC's determinations, and we stand ready to help.

Information Sharing and Training

DHS has prioritized sharing information and raising awareness as important elements in combating the spread of Ebola, and CBP has a unique opportunity to deliver critical information to targeted travelers from the affected countries in ports of entry. Secretary Johnson recently directed CBP to distribute health advisories to all travelers arriving in the U.S. from the Ebola-affected countries of Liberia, Sierra Leone, and Guinea. These advisories provide the traveler with information on Ebola, health signs to look for, and information for their doctor should they need to seek medical attention in the future.

CBP and TSA have posted messages from the CDC at select airport locations that provide awareness on how to prevent the spread of infectious disease, typical symptoms of Ebola, and instructions to call a doctor if the traveler becomes ill in the future.

We also share information with our nongovernmental and state and local partners. TSA is engaging with industry partners and domestic and foreign air carriers to provide awareness on the current outbreak, and has issued an Information Circular to air carriers reinforcing the CDC's message on Ebola and providing guidance on identifying potential travelers with Ebola.

OHA, through the National Biosurveillance Integration Center, is continuing to monitor the outbreak to coordinate information in response to the event. These reports on biological events are disseminated to more than 15,000 Federal, State, and local users, many of whom work in the public health sector or support 78 fusion centers across the Nation, helping to ensure that the most up-to-date information is available.

DHS is committed to ensuring that our own employees have up-to-date and accurate information. We have provided our own personnel with background information on the current outbreak, information on the regions of importance; symptoms of the virus and mode of transmission; and operational procedures and precautions for processing travelers showing signs of illness. CBP field personnel will be kept up to date on national, regional and location-specific information on Ebola preparedness and response measures through regular field musters. CBP has provided guidance to the field on baggage inspection for international travelers from impacted countries, proper procedures for inspection and handling of prohibited meat products, and proper safeguarding and disposal of garbage from all inbound international flights.

CBP officers receive the CDC's public health training, which teaches officers to identify symptoms and characteristics of ill travelers. CBP also provides operational training and guidance to frontline personnel on how to respond to travelers with potential illness, including referring individuals who display signs of illness to CDC quarantine officers for secondary screening, the use of personal protective equipment (which is available for employees at these airports along with instructions for use), as well as training on assisting CDC with implementation of its isolation and quarantine protocols. CBP officers are trained to employ universal precautions, an infection control approach developed by the CDC, when they encounter individuals with overt symptoms of illness or contaminated items in examinations of baggage

and cargo. Universal precautions assume that every direct contact with body fluids is infectious and requires exposed employees to respond accordingly. TSA also ensures that its employees are adequately trained and, where appropriate, are provided personal protective equipment. The health and safety of DHS employees is also our priority as we carry out this critical mission.

Conclusion

The Department of Homeland Security has worked closely with its interagency partners to develop a layered approach to identifying ill travelers and protecting the air traveling public. DHS is always assessing the measures we have in place and continues to look at any additional actions that can be taken to ensure the safety of the American people. We look forward to working with you to address this problem collaboratively. We will continue to closely monitor the Ebola outbreak, and will evaluate additional measures as needed.

We thank you for your time and interest in this important issue. We look forward to answering your questions.

Dr. David Lakey
Commissioner
Texas Department of State Health Services
October 10, 2014
U.S. House Committee on Homeland Security
Ebola in the Homeland: The Importance of Effective International, Federal, State and Local
Coordination

On October 8, 2014, Thomas Eric Duncan passed away as a result of contracting the Ebola virus in Liberia. Mr. Duncan was provided therapeutic care at Texas Health Presbyterian Hospital in Dallas, Texas, but he was unfortunately unable to recover from this often fatal disease.

Mr. Duncan's death is a reminder of the importance of disease prevention and control, and provides additional meaning to efforts in Texas to prevent further exposure to the disease. The goal in Texas is to continue to minimize risk, thus reducing the likelihood of another Ebola death within the state.

Every sympathy and concern is extended to Mr. Duncan's family, as they both grieve for their loved one and worry for their own health.

Background: Ebola Case in Dallas

On September 30, 2014, the Department of State Health Services (DSHS) Laboratory and Centers for Disease Control and Prevention (CDC) tested a specimen for Ebola virus, and found it positive. This is the first Ebola patient to be diagnosed in the country.

The patient contracted Ebola in Liberia, and was not symptomatic when travelling into the United States. Ebola is only communicable when an infected person is ill with symptoms. During the incubation period, when no symptoms are present, a person is not infectious.

Texas Presbyterian Hospital received the patient, and contacted the Dallas County Health and Human Services on September 28, 2014, after the patient was transported to the emergency room by ambulance. He had previously presented at the hospital on September 26, was evaluated, provided medications, and discharged. Dallas County contacted DSHS and the CDC, to allow for coordination. Texas Health and Safety Code, Chapter 81, requires that Viral Hemorrhagic Fever (Ebola) be immediately reported to the local health department, which in turn notifies state and federal partners, as warranted.

Once Ebola was suspected as a possible diagnosis on the 28th, Dallas County began a public health investigation to determine if others were exposed to the virus while the patient was symptomatic. After the patient's diagnosis, DSHS and CDC staff were on site to provide assistance in the epidemiological investigation. The initial investigation identified 114 individuals who may have had contact with the patient. Additional investigation narrowed this number down, and a total of 48 contacts of varying risk were identified for monitoring. The investigation is ongoing.

Ebola symptoms can become evident between two and 21 days after the initial infection. However, eight to 10 days is the most common time frame for Ebola symptoms to become apparent. Ebola is only transmittable through direct contact with blood or body fluid, or exposure through contaminated objects, such as needles. Direct contact requires exposure through broken skin or unprotected mucous membranes.

By determining whether contact with the patient occurred, and whether possible contact was direct or indirect, investigating epidemiologists concluded that ten individuals should be considered high risk exposures. All 48 identified contacts were placed under monitoring for symptoms, with regular visits from local, state, and CDC health department officials.

