Mr. WALKER. Thank you very much.

I appreciate the opportunity to participate in the committee's hearing on pandemic influenza and continuity planning. As each of you are well aware, the Government plays many important roles in responding to emergency situations, such as natural disasters, terrorist events, and pandemic flu outbreaks should they occur.
But in order to provide both direct emergency response as well as other essential services, Government agencies must be positioned to continue functioning even when the agencies themselves are disrupted. Accordingly, agencies are required to develop plans to ensure continuity of operations, or so-called COOP plans.

In preparing such plans, the executive branch agencies are to follow guidance that is issued by the Federal Emergency Management Agency [FEMA]. In developing COOP plans, a potentially useful option is telework. That is employees performing work from remote sites, often their homes or another location that is not a traditional office.

As we pointed out in April 2004, telework offers potential benefits to employers, employees, and society as a whole in the normal course of operations. It is also important and a viable option for Federal continuity planning, especially as the duration of an emergency is extended, which would be the case if a flu pandemic were to come to the United States.

According to health experts, absentee rates in a pandemic could reach 40 percent during peak periods. The need for care for family members, the need to deal with the illness, and the fear of infection would have a broad-based effect within the country.

In such a situation, the use of telework or other means to avoid unnecessary contacts among people, which is referred to as social distancing measures, is clearly appropriate. This is recognized by recent executive branch guidance recommending social distancing measures, such as telework and public health interventions, to control and contain infection during a pandemic outbreak.

GAO recognizes the importance of telework in continuity planning and is striving to lead by example on these issues. For example, about 13.5 percent of GAO employees used telework last year, as compared to 5.2 percent for Federal civilian employees in 2004.

Furthermore, our current telework policy allows me, during certain emergencies, to approve telework for all employees in an affected area to promote continuity of operations. We are also completing a supplement to our COOP plan that addresses preparation specific to a pandemic and are coordinating our continuity planning efforts with those of other legislative branch agencies and of Congress as a whole.

As per your request, the balance of my remarks will focus on the report that we are issuing today, which was referred to by Mr. Davis. In 2005, we previously issued a report based upon a survey of Federal officials responsible for continuity planning at 23 major agencies. For the current report, we basically reissued the same survey in order to try to be able to get an update and find out what type of progress has been made.

This time, more agencies reported plans for essential team members to telework during the COOP event than in the previous survey. However, only a few of the agencies documented that they had made the necessary preparations to effectively use telework during an emergency.

For example, although 9 of 23 agencies reported that they expected some of their essential team members to telework during a COOP event, only 1 agency documented that it had notified its team members of this expectation. In addition, none of the 23 agen-
cies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during an emergency, and only 3 of 23 agencies documented that they had actually tested the ability of their staff to telework effectively during an emergency.

One reason why agencies reported these low levels of preparation for telework is that none of FEMA's COOP guidance addresses the steps that agencies should take to ensure that they are fully prepared to use telework during a COOP event. In 2005, when we reported on the previous survey, we recommended that FEMA develop such guidance in consultation with the Office of Personnel Management. Unfortunately, this guidance has yet to be created.

This guidance suggests the use of telework and recommends that agencies consider which essential functions should be performed from remote locations, such as employee homes. That's the most recent guidance that the agency—that the executive branch has issued.

However, the guidance still does not address the steps that agencies should take when preparing to use telework during an emergency. For example, it does not address certain necessary preparations, such as informing designated staff that they are expected to telework or providing them with adequate technical resources and support to make it effective.

If agencies do not make adequate preparations, they may not be able to use telework effectively to ensure the continuity of their essential functions in emergencies, including in the event of a pandemic influenza. Accordingly, we recommended in our report that FEMA establish a timeline for developing such guidance. DHS partially agreed with our recommendation and stated that FEMA will cooperate with OPM in developing this timeline.

Last week, the White House released an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls for OPM to work with DHS and other agencies to revise existing telework guidance and to issue new guidance on human capital planning and COOP planning. The plan establishes an expectation that these actions will be completed within the next 3 months. We'll see.

We are encouraged that DHS has now established a timeline for issuing revised telework guidance. However, unless the forthcoming guidance addresses the necessary preparations, agencies may not be able to use telework effectively to ensure the continuity of essential functions.

On the other hand, if they prepare telework effectively, agencies could enable both essential and nonessential employees to contribute to agency missions during the extended emergencies, including a pandemic influenza.

