



Taking Measure of Countermeasures Part 3: Protecting the Protectors

Written Testimony of

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Good afternoon, Chairman Bilirakis, Ranking Member Richardson, and members of the committee. I am Chief Al Gillespie, of the North Las Vegas Fire Department located in North Las Vegas, Nevada and the President and Chairman of the Board of the International Association of Fire Chiefs. The International Association of Fire Chiefs represents the leadership of over 1.2 million firefighters and emergency responders. IAFC members are the world's leading experts in firefighting, emergency medical services, terrorism response, hazardous materials spills, natural disasters, search and rescue, and public safety policy. As far back as 1873, the IAFC has provided a forum for its members to exchange ideas, develop professionally, and uncover the latest services available to first responders. The IAFC is also a member of the Emergency Services Coalition for Medical Preparedness. I thank the committee for your continued interest in our nation's medical countermeasures and for the opportunity to represent fire and EMS responders during today's hearing.

My testimony is based upon my experiences as a fire chief. As one of our nation's most attractive tourist destinations, we in the Las Vegas area are a high target for a potential terrorist attack. In response, our department has stood up a Homeland Security & Special Operations Division composed of emergency management, tactical medics, urban search and rescue (USAR), technical rescue, and haz-mat rescue teams.

Our entire department is staffed by over 200 uniformed and civilian employees who provide a great service to our community. Day in and day out, I count on each one of these proud and well-trained men and women to fulfill our diverse missions. As their chief, I know that they will respond rapidly and professionally when called upon for natural and man-made disasters.

Throughout the fire and emergency services as we remembered the 10th anniversary of 9/11, we marked the sacrifice our men and women made that day for our nation. In the days that followed, the first responders continued to serve our nation with little concern for their personal health. We have learned many lessons from the terrorist attacks that day and from the anthrax attacks later that year. With Congress' leadership and support, we have raised preparedness and training in many areas, but there is more work that can be done.

As I've said, as a chief, I know my personnel will respond. If you asked me if they would respond to a fire, the answer is "yes." If you asked me if they would respond to a medical emergency, the answer is "yes." If you asked me if they would respond to a pandemic or a bio-attack, my answer is "yes."

However, in recent years, numerous published studies have uncovered interesting questions and concerns held by responders. For instance, the Journal of Occupational & Environmental Medicine published a study by Columbia University examining the factors associated with the ability and willingness of essential workers to report to duty during a pandemic. The study surveyed 1103 workers from six essential workgroups in Nassau County, New York and found that although a substantial proportion of participants reported that they would be able (80%); much less would be willing (65%) to

report for duty. In fact, only 49% of the participants answered that they would be both able and willing.

Other studies report similar trends. A study published in a 2007 issue of Disaster Management & Response surveyed paramedics to examine their concerns about responding to a pandemic. In this study, 80% of respondents reported they would not stay on duty without protective equipment or proper vaccination. If provided protective equipment, but not a vaccine, this rate decreased to 61% of respondents reported they would not stay on duty. This study also revealed that 91% of the respondents reported they would remain on duty if they were fully protected. While that response rate is a good sign, it dramatically falls to a projected response rate of only 38% if the respondent fears that their immediate family is not protected.

Mr. Chairman, the fire and emergency services will do everything we can to protect our communities, but we need Congress to do all it can to protect first responders and address a major gap in preparedness for a pandemic or a bioterrorist attack in the U.S. Currently, we only have surveys that suggest a lack of response, but we should not wait for an attack to provide absolute proof. Your committee has a strong legislative record of addressing gaps in preparedness from supporting legislation to allocate the D-Block to public safety to authorizing grants and other programs for local governments to increase preparedness capabilities. Although the Pandemic and All-Hazards Preparedness Reauthorization Act has passed both the House and the Senate, I am concerned that unless Congress adds language during the conference committee that focuses on protecting first responders, a major gap will continue to exist.

As such, the IAFC believes Congress should task the Department of Homeland Security (DHS) and the Department of Health and Human Services (HHS) to test and create a voluntary anthrax immunization program. In addition, Congress should request these federal agencies deploy pre-positioned antibiotic kits into the homes of emergency services providers to protect first responders and their families. The DHS and the HHS should work together to boost the immunization levels of all emergency services providers on a voluntary basis and protect responders and their families. Extending these protections to first responders and their families (those who live in the responder's home) will improve preparedness and prevent the responder from infecting their families during times of great national need.