The 48 individuals will be monitored until they have passed the 21 day threshold for presentation of symptoms.

Infectious Disease Surveillance in Texas

The State of Texas is divided into eight DSHS health service regions. In areas where a local health department exists, DSHS health service regional offices provide supplemental or supporting public health services. In areas where there is no local health department, DSHS health service regional offices act as the local health authority.

Local health departments are of varying size, resources, and capacities. While some health departments, like Dallas County, support a full array of services, others have more limited functions. Approximately 60 health departments in Texas are “full service,” while 80 offer fewer services. DSHS’ role is to fill in, as needed, core public health services not offered at the local level.

For infectious disease, DSHS health service regions ensure that disease surveillance occurs in every Texas county through the continual and systematic collection, analysis, and interpretation of health data. This effort is dependent on disease reporting by providers, which is required by law. Currently, in Texas, over 60 conditions are subject to mandatory reporting, including: foodborne, vector-borne, respiratory, and sexually transmitted diseases. Viral Hemorrhagic Fever, or Ebola, is an immediately-reportable disease in Texas.

In order to allow real-time monitoring of disease surveillance data, the CDC provides and maintains the National Electronic Disease Surveillance Network (NEDSS) for use by local, regional and state health departments. NEDSS is used by nearly every local health department in the state, and allows DSHS to identify unusual increases or pattern shifts in disease numbers.

In concert with NEDSS, Electronic Laboratory Reporting (ELR) has improved the timeliness and comprehensiveness of diseases reporting. ELR electronically links laboratory test reports to NEDSS, allowing immediate access by DSHS or the local health department with legal jurisdiction.

Infectious Disease Investigation and Response in Texas

Timely disease reporting to the public health system is imperative for quick mobilization of public health investigation and response efforts. Since Texas is a home rule state, epidemiological investigations begin at the local level, unless there is no local health department. This local responsibility aids in effective epidemiological investigations by ensuring that investigations are based on close understanding of the community and its residents. While local entities have the statutory responsibility to lead infectious disease investigations, state and CDC guidance is available and widely used.

More complicated or widespread events can increase the state and federal roles. If an outbreak involves multiple jurisdictions, the state role becomes more prominent. If, at any time, an investigation goes beyond local capabilities, the state may take the lead. In turn, if an investigation exceeds state resources, the state may ask the CDC for assistance. Additionally, the CDC leads multi-state investigations. No matter the level of outbreak, the norm is for all three levels of government to work in cooperation, with varying levels of state and federal involvement depending on the size and type of infectious disease event, and the resources and expertise of the local entity. Throughout the event in Dallas, the state and local authorities have been supported by CDC, both in the field and by home office staff.

Support provided by the state and CDC can include a number of options, depending on the scope of an investigation and local needs. This support might consist of subject matter expertise and onsite assistance; state or CDC laboratory testing; provision of personal protection equipment; or mobilizing of DSHS Rapid Assessment Teams or CDC Epi-Aids. The state and CDC can also assist with administering questionnaires and interviews to cases and potential contacts, inspecting relevant hospital facilities or restaurants, and helping examine pertinent records.

In cases of large-scale outbreaks, the State Medical Operations Center (SMOC) at DSHS may be activated. The SMOC is staffed by DSHS Community Preparedness, Infectious Disease, and Communications staff. Its function is to ease the flow of information among multiple jurisdictions, provide dependable tracking of events, and facilitate requests for resources and supplies from local jurisdictions. For the Ebola case and investigation in Dallas, the SMOC has been activated.

Successful Infectious Disease Response in Texas

The public health response system in Texas, led by local entities and supported by state and federal government, has a long history of successful outbreak responses. Texas has effectively contained events involving disease like Tuberculosis, measles, hepatitis, and Middle East Respiratory Syndrome (MERS).

As an example, DSHS disease investigators are currently assisting the local health authority in El Paso, Texas, to track a number of exposures to Tuberculosis (TB) that occurred through a health care worker in the labor and delivery unit of a local hospital. This situation is a prime example of how, under the current system, all levels of government successfully work together to respond to an infectious disease event.

Once the index case was identified, local and state health department investigators meticulously examined hospital records to determine infants, parents, coworkers, and volunteers who were at risk of exposure. This investigation identified an initial 3,227 potentially-exposed newborns, and 69 potentially-exposed health care workers. Together, public health workers evaluated the index case's history to determine where exposure may have actually occurred. Then, they prioritized potential contacts by level of risk, decided on a contact investigation protocol specific to this incident, and executed the contact investigation. The CDC has been on site to provide assistance, and home office CDC staff has provided expertise and advice. International coordination took place due to the city's proximity to the U.S.-Mexico Border; interstate coordination with New Mexico was also necessary.

While the investigation is not yet complete, its results are already evident. Public health investigators were able to narrow down the initial 3,227 number to 757 infants who had some level of risk of exposure. Follow up with parents occurred, and testing was recommended, as appropriate, for potentially-exposed children. Additionally, DSHS gave providers guidance on treatment algorithms for possible cases. Of the 503 infants tested, six have tested positive for TB infection, and are being treated to ensure they do not develop active TB. Of the 58 health care workers tested, four tested positive for TB infection, and public health follow up will ensure that these positive cases do not develop into a risk for further community exposure.

Initial Lessons Learned: Ebola Case and Investigation in Dallas, Texas

The Ebola investigation is ongoing, but events like the TB exposure in El Paso and past infectious disease events reveal key themes to successful prevention and control of disease outbreaks in Texas and in the country.

The crux of infectious disease response is reporting. Providers must be aware of what diseases are reportable to their local health department, and promptly report contagious disease through the reporting system. Provider awareness of this responsibility allows for more effective disease surveillance, and more timely response to developing infectious disease events. DSHS works to reinforce this requirement through reminders, updates, and by making the reporting system user friendly.