Mr. Chairman, thank you very much. And I obviously will make Ms. Koontz available for any questions that you may have or the other members of the committee.

[NOTE.—The May 2006 GAO report entitled, “Continuity of Operations, Selected Agencies Could Improve Planning for Use of Alternate Facilities and Telework during Disruptions,” GAO–06–713, may be found in committee files.]

[The prepared statement of Mr. Walker follows:]
United States Government Accountability Office

Testimony
Before the Committee on Government Reform, House of Representatives

CONTINUITY OF OPERATIONS
A agencies Could Improve Planning for Telework during Disruptions

Statement of David M. Walker
Comptroller General of the United States
CONTINUITY OF OPERATIONS

Agencies Could Improve Planning for Telework during Disruptions

What GAO Found

Although agencies are not required to use telework in continuity planning, 9 of the 23 agencies surveyed reported plans for essential team members to telework during a COOP event, compared to 5 in GAO’s previous survey. However, few documented that they made the necessary preparations to effectively use telework during such an event. For example, only 1 agency documented that it had communicated this expectation to its emergency team members. One reason for the low levels of preparations reported is that FEMA has not provided specific guidance on preparation needed to use telework during emergencies.

Recently, FEMA disseminated guidance to agencies on incorporating pandemic influenza considerations into COOP planning. Although this guidance suggests the use of telework during such an event, it does not address the steps agencies should take when preparing to use telework during an emergency. Without specific guidance, agencies are unlikely to adequately prepare their telework capabilities for use during a COOP event. In addition, inadequate preparations could limit the ability of essential employees to contribute to agency missions during extended emergencies, including pandemic influenza.

In its report released today, GAO recommends, among other things, that FEMA establish a time line for developing, in coordination with the OPM, guidance on preparations needed for using telework during a COOP event. In commenting on a draft of the report, DHS partially agreed with GAO’s recommendation and stated that FEMA will coordinate with OPM in developing a time line for further telework guidance. DHS also stated that both FEMA and OPM have provided telework guidance. However, as GAO’s report stated, present guidance does not address the preparations federal agencies should make for using telework during emergencies.

On May 3 the White House announced the release of an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls on OPM to work with DHS and other agencies to revize existing telework guidance and issue new guidance on human capital planning and COOP. The plan establishes an expectation that these actions will be completed within 9 months. If the forthcoming guidance does not require agencies to make necessary preparations for telework, agencies are unlikely to take all the steps necessary to ensure that employees will be able to effectively use telework to perform essential functions in extended emergencies, such as a pandemic influenza.
Mr. Chairman and Members of the Committee:

I appreciate the opportunity to participate in the Committee’s hearing on pandemic influenza and continuity of operations (COOP) planning. As you know, essential government services can be interrupted by a range of events, including terrorist attacks, severe weather, building-level emergencies, and public health emergencies, such as pandemic influenza. The federal government requires agencies to develop plans for ensuring the continuity of essential services during such emergencies. To assist agencies, the Federal Emergency Management Agency (FEMA), within the Department of Homeland Security (DHS), which is responsible for managing federal response and recovery efforts following any national incident, has issued guidance that defines the elements of a viable COOP capability.

A potentially useful option for continuity planning is telework (in which work is performed at an employee’s home or at a work location other than a traditional office); this alternative has gained widespread attention over the past decade in both the public and private sectors as a human capital flexibility that offers a variety of potential benefits to employers, employees, and society. In a December 2005 report to Congress, the Office of Personnel Management (OPM) indicated that 43 of the 82 federal agencies it surveyed had employees eligible to telework during 2004, and more than 140,000 federal employees used telework that year.1

OPM also reported that there is a symbiotic relationship between COOP and telework because many government functions that must be carried out in emergencies can be accomplished using telework. Similarly, we reported in April 2004 that telework is an important and viable option for federal agencies in continuity planning and implementation efforts, especially as the duration of an emergency event is extended.2 This option appears particularly appropriate in

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the case of pandemic influenza, which occurs when an influenza virus causes an outbreak of disease that spreads easily from person to person and results in serious illness worldwide. Experts believe that the effects of a pandemic could come in waves that last for weeks or even months, in which time absentee rates could reach 40 percent during peak periods due to illness, the need to care for family members, and fear of infection. Recent executive branch guidance states that social distancing measures, such as telework, may be appropriate public health interventions for infection control and containment during a pandemic outbreak.