Voluntary Anthrax Immunization Program

First, I would like to reiterate that any anthrax immunization program should be voluntary. We have heard great debate that an anthrax attack is a low-risk threat, due in part to the existence of a vaccine. This vaccine is a major tool in the Strategic National Stockpile (SNS), maintained by the Centers for Disease Control and Prevention (CDC), U.S. Department of Defense (DoD) and other federal agencies, including HHS and DHS. The SNS's cache of antibiotics, chemical antidotes, antitoxins, life-supporting medications, IV administration, airway maintenance supplies, and medical or surgical items is pre-positioned regionally throughout the country and ready to be deployed after an attack. However, if there is an attack, immediate emergency response will be expected

by the public. Under current models, this response will be provided by local jurisdictions whose personnel are not necessarily immunized. This will result in a major lag in response, putting public safety and public health at great risk. The current plan calls for vaccines and medicines to be delivered to any state in the U.S. within 12 hours of Federal and state/local declarations. Each state then utilizes their plan to receive and distribute vaccines and other medicines, which will result in a lengthier time lapse before local emergency services and first response are deployed.

Over time, drugs and vaccines in the SNS expire. While a Shelf-Life Extension Program (SLEP) has been developed for select federal stockpiles, other vaccines and drugs are appropriately rotated out of the SNS and destroyed. Changing federal policy to set up a pilot program that rotates non-expired, potent, and safe vaccines and drugs from the SNS to voluntary emergency responder immunization programs would greatly improve preparedness levels and better utilize federal resources and tax dollars. Additionally, such an effort to rotate and release vaccines to state and local jurisdictions could provide real-world practice for the federal plan to rapidly push out the SNS cache after an attack.

The DHS and the HHS should work together to develop and test a voluntary anthrax vaccination pilot program, which ultimately could address a gap in preparedness and improve emergency response time to a bio-attack. As these departments design the program, they can create record-keeping guidelines to assist chiefs ensure their personnel who volunteer for the program receive the proper and full vaccinations. In addition, utilizing the SNS could lower the costs of standing up such an operation while increasing preparedness levels around the nation.

We have learned that DHS and HHS are developing pilot programs to make vaccines in the SNS available as “federal excess property,” and are interested in receiving more information about this type of program.

Pre-Positioned Antibiotic Kits in the Homes of Emergency Responders

Not all bioterrorist attacks can be treated with a vaccine, which the SNS cache and other federal programs take into account. The National Postal Model (NPM) utilizes postal workers who volunteer to dispense antibiotics after a bioterrorist attack to reduce surge at dispensing points. The brave postal workers who volunteer to serve their nation in such a capacity are provided Household Antibiotic Kits (HAKs) or med-kits. These kits are pre-positioned in their homes and provide coverage for the individual and their family. This type of program should be extended to pre-position med-kits into the homes of the emergency responders and further mirror the postal model to include the emergency responder’s family.

The United States Postal Service (USPS) along with HHS, local and state public health and law enforcement partners tested the operational capability to distribute medical countermeasures through the National Postal Model with three Cities Readiness Initiative (CRI) proof-of-concept drills (in Seattle, Boston, and Philadelphia) and a comprehensive pilot in Minneapolis/St. Paul. The CDC also conducted a Home Med-Kit Evaluation Pilot Study in St. Louis to examine the household’s ability to maintain the kit as directed and

preserved for emergency use. This study found that of 4,000 households, including first responders, corporation employees, and community health clinic staff, 97% of participants returned their med-kit intact at the end of the study. While this is just one study, I firmly believe that the emergency services community can be trusted to follow instructions and maintain med-kits in their home. To do so, instructions for the kits will have to be developed that address best practices for storage, as we know that the bathroom medicine cabinet is one of the worst places to store medications due to temperature and humidity issues.

Pre-positioning med-kits into the homes of emergency responders will address a time-gap in preparedness. During an attack, if first responders are waiting for the release of medical countermeasures from the SNS to the state and then through public health agencies to responders, they have indicated through multiple studies less inclination to report for duty. For a response to disasters or attacks, this lag time may create an unacceptable situation, and pre-positioned med-kits for emergency responders and their families are warranted.

Emergency response is primarily a local responsibility. First responders throughout our nation are rightfully assumed to be able and willing to respond to emergencies including disasters and attacks. However, we do not send firefighters to a call without the proper equipment and training. Our ability to fulfill our missions requires proper preparation. Congress must address the current gaps to enhance emergency service providers' willingness and ability to safely respond and save lives during a biological emergency.

On behalf of America's fire and EMS leaders, I would like to thank you for holding this hearing and the opportunity to address this subcommittee. I look forward to answering any questions that you may have.