Secondly, the Ebola case in Dallas highlights the need for providers to vigilantly take travel histories, and streamline sharing of this information while a patient is being diagnosed. Providers must be aware of outbreaks worldwide, to inform their consideration of patient travel history. Until the Ebola outbreak in West Africa is over, Ebola must be a differential diagnosis for those who have recently traveled from one of the outbreak countries. At the same time, moving forward, providers must be aware of what other outbreaks are occurring internationally. Electronic notifications from the CDC help providers stay informed, and these messages can be strengthened through state and local-level communications.

After Action Assessments

After the response to the Ebola case and investigation comes to a close, DSHS will perform an after action review of the response to this situation. Throughout the event, responders keep in mind how the response flows, what difficulties are encountered, and what successes are achieved. After the response, a thoughtful assessment brings all these experiences into one evaluation. An after action review is essential to close out any response effort, in order to improve future responses. The assessment will include input from local, state, and federal responders who were part of the effort, and will analyze each part of the response. The assessment will determine what worked, what can be improved, and how those improvements can be made. The final result will be enhanced preparedness plans for future infectious disease events.

In addition, Texas Governor Rick Perry has formed a Texas Task Force on Infectious Disease Preparedness and Response, the purpose of which is to assess and enhance the state's capabilities to respond to outbreak situations. The task force is composed of 17 members, headed by infectious disease and Ebola experts, and will be supported by DSHS and other state agencies. The Task Force will evaluate infectious disease response in Texas, and determine what recommendations can be made for improvements, either through agency or legislative action. The Task Force will make its report to the Texas State Legislature in December 2014.

Conclusion

The response to the Ebola case in Dallas is ongoing. Conclusion of this event will allow a systematic review of the response efforts, and the Governor's Task Force on Infectious Disease Preparedness and Response will facilitate an evaluation of the public health response system as a whole. It is evident from a long history of success that public health interventions work, and that infectious disease investigation and follow up can stop the spread of disease. However, each infectious disease event provides a new opportunity to make improvements to disease investigation response and coordination among public health entities. The current focus is on ensuring that no more Texans are exposed to the Ebola virus. When that mission is complete, the focus will shift to recommending and implementing improved plans for future infectious disease response in Texas.

Committee on Homeland Security
U.S. House of Representatives
Invited Testimony

Brett P. Giroir, M.D.
Chief Executive Officer, Texas A&M Health Science Center
Director, Texas Task Force on Infectious Disease Preparedness and Response

Dallas, Texas
October 10, 2014

Chairman McCaul and members of the committee:

I am Dr. Brett Giroir, Chief Executive Officer of Texas A&M Health Science Center, and Professor in the Colleges of Medicine and Engineering. By training, I am a critical care physician-scientist with specific experience in treating life threatening infectious diseases. I also have experience in the federal government as Director of the Defense Sciences Office at the Defense Advanced Research Projects Agency (DARPA) and Chair of the Chemical and Biological Defense Panel of the Department of Defense Threat Reduction Advisory Committee. In addition, earlier this week, Governor Perry named me Director of the Texas Task Force on Infectious Disease Preparedness and Response.

The risk of infectious disease outbreaks is real, and these outbreaks are inevitable given the interconnected nature of the world we live in. An outbreak anywhere becomes a threat everywhere. Given our location along the U.S. border, our experience with major natural disasters, and our unique assets such as the Galveston National Laboratory and the Texas A&M Center for Innovation in Advanced Development and Manufacturing (CIADM), Texas is on the front lines of public health preparedness and protection.

In response to the first case of Ebola diagnosed in the U.S., Governor Perry swiftly established the Task Force on Infectious Disease Preparedness and Response to assess and manage the risk in Texas and to prospectively plan for future infectious disease threats – whether natural or the result of bioterrorist attacks. The Task Force includes internationally recognized infectious disease and public health experts, seasoned biodefense leaders, and state agency professionals across major areas including health and human services, emergency management, public safety, transportation, environmental quality, public education, and housing and community affairs. The members of this task force volunteered in order to serve the people of Texas, and as a result, the nation, and each of us has accepted this call to duty from the Governor for that sole purpose.

There is no question that there will be opportunities for increased performance across many of the complex elements that have been brought together to effectively contain Ebola within Texas. Remember, this was the first Ebola patient to be diagnosed in the United States. If there is room for improvement, we will work to assure that Texas learns, documents, disseminates information, and implements optimal changes to further protect our citizens – and that the United States, as a whole, benefits from the process. The Texas Task Force took action right away, meeting for the

first time immediately after the Governor issued the Executive Order, and we have been actively engaged in assessments and discussion since that time. We have preliminarily identified six areas of focus that have been prominent in the current Ebola response, and we believe that these areas will have implications for many potential disease outbreaks should they arrive in the United States. These areas include:

1. Hospital Preparedness and the Potential Role of Improved Rapid Diagnostics
The Task Force will focus on the initial identification of a patient, or potential patient, and the education and preparedness of diverse health care professionals essential for this key step in the containment process.
2. Command and Control Issues
The Task Force will focus on processes related to the initial activation of the Incident Command Structure, integration of local, state, and federal resources, development of a common operating picture, and the unique differences of a public health challenge, such as an Ebola patient, compared to the challenges experienced in natural disasters such as hurricanes.
3. Organization and Implementation of Epidemiologic Investigations and Monitoring
The Task Force will assess opportunities for improved integration of disease tracking, data and information synthesis, and potential opportunities for automated technologies and scalable common data platforms that could be shared at the local, state, and federal levels.
4. Decontamination and Waste Disposal
The Task Force will review and assess a plethora of issues faced in this area, including but not limited to: determining what could be decontaminated, versus contained-hauled-incinerated, availability of appropriate containers, logistics of transport, and complex permitting issues across multiple levels of jurisdiction.
5. Patient Care Issues
The Task Force will examine how to improve information flow to front line care providers, including information on new drugs, their risks and potential benefits, and how they might be accessed under investigational protocols.
6. Care of Patients Being Monitored.
The Task Force will examine the diverse needs of individuals under monitoring or controlled monitoring, including the needs for basic necessities, such as food, clothing, and housing, as well as potential needs for social services and/or counseling. Due to the rich diversity of the Texas population, cultural competency in communication and interactions are important aspects of this area.