GAO recognizes the importance of telework and continuity planning and is striving to lead by example on these issues. For example, during certain emergencies, our current telework policy allows me to approve telework for all employees in an affected area to promote continuity of operations. We are also completing a supplement to our COOP plan that addresses preparations specific to a pandemic, and are coordinating our continuity planning efforts with those of other legislative branch agencies.

As you requested, I will discuss how agencies are addressing the use of telework in their continuity planning, based on work described in a report that we are issuing today. In earlier work, we identified steps agencies that should take to effectively use telework during an emergency, and we surveyed agency officials responsible for continuity planning at 23 major agencies. For this report, we repeated this survey to obtain updated information on the extent to which key telework practices were used in making continuity preparations. We reviewed documentation submitted by agency officials to support their survey responses and compared these responses to those from our earlier work; we briefed your staff on the results of our work on April 13, 2006. This work was conducted


in accordance with generally accepted government auditing standards.

Results in Brief

More agencies reported plans for essential team members to telework during a COOP event than in our previous survey, but few documented that they made the necessary preparations to effectively use telework during an emergency:

- Nine of the 23 agencies reported that some of their essential team members are expected to telework during a COOP event. However, only one agency documented that it had notified its team members of the expectation that they would telework during such an event.
- None of the 23 agencies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during an emergency.
- Only 3 of the 23 agencies documented testing the ability of staff to telework during an emergency.

FEMA's guidance on COOP planning does not include specific information on preparations to use telework during emergencies; the absence of such specific guidance contributed to the low levels of preparations that agencies reported. Recently, FEMA disseminated additional guidance to agencies regarding the incorporation of pandemic influenza considerations into COOP planning. Although this guidance suggests the use of telework during such an event, it does not address the steps agencies should take when preparing to use telework during an emergency. If agencies do not make adequate preparations, they may not be able to use telework effectively to ensure the continuity of their essential functions in emergencies, including pandemic influenza events.

In our report, we recommended, among other things, that FEMA establish a time line for developing, in consultation with OPM, guidance on preparations needed for using telework during a COOP event. In commenting on a draft of this report, DHS partially agreed.
with our recommendation and stated that FEMA will coordinate with OPM in the development of a time line for telework guidance.

Background

Federal operations and facilities have been disrupted by a range of events, including the terrorist attacks on September 11, 2001; the Oklahoma City bombing; localized shutdowns due to severe weather conditions, such as hurricanes Katrina, Rita, and Wilma in 2005; and building-level events, such as asbestos contamination at the Department of the Interior's headquarters. In addition, federal operations could be significantly disrupted by people-only events, such as an outbreak of severe acute respiratory illness (SARS). Such disruptions, particularly if prolonged, can lead to interruptions in essential government services. Prudent management, therefore, requires that federal agencies develop plans for dealing with emergency situations, including maintaining services, ensuring proper authority for government actions, and protecting vital assets.

Until relatively recently, continuity planning was generally the responsibility of individual agencies. In October 1998, Presidential Decision Directive (PDD) 67 identified FEMA—which is responsible for leading the effort to prepare the nation for all hazards and managing federal response and recovery efforts following any national incident—as the lead agent for federal COOP planning across the federal executive branch. FEMA's responsibilities include:

- formulating guidance for agencies to use in developing viable plans;
- coordinating interagency exercises and facilitating interagency coordination, as appropriate; and
- overseeing and assessing the status of COOP capabilities across the executive branch.

In July 1999, FEMA issued the first version of Federal Preparedness Circular (FPC) 65, its guidance to the federal executive branch on developing viable and executable contingency plans that facilitate the performance of essential functions during any emergency. FPC 65 applies to all federal executive branch departments and agencies
at all levels, including locations outside Washington, D.C. FEMA released an updated version of FPC 65 in June 2004, providing additional guidance to agencies on each of the topics covered in the original guidance.

In partial response to a recommendation we made in April 2004, the 2004 version of FPC 65 also included new guidance on human capital considerations for COOP events.\(^1\) For example, the guidance instructed agencies to consider telework—also referred to as telecommuting or flexplace—as an option in their continuity planning.