The Task Force will submit initial draft assessments and recommendations by December 1 for consideration by the Office of the Governor and Texas Legislature, so that actions requiring statutory changes could be proposed in the 2015 legislative session. In the meantime, the Task Force is committed to insuring that the teams on the ground have all necessary expertise and resources at their disposal to respond to the potential for additional Ebola cases in Texas, and to begin the process of developing an infectious disease preparedness and response plan to

complement the State Emergency Management Plan already in place and proven highly effective in response to natural disasters.

Regarding the current situation here in Dallas, the response and coordination of local, state and federal resources has generally been very good, but the Task Force will seek opportunities for improvement at all levels of collaboration and integration. Looking forward, the issues at hand are highly dependent on the larger security and preparedness system. State and local planning is critical, but so is clear and defined support to local and state authorities from the federal government, including the Centers for Disease Control (CDC) and Office of the Assistant Secretary for Preparedness and Response (ASPR). While there have been lessons learned, the successes in controlling this potentially dangerous situation are a testament to the incredible skill and dedication of all those on the ground in Dallas, who in my mind are nothing less than national heroes.

Gaps in Hospital Preparedness and Public Health Infrastructure

It is important to understand that our state's and the nation's public health infrastructure has been subject to significant funding reductions in the Federal Hospital Preparedness Program (HPP), which is intended to provide funding and support to improve surge capacity and enhance community and hospital preparedness for public health emergencies. These funds are expressly for enhanced planning at the state and local level, for increased integration across the public and private healthcare sectors, including hospitals, and other healthcare organizations and providers, and for improving infrastructure for public health emergencies. It should come as no surprise that hospitals require public funding to train and prepare for what are low probability yet high consequence, and potentially catastrophic, events.

HPP is meant to provide the foundation and core for exercises and ability to respond and get information out so that the nurse or physician on the front line would contemplate Ebola or anthrax in their differential diagnosis. HPP has been cut significantly in recent years by the federal government, and these actions have had clear, identifiable consequences here in Dallas. In fact, during the Federal Budget compromise last year, HPP funds were diverted to fund the Biomedical Advanced Research and Development Authority (BARDA) rather than use another funding source that was suggested by Congressional leaders. While we are very thankful this action allowed BARDA to continue operations (especially since the importance of its mission has been made abundantly clear during this Ebola response) robbing Peter to pay Paul has left us less far less prepared than we could have been, and indeed should have been. This must change if we are to be prepared for public health emergencies, now and in the future.

Guidelines for Health Preparedness and Technological Field Support

In January 2012, ASPR issued "Healthcare Preparedness Capabilities," providing national guidelines for healthcare system preparedness. Unfortunately, several of the critical capabilities identified in the report remain problematic areas in our public health preparedness and response infrastructure.

For instance, ASPR recommendations address the ability to coordinate multiple agencies and their decision-making, to provide incident information sharing, to manage resource

implementation, to provide an inventory management system, and to notify stakeholders of healthcare delivery status. In reality, the incident command team does not have the necessary technology in place to provide data tracking and analysis that would support the prescribed common operating picture across the multiple layers necessary to coordinate an effective and integrated response. Currently, information is housed on individual laptops and other devices, being reported manually, and compiled once or twice daily for the Texas Department of State Health Services Commissioner, Dr. David Lakey, who is leading the response in Dallas, and to whom we all owe a debt of gratitude, along with his colleagues in the CDC and other responders, who are working around these technological coordination challenges to the degree possible.

Another critical capability outlined by the ASPR report, Information Sharing, is to “Provide healthcare situational awareness that contributes to the incident common operating picture.” This critical capability has not been realized in the current Ebola scenario. In short, our public health infrastructure has not kept pace with technological and communications breakthroughs that are now widespread, and also has not yet incorporated tools to facilitate data collection, analysis, communication, and decision-making. This reality must be acknowledged by ASPR leadership, and a strategy to address these significant challenges should be developed in partnership with the caregivers at the epicenter of the current Ebola containment mission.

National Inventory of Potentially Available Ebola Therapeutics

Another major gap is the lack of any sort of inventory of candidate therapeutics to treat Ebola patients who are brought to the U.S. for treatment or who are diagnosed in our country. The fact of the matter is that we had a person fighting for his life on American soil and no easily available information about drugs available to administer. This is not a new issue; Dr. Keith Brantley received ZMapp in August by hearing about it from a colleague, not from U.S. federal authorities. Unfortunately, because of a number of issues as further described in this testimony, ZMapp was not available to be given to Mr. Duncan.

The federal government should provide a timely and frequently updated list of all possible medical countermeasures to treating physicians or to appropriate state public health officials. This list should include a concise summary of risks and potential benefits, instructions for how to obtain these therapies, and also should insure that there are specific research protocols in place to capture the meaningful data that will be generated through the use of these drugs. Today, physicians and patients often must track down the companies directly and ask for the drug candidates, or officials such as myself use personal contacts within the government to provide as much information as possible to the hospital treatment team. This is both inefficient and time consuming – and thus leaves patients and doctors less than optimally equipped in this struggle for life and death of a critically ill patient. This is completely unacceptable given the more than decade-long effort the federal government has undertaken to evaluate and advance medical countermeasures.

In terms of availability of therapies or vaccines against Ebola, our country is woefully and indeed frighteningly deficient. While it is true that the mainstay of Ebola treatment is supportive care, that is only the case because we have little else to offer. It is my personal assessment after experiences in both the academic and federal sectors that this deficiency relates less to scientific and technical obstacles, than it does to the lack of federal prioritization of the efforts; lack of

clear federal leadership accountability; and difficult, if not oppressive, contracting procedures that are often at odds with the iterated national strategy and objectives.

Special Assistant to the President on Biodefense

When Congress created the Assistant Secretary for Preparedness and Response role in 2006 as part of the Pandemics and All Hazards Preparedness Act, ASPR was intended precisely for the kind of situation we face today with Ebola. The nation was to be provided with a Senate-confirmed assistant secretary to take an all-hazards approach to bring to bear all necessary resources, regardless of where they belong on the federal government's organizational chart. That resource exists today in ASPR, but what is critically lacking is a White House Special Assistant to prepare for and lead such responses. Unfortunately, that position was eliminated by the current administration in January 2009.

We commend Chairman W. "Mac" Thornberry and James Langevin, Ranking Member, of the House Armed Services Committee subcommittee on Intelligence, Emerging Threats and Capabilities, for their April 22, 2014 letter to the President on this very topic, in which they call for the appointment of a Special Assistant to the President for Biodefense. This position has existed under both the Clinton and Bush administrations but was eliminated early in 2009. The letter notes that "there are at least 12 separate government agencies with biodefense responsibilities." As pointed out in a 2001 U.S. Government Accountability Office report, "Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue," there are more than "two dozen presidentially appointed individuals with some responsibility for biodefense."

Contracting Authority

ASPR, which is housed within the U.S. Department of Health and Human Services, oversees BARDA and the Office of Acquisitions Management, Contracts and Grants (AMCG). Several years ago an administrative decision was made to centralize all contracting under AMCG, and remove it from under BARDA's responsibility. While this made sense at the time, in practice, this has significantly slowed BARDA's efforts to move medical countermeasures through the manufacturing pipeline. Returning contracting authority to BARDA would certainly clear the way for the development of medical countermeasures, including experimental Ebola therapies. I want to specifically state that my team, and indeed most if not all of the scientific and technical community, has great respect for the leadership and technical expertise of BARDA. Without BARDA, the country would be gravely behind the curve without even the basic national response infrastructure to address this problem, or ever-present global challenges such as pandemic influenza.

Texas A&M CIADM AND Ebola Therapeutics

As you know, the Texas A&M Center for Innovation in Advanced Development and Manufacturing is a public-public-private partnership with the U.S. Department of Health and Human Services and one of three government-funded biosecurity centers designed to enhance the nation's preparedness against pandemic influenza, and chemical, biological, radiological, and nuclear threats by accelerating the research and development of vaccines and therapeutics, and

rapidly manufacturing these products at scale in cases of national emergencies. The Texas A&M CIADM is responsible for producing 50 million vaccine doses within four months of a declared influenza pandemic and receipt of the viral strain. It is also responsible for having the capabilities to manufacture, at scale, vaccines or biological therapeutics required for an outbreak, such as Ebola, if requested by the federal government. Our team is made up of leading academic, non-profit, and commercial partners including GSK.

The Texas A&M CIADM represents a long-term, strategic initiative – sponsored by BARDA – to assure preparedness by creating indispensable infrastructure and staff capabilities to rapidly respond against highly diverse threats. The CIADM will deliver on several critical objectives, including:

- Ensure the U.S. can develop and manufacture life-saving vaccines and therapies quickly, flexibly, and cost effectively at scale;
- Improve the ability to protect the health of Americans in response to emergency situations; and
- Train an expert workforce that can fill the needs of national biosecurity for the next generation.

The Center stands ready, and if called upon, will compete for manufacturing of a wide range of vaccines or therapeutics required by the U.S. government, including products against Ebola. Texas A&M Health Science Center also has a proprietary vaccine candidate now in preclinical evaluation that holds promise as one of the weapons against this growing global threat.

In closing, I thank you Chairman McCaul, and the members of the Committee for your leadership and for engaging on this important series of challenges that I have outlined. The members of the Texas Task Force and Texas A&M Center for Innovation want to be seen as your partners in solving the current Ebola situation in Texas and building a resilient and prepared homeland that can overcome threats, regardless of the source. I am honored and privileged to serve as resource to you now and going forward.



DALLAS COUNTY JUDGE CLAY LEWIS JENKINS

REMARKS FOR THE OCTOBER 10, 2014, FIELD HEARING

One Hundred Thirtieth Congress
U.S. House of Representatives
Committee on Homeland Security
Washington, DC

Local government has treated everyone involved in this Ebola crisis with dignity and compassion as fellow human beings; not merely as disease contacts.

In interacting with the family, it was important that I followed all CDC protocols to avoid any chance of spreading the virus. It was also important that I not move the family while wearing a hazmat suit; for them to see me face to face and for me to converse with them as equals.

That is a basic tenet of leadership and in keeping with modern medicine.

Louise Troh and the three young men have been handling an extraordinarily scary, sad and difficult situation with grace. Louise and Eric's nineteen-year-old son Karsiah is a fine young man forced to deal with the loss of his father without being able to hug and hold his mother.

The death of Eric Duncan is the loss of a father, fiancée, son and person loved by an extended family.

Forty-eight people were found to be potentially-exposed disease contacts by the excellent epidemiological and disease-detection work performed by Dallas County, the State of Texas and the federal government. For these 48 people and their families, this remains a tense and anxious period. They need all of our thoughts and prayers. Thankfully, all are without symptoms or fever on this twelfth day of monitoring.

We are one team, one fight and we are committed to working together.

We activated our Dallas County Emergency Operations Center and are operating under the Incident Command System with federal, state, county and city assets. Many partners, but one team.

One Team, One Fight! Simply said, there is no other way to stop Ebola.

There is a lot of fear out there and I understand why. Ebola is a scary, terrible viral disease. However, there is a zero percent chance of contracting Ebola without coming into contact with the bodily fluids of a symptomatic Ebola victim. People who have been exposed to Ebola but have no fever or symptoms cannot transmit the virus. We must not allow fear and panic to weaken our resolve nor abandon the values that built this great nation.

Everybody has a job to do in this outbreak. The federal, state and local governments are doing their jobs. I urge Congress to pass the appropriations necessary to fight Ebola in Africa which is the best way to stem the epidemic, protect humankind and for you to perform your important role in strengthening and streamlining the Ebola response in the United States.

We are doing something that has not been done before and we cannot fail. We will contain Ebola in Dallas, Texas. It's only a matter of time before the next case comes to our shores. Help us, help us win this fight. We must win now. Work with us to fight this disease abroad and strengthen our public health security.