Telework has gained widespread attention over the past decade in both the public and private sectors as a human capital flexibility that offers a variety of potential benefits to employers, employees, and society. In a 2003 report to Congress on the status of telework in the federal government, the Director of OPM described telework as "an invaluable management tool which not only allows employees greater flexibility to balance their personal and professional duties, but also allows both management and employees to cope with the uncertainties of potential disruptions in the workplace, including terrorist threats."\(^2\) A 2005 OPM report on telework notes the importance of telework in responding flexibly to emergency situations, as demonstrated in the wake of the devastation caused by Hurricane Katrina, when telework served as a tool to help alleviate the issues caused by steeply rising fuel prices nationwide.\(^7\)

In 2004, we surveyed major federal agencies at your request to determine how they planned to use telework during COOP events.\(^8\)

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\(^8\) The plans that we reviewed in 2004 were created before the issuance of FEMA’s revised FPC 65, which instructs agencies to consider the use of telework in their continuity planning.
We reported that, although agencies were not required to use telework in their COOP plans, 1 of the 21 agency continuity plans in place on May 1, 2004, documented plans to address some essential functions through telework. In addition, 10 agencies reported that they intended to use telework following a COOP event, even though those intentions were not documented in their continuity plans.

The focus on using telework in continuity planning has been heightened in response to the threat of pandemic influenza. In November 2006, the White House issued a national strategy to address this threat, which states that social distancing measures, such as telework, may be appropriate public health interventions for infection control and containment during a pandemic outbreak. The strategy requires federal departments and agencies to develop and exercise preparedness and response plans that take into account the potential impact of a pandemic on the federal workforce. It also tasks DHS—the parent department of FEMA—with developing plans to implement the strategy in regard to domestic incident management and federal coordination. In May 2006, the White House issued an implementation plan in support of the pandemic strategy. This plan outlines the responsibilities of various agencies and establishes time lines for future actions.

Few Agencies Demonstrated That They Had Adequately Prepared to Use Telework in a COOP Event

Although more agencies reported plans for essential team members to telework during a COOP event than in our 2004 survey, few documented that they had made the necessary preparations to effectively use telework during an emergency. While FPC 65 does not require agencies to use telework during a COOP event, it does state that they should consider the use of telework in their continuity plans and procedures. All of the 23 agencies that we surveyed indicated that they considered telework as an option during COOP planning, and 15 addressed telework in their COOP plans (see table 1). For agencies that did not plan to use telework during a COOP event, reasons cited by agency officials for this decision included (1) the need to access classified information—
which is not permitted outside of secured areas—in order to perform agency essential functions and (2) a lack of funding for the necessary equipment acquisition and network modifications.

<table>
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<th>Table 1: Agency Responses to Selected Questions on Telework in COOP Plans</th>
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<td><strong>Question</strong></td>
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<td>Does the agency's COOP plan specifically address telework?</td>
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<td>Are any of the agency's essential team members expected to telework in a COOP event?</td>
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<td>Were staff informed of their responsibility to telework during a COOP event?</td>
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<td>Has the agency ensured that it has adequate technological capacity for staff to telework during a COOP event?</td>
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<td>Will the agency provide technological assistance to staff during a COOP event?</td>
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<td>Has the agency tested the ability of staff to telework during a COOP event?</td>
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Source: Analysis of agency responses to COOP questions.

*Agencies provided a positive response but did not provide adequate documentation to support their responses.

*In 2004, one agency did not respond, resulting in a total of 22 responses.

The agencies that did plan to use telework in emergencies did not consistently demonstrate that they were prepared to do so. We previously identified steps agencies should take to effectively use telework during an emergency. These include preparations to ensure that staff has adequate technological capacity, assistance, and training. Table 1 provides examples of gaps in agencies' preparations, such as the following:

- Nine of the 23 agencies reported that some of their COOP essential team members are expected to telework during a COOP event. However, only one agency documented that it had notified its team members that they were expected to telework during such an event.

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None of the 23 agencies demonstrated that it could ensure adequate technological capacity to allow designated personnel to telework during a COOP event.

No guidance addresses the steps that agencies should take to ensure that they are fully prepared to use telework during a COOP event. When we reported the results of our 2004 survey, we recommended that the Secretary of Homeland Security direct the Under Secretary for Emergency Preparedness and Response to develop, in consultation with OPM, guidance on the steps that agencies should take to adequately prepare for the use of telework during a COOP event. However, to date, no such guidance has been created.