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**Field Hearing: Ebola in the Homeland: The Importance of Effective
International, Federal, State and Local Coordination**

**Committee on Homeland Security
October 10, 2014**

Chairman McCaul, Ranking Member Thompson, and members of the Committee, my name is Catherine Troisi. I am an infectious disease epidemiologist at the University of Texas School of Public Health and, in addition to my years in academia, I have practiced public health at the Houston Department of Health and Human Services. I am also a member of the American Public Health Association, a diverse community of public health professionals who champion the health of all people and communities. Adequate funding at all levels of our public health system is a top priority for the association

Thank you for this opportunity to talk about public health, its role in disease outbreak detection, and recent trends in resources for these important public safety efforts. I'm delighted to remind the members from Texas that the University of Texas School of Public Health has regional campuses in Austin, Brownsville, Dallas, El Paso, and San Antonio, fulfilling our mission to improve and sustain the health of people by providing the highest quality graduate education, research and community service for Texas, the nation, and the world; to provide quality graduate education in the basic disciplines and practices of public health; to extend the evidence base within those disciplines; and to assist public health practitioners, locally, nationally, and internationally, in solving public health problems.

I'd like to start with a definition of public health, a term that is sometimes confused with medical care. Public health has been defined by the U.S. Centers for Disease Control and Prevention (CDC, the nation's public health agency) as "the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases." There are a couple of concepts in that definition I'd like to emphasize. The first is that public health is science-based and the corollary of that is

that we should employ techniques that have been proven to be of value. The second is the idea of protection which implies action before disease occurs. Public health has two main functions – disease prevention and health promotion. As our grandmothers said “an ounce of prevention is worth a pound of cure”. The last concept in this definition that I want to emphasize is that of communities. While traditional medical care is concerned with the individual, public health’s “patient” is the community. Individual interventions can be the mandate of public health, e.g., immunizations, but the overall goal is to protect the community. One specific function of public health agencies, largely limited to governmental public health, is detection of outbreaks of infectious diseases and mitigation of spread.

With these definitions in mind, what are public health tasks? The Institute of Medicine has broken these into three core functions – assessment, policy development, and assurance. In simple terms, this means that public health is responsible for evaluating and responding to health problems in the community as well as prioritizing these efforts, developing policies to protect communities’ health, and assuring that all populations have access to appropriate and cost-effective prevention services. I would argue that this academic and functional definition of public health puts it in the realm of public safety. Just as police protect communities from crime and fire fighters from the devastations of fire, public health protects communities from disease. Indeed, of the 30 years of life expectancy added to the average US life expectancy in the twentieth century, 25 of these are due, not to medical care, but to public health interventions, such as sanitation, immunizations, control of infectious diseases, tobacco control, etc. It’s important to emphasize that we talk about the “public health system” which consists of all organizations involved in protecting and improving the health of the community, whether governmental, medical, non-profit, educational, social services, etc. However, given the scope of these hearings and the fact that it is governmental public health that is largely concerned with detecting and controlling infectious disease outbreaks, I’m going to be talking about governmental local, state, and national public health.

I hope that I have convinced you of the importance of public health efforts in maintaining and promoting the health of our nation and our world. Obviously, this cannot be done without adequate resources. Public health activities occur at the federal, state, and local level and are funded as such. However, the CDC and other federal agencies provide flow through funding for many public health activities at the state and local level. I’m sure that you are much more familiar than I with the negative effects of spending caps and sequestration on public health agencies such as the CDC over the past few years. However, in a nutshell, federal funding for public health has

been relatively flat-funded and has shown a significant decline in recent years (Figure 1).