In March 2006, FEMA disseminated guidance to agencies regarding the incorporation of pandemic influenza considerations into COOP planning. The guidance states that the dynamic nature of a pandemic influenza requires that the federal government take a nontraditional approach to continuity planning and readiness. It suggests the use of telework during such an event. According to the guidance, agencies should consider which essential functions and services can be conducted from a remote location (e.g., home) using telework. However, the guidance does not address the steps agencies should take when preparing to use telework during an emergency. For example, although the guidance states that agencies should consider testing, training, and exercising of social distancing techniques, including telework, it does not address other necessary preparations, such as informing designated staff of the expectation to telework or providing them with adequate technical resources and support.

Earlier this month, after we briefed your staff, the White House released an Implementation Plan in support of the National Strategy for Pandemic Influenza. This plan calls on OPM to work with DHS and other agencies to revise existing telework guidance and issue new guidance on human capital planning and COOP. The plan establishes an expectation that these actions will be completed within 3 months.

If the forthcoming guidance from DHS and other responsible agencies does not require agencies to make the necessary
preparations for telework, agencies are unlikely to take all the steps necessary to ensure that employees will be able to effectively use telework to perform essential functions during any COOP event. In addition, inadequate preparations could limit the ability of nonessential employees to contribute to agency missions during extended emergencies, including a pandemic influenza scenario.

In summary, Mr. Chairman, although more agencies reported plans for essential team members to telework during a COOP event than in our previous survey, few documented that they had made the necessary preparations to effectively use telework during an emergency. In addition, agencies lack guidance on what these necessary preparations are. Although FEMA's recent telework guidance does not address the steps agencies should take to prepare to use telework during an emergency event, new guidance on telework and COOP is expected to be released later this year. If the new guidance does not specify the steps agencies need to take to adequately prepare their telework capabilities for use during an emergency situation, it will be difficult for agencies to make adequate preparations to ensure that their teleworking staff will be able to perform essential functions during a COOP event.

In our report, we made recommendations aimed at helping to ensure that agencies are adequately prepared to perform essential functions following an emergency. Among other things, we recommended that the Secretary of Homeland Security direct the FEMA Director to establish a time line for developing, in consultation with OPM, guidance on the steps that agencies should take to adequately prepare for the use of telework during a COOP event.

In commenting on a draft of the report, the Director of DHS's Liaison Office partially agreed with this recommendation and stated that FEMA will coordinate with OPM in the development of a time line for further telework guidance. In addition, he stated that both FEMA and OPM have provided guidance on the use of telework. However, as stated in our report, present guidance does not address the preparations agencies should make for using telework during emergencies.
With the release of the White House's Implementation Plan regarding pandemic influenza, a time line has now been established for the issuance of revised guidance on telework; however, unless the forthcoming guidance addresses the necessary preparations, agencies may not be able to use telework effectively to ensure the continuity of their essential functions.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Committee may have at this time.

Contacts and Acknowledgements

For information about this testimony, please contact Linda D. Koontz at (202) 512-6240 or at koontzd@gao.gov. Key contributions to this testimony were made by James R. Sweetman, Jr., Assistant Director; Barbara Collier; Sairah Ijaz; Nick Marinov; and Kim Zelentiz.
Chairman Tom Davis. Thank you, Mr. Walker.
If you don’t mind just coming up here a quick second, we will
start with you, Ms. Springer. Thank you.

STATEMENT OF LINDA SPRINGER

Ms. Springer. Thank you, Mr. Chairman and members of the
committee.
OPM appreciates being invited to testify before this committee
today about the steps we are taking to prepare the Federal Govern-
ment as an employer for the possibility of a pandemic influenza.

The President’s Implementation Plan for the National Strategy
for Pandemic Influenza tasks OPM with developing appropriate
guidance on human resources management policies relating to a
possible flu epidemic. In addition, the implementation plan directs
OPM to update three existing telework guides.

We’ve approached these tasks with a set of guiding principles in
mind. First, that we should cause no harm. In other words, don’t
induce any panic or contribute to that type of atmosphere in the
Federal work force while, at the same time, maintaining a sense
of urgency.

Communication will be a key to carrying out our role. Our com-
munications with Federal agencies and employees on these HR
issues relating to a possible pandemic epidemic would be credible,
clear, timely, frequent, visible, and sensitive.

In coordination with the White House, we will consult with other
key departments and agencies, as well as the Chief Human Capital
Officers Council and the Federal executive boards, to identify the
issues to be addressed in our guidance materials and the audiences
to which these materials should be directed.

Our policies will strike an appropriate balance between the insti-
tutional interests of the Federal Government as an employer and
the needs and concerns of individual Federal employees and their
families.

Finally, we will draw on OPM’s considerable experience in pro-
viding advice and assistance to Federal agencies and employees in
emergency situations. The internal pandemic working group we
have already established at OPM has been at work identifying cat-
egories of human resource issues for which guidance already exists,
needs revision, or should be developed.

We’ve been aided in this process by keeping an inventory of ques-
tions we’ve already received from Federal HR professionals and
from individual employees. I’d like to share a couple of those with
you and give you a sense——

Mr. Shays [presiding]. I am going to interrupt you and ask you,
Mr. Walker, why don’t you get on your way? Because you have
things you have to do.
Mr. Walker. Thank you, Mr. Chairman.
Mr. Shays. Thank you. You are making me nervous here.
[Laughter.]
I am sorry to interrupt you.
Ms. Springer. We’ve received so far dozens of questions from
employees from HR professionals in the Federal Government. I will
give you a couple of examples, and you’ll get the flavor of this.
Question No. 1, what kinds of alternative work arrangements are available to assist agencies and employees in accomplishing a critical agency mission during a pandemic influenza?

Local health officials have confirmed that since the children in my son’s daycare center have been exposed to the flu, their families have also been exposed to the virus. My child is not yet sick. What leave may I take to care for my child?

Another one. My elderly mother died due to complications from the flu. I have to make arrangements for and attend her funeral. May I use sick leave?

If I have been designated as an emergency employee, may I refuse to report for work if I don’t think it is safe to do so?

And these go on and on and on. And that’s been an ongoing indicator to us of the concern and the interest at all levels throughout the civilian work force.

So while we have not yet finalized answers to these questions and the others that we’ve received, or completed our consultation with other Federal departments and agencies, it is clear that our guidance materials must include information on alternative work arrangements.

We’re also keenly aware of this committee’s interest in ensuring that Federal agencies take appropriate steps to integrate telework policies into their continuity of operations plans. And let me assure you that we will include a discussion on teleworking options and policies in our guidance to Federal agencies, as we’re required to do under the President’s plan.

Our guidance will also describe relevant leave and work scheduling policies, as well as other benefits and flexibilities designed to assist Federal employees in the event of a pandemic influenza. In addition, our guidance will include information on hiring flexibilities and additional categories of guidance that we will identify as our review continues.

OPM is on track to meet the 3-month deadline specified in the President’s implementation plan. In addition, we anticipate and plan to release some information interimly during that 90-day period.

It is important to note that OPM must prepare to carry out its own responsibilities in the event of a pandemic influenza. We will be practicing our plan for continuing to carry out the work that Congress and the President have entrusted to us. We expect that what we learn from these efforts will help inform the guidance we provide to other Federal agencies and employees.

Mr. Chairman, I appreciate again the opportunity to testify today and look forward to any questions you may have.

[The prepared statement of Ms. Springer follows:]
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STATEMENT OF LINDA M. SPRINGER
DIRECTOR
OFFICE OF PERSONNEL MANAGEMENT

before the

COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

on

PANDEMIC INFLUENZA PREPAREDNESS EFFORTS

MAY 11, 2006

Mr. Chairman and Members of the Committee:

Thank you for inviting OPM to testify before this committee today about the steps we are taking to prepare the Federal Government, as an employer, for the possibility of a pandemic influenza. This responsibility is consistent with our mission to ensure the Federal Government has an effective civilian workforce. As the President’s principal advisor on human resources management policies in the Federal Government, OPM has a Governmentwide role to play in preparing for a possible pandemic influenza.

The President’s Implementation Plan for the National Strategy for Pandemic Influenza (Implementation Plan) tasks OPM with developing appropriate guidance on human resources (HR) management policies relating to a possible pandemic influenza. In addition, the President’s Implementation Plan directs OPM to update three existing telework guides. But even before the Implementation Plan was released by the White House last week, I established an internal working group to identify issues facing Federal HR professionals and other officials responsible for ensuring that the business of
Government continues even in the face of potential disruptions to the Federal workforce caused by a pandemic influenza. The working group also is charged with addressing the concerns of Federal employees regarding the possibility that they, or members of their family, might be affected by a pandemic influenza.