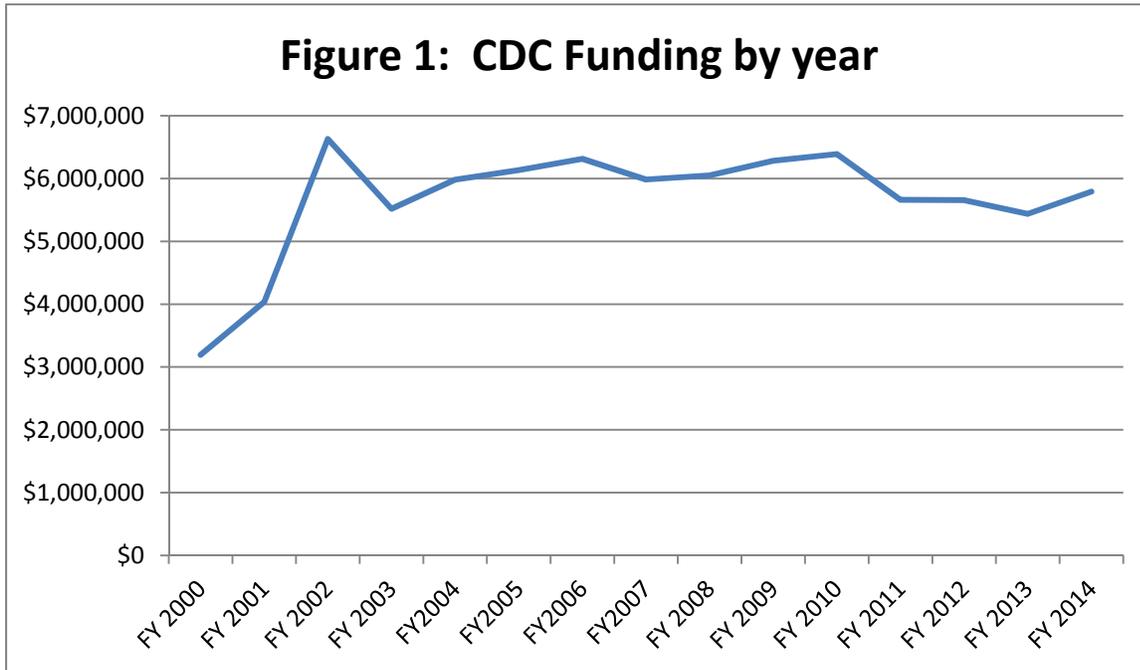
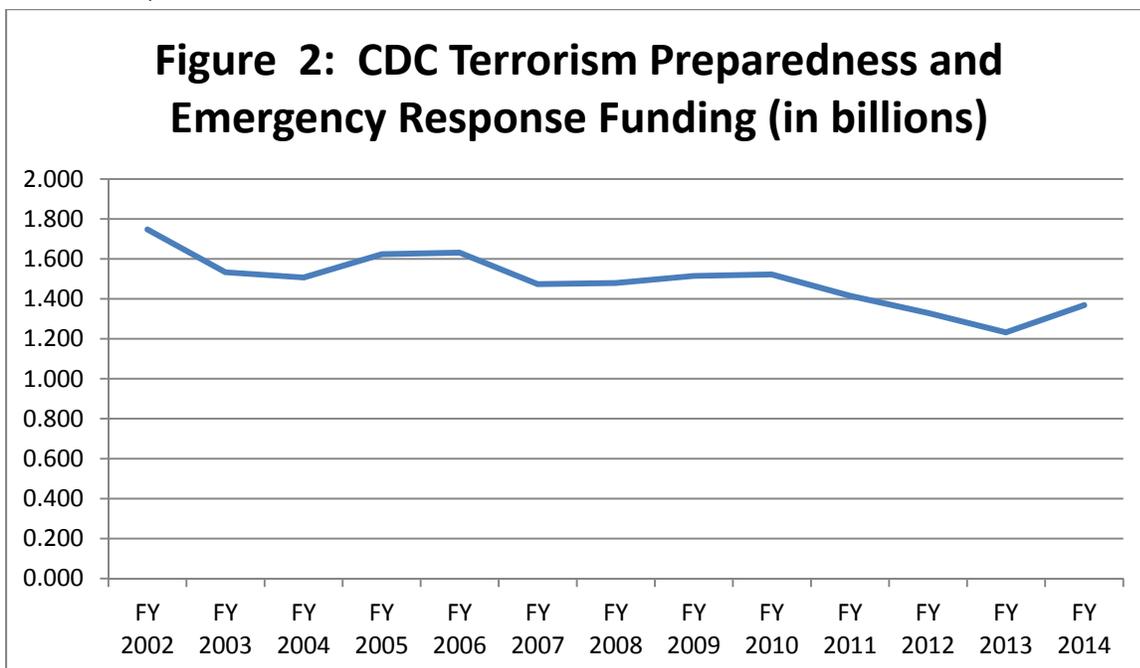


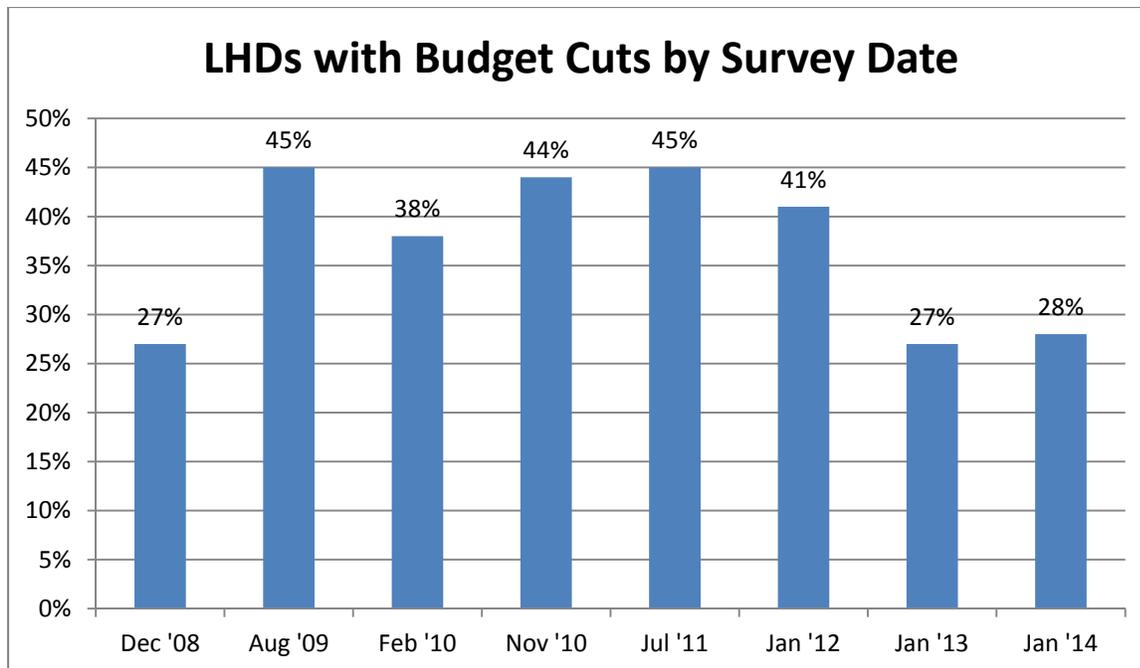
Figure 2 shows the declining level of terrorism preparedness and emergency response funding allotted to CDC for activities at the national, state and local levels and for the Strategic National Stockpile (www.cdc.gov/fmo/topic/Budget%20Information/index.html). Following infusion of after 9/11, levels have been on the decline.



This situation is also reflected at the state level. The Association of State and Territorial Health Officials (ASTHO) reported in September of this year that budget cuts continue to affect the health of Americans. Health departments in 48 states, three territories, and the District of Columbia have had budget cuts since 2008, with 95 percent of state or territorial health departments experiencing reduced services. Approximately 11,000 public health jobs have been lost in state health departments (<http://www.astho.org/budget-cuts-Sept-2014/>). The Trust for America's Health and Robert Wood Johnson Foundation released a report last December showing that the majority of states reached half or fewer of key indicators of policies and capabilities to protect against infectious disease threats. Texas scored 4 out of 10. One of the indicators (increased or maintained level of funding for public health services from FY 2011-12 to FY 2012-2013) was met by only 17 states (Texas was one of these 17 states), meaning that 33 states had decreased funding. Budgets in 20 states decreased two or more years in a row and 16 states had decreased budgets three or more years in a row (<http://healthyamericans.org/report/114/>).