We have approached these tasks with a set of guiding principles in mind. First, we should “cause no harm” and avoid contributing to an atmosphere of panic in the Federal workforce, while at the same time maintaining a sense of urgency. Communication will be key to carrying out our role. Our communications with Federal agencies and employees on HR issues relating to a possible pandemic influenza will be credible, clear, timely, frequent, visible, and sensitive. In coordination with the White House, we will consult with other key departments and agencies, as well as the Chief Human Capital Officers Council and Federal Executive Boards, to identify the issues to be addressed in our guidance materials and the audiences to which these materials should be directed. Our policies will strike an appropriate balance between the institutional interests of the Federal Government as an employer and the needs and concerns of individual Federal employees and their families. Finally, we will draw on OPM’s considerable experience in providing advice and assistance to Federal agencies and employees in emergency situations.

OPM will reach out to any information source or other resource that can help us carry out the tasks assigned by the President’s Implementation Plan.

The internal Pandemic Working Group we established at OPM has already been at work identifying the categories of HR issues for which guidance already exists, needs revision, or should be developed. We’ve been aided in this process by keeping an
inventory of questions we’ve already received from Federal HR professionals and individual employees. Here is a sampling of the questions we’ve received so far:

What kinds of alternative work arrangements are available to assist agencies and employees in accomplishing a critical agency mission during a pandemic influenza?

Local health officials have confirmed that since the children in my son’s day care center have been exposed to the flu virus, their families have also been exposed to the virus. My child is not yet sick. What leave may I take to care for my child?

My elderly mother died due to complications from the flu. I have to make arrangements for and attend her funeral. May I use sick leave?

If I have been designated as an emergency employee, may I refuse to report for work if I don’t think it is safe to do so?

While we have not yet finalized answers to the questions we’ve received so far or completed our consultation with other Federal departments and agencies, it is clear that our guidance materials must include information on alternative work arrangements and other HR policies—including telework policies—that can assist Federal agencies in continuing to perform their critical missions in the event of a pandemic influenza. We are keenly aware of this Committee’s interest in ensuring that Federal agencies take appropriate steps to integrate telework policies into their continuity of operations plans. Let me assure you that we will include a discussion on teleworking options and policies in our guidance to Federal agencies.

Our guidance also will describe relevant leave and work scheduling policies, as well as other benefits and flexibilities designed to assist Federal employees and their families in the event of a pandemic influenza. In addition, our guidance will include
information on hiring flexibilities available to deal with the possibility that large numbers of Federal employees might be unable to carry out their duties and responsibilities for an extended period of time—at least on a local or regional basis, if not on a national or worldwide basis. We may identify additional categories of guidance that should be provided as our review continues.

OPM is on track to meet the 3-month deadline specified in the President’s Implementation Plan. In addition, we anticipate that some information will be provided in the interim.

It is important to note that OPM also must prepare to carry out its own responsibilities in the event of a pandemic influenza. To this end, we have been updating OPM’s critical responsibilities and tasks and making decisions about how those tasks will be accomplished in the adverse circumstances presented by a different kind of emergency situation. We will be practicing our plan for continuing to carry out the work Congress and the President have entrusted to us. We expect that what we learn from these efforts will help inform the guidance we provide other Federal agencies and employees. We will also encourage other Federal Departments and agencies to practice their continuity of operations plans in the context of a possible pandemic influenza.

The Federal Government must ensure that it can respond to the needs of our employees so that we will be able to respond to the needs of the Nation. OPM will fulfill its responsibility to prepare the Federal Government to do just that.

Thank you again for the opportunity to testify today. I look forward to responding to any questions you may have.
Mr. SHAYS. Thank you.
I want to make sure I am pronouncing your name correctly. It is Dr. Agwunobi?
Dr. AGWUNOBI. That is correct.
Mr. SHAYS. Thank you. Your mic needs to be on. So you have to hit that button there.
Dr. AGWUNOBI. That is correct.
Mr. SHAYS. Thank you. Lovely to have you here. Thank you. You have the floor.

STATEMENT OF JOHN O. AGWUNOBI, M.D.

Dr. AGWUNOBI