Not unexpectedly, these trends in budget cuts can also be found at the local level. The National Association of County and City Health Officials (NACCHO) administers a biannual survey of local health departments (<http://www.naccho.org/topics/infrastructure/lhdbudget/upload/Survey-Findings-Brief-8-13-13-2.pdf>). Over 1 in 4 local health departments experienced a budget cut in the current fiscal year and, as shown in Figure 3, this has been an ongoing declining trend.

Data from the 2013 survey show that the size of the public health workforce has decreased since 2008 when best estimates were 190,000 (range of 160,000 to 219,000) to 139,000 (range of 139,000 to 185,000), representing a total of 48,300 jobs lost. Almost half (41%) of local health departments nationwide experienced some type of reduction in workforce capacity, with 48 percent of all local health departments reducing or eliminating services in at least one program area. Overall, state and local public health departments, the “boots on the ground” purveyors of public health, have lost over 51,000 jobs since 2008, representing one in five public health jobs.



Now I'd like to put on my infectious disease expertise hat. The news coming out of West Africa is alarming. Almost 7,500 cases of Ebola with almost 3,500 deaths have been reported with many more suspected. Ebola is a frightening disease with horrific symptoms and concern is naturally high that further spread may occur. Is there a possibility that the next pandemic (defined as a world-wide epidemic) will be caused by Ebola? By looking at the characteristics of viruses that can spread world-wide, we can see that while there are some viruses capable of causing pandemics, Ebola is not one of them, and our undue anxiety over spread in the U.S. is diverting attention from true public health concerns.

Characteristics of a pandemic virus include:

- many people are susceptible to becoming infected
- people can transmit the virus before they have symptoms
- the virus causes severe symptoms and deaths
- the virus is easily transmitted from person to person.

While Ebola has the first characteristic and certainly causes many deaths, it is lacking the two important ones – spread before symptoms occur and easy transmission. To become infected with Ebola, you must have physical contact with blood or bodily fluids from someone with symptoms. Unlike other viruses like influenza, people with Ebola are NOT infectious before symptoms appear. We know how to stop transmission by

using barrier nursing practices such as gloves, disinfectants, and patient isolation. Unfortunately, many countries in Africa do not have the resources to provide for these precautions in their hospitals and so spread of Ebola is occurring in the healthcare setting. Adding to the problem are cultural practices where families prepare bodies of Ebola victims for burial, inadvertently becoming exposed to the virus. The conditions for spread of the Ebola virus in the US and other resource rich countries do not exist and the only danger is that we may be fixated on this virus and not on ones that could actually cause world-wide harm.

Given these characteristics, there *are* viruses that have outbreak or pandemic potential (or have caused these in the past) that public health agencies need to be on the lookout for – viruses such as influenza, SARS (severe acute respiratory syndrome), and MERS-CoV (Middle East Respiratory Syndrome), among others. Other “common” viruses such as measles and pertussis periodically cause outbreaks due to lack of immunity among those not vaccinated. Influenza is a virus that has caused pandemics in the past and has the potential to do so again. The virus can mutate so much that it’s like a new virus no one has experienced before and so no-one is immune. The great influenza pandemic of 1918 killed more people than World War I. There was concern in 2009 (when a new influenza virus appeared that looked like the 1918 virus) that we would again see a major influenza pandemic. While many people got infected, we were “lucky” that the virus did not kill more people than we typically see each flu season – although that number can be very high and the very young, seniors, and those with underlying illness are particularly susceptible. In Texas alone, over 2,300 people were hospitalized with 20 deaths in children last year. Many more were sick with the disease. Indeed, estimates are that up to 49,000 deaths occur nation-wide each year due to seasonal influenza. Scientists are carefully monitoring some new influenza viruses that have been transmitted from birds to people, killing more than half of those infected, and although so far these avian flu viruses have not spread easily from person to person, the viruses could mutate to allow this to happen. Should this occur, a pandemic, with resultant high number of deaths, is almost inevitable.

MERS-CoV is caused by a virus currently occurring throughout countries in the Middle East. Although the disease spread through the air, as of right now, the virus does not appear to transmit easily from person to person (camels and/or bats are the most likely source of infection). While the chances of Ebola becoming airborne are exceedingly small (no pathogen has changed the way in which it is spread), it is more likely that small changes in the RNA of MERS-CoV could allow the virus to spread from person-to-person in a more efficient manner. Should this happen, the likelihood of a pandemic increases dramatically.

So what can we do to prepare for potential pandemics? Public health agencies such as CDC are constantly monitoring infections around the world to determine if new viruses are appearing. State and local health departments also are involved. Ebola virus is a major concern for the affected countries and the fear and loss of life are devastating on a humanitarian level. But we do not have to fear spread of the virus to the United States or other resource rich countries. We would better spend our time preparing for diseases such as influenza which do have the potential to cause pandemics around the world, including the United States.

Congress must begin to prioritize public health funding and not just when a crisis occurs. Level or reduced funding for public health activities means that the same or less amount of money must cover prevention activities for an increased population. As recent outbreaks of foodborne illnesses, vaccine preventable diseases, hospital-acquired infections, and emerging infectious diseases have shown, the threats remain and we need our public health community adequately funded to respond to these threats. While we are appreciative of the increased funding to combat Ebola contained in the recent continuing resolution signed by President Obama, an adequate response to the initial outbreak would have mitigated spread within Africa. According to a report by the Congressional Research Service, US funding for World Health Organization (WHO) activities have decreased about one-third from 2010 to 2013. As seen in the US public health system, this decreased funding resulted in WHO job losses and the ability to respond to emergencies such as Ebola.

Thank you for the opportunity to testify before you today about public health and our ability to deal with public health threats. I am happy to answer any questions you may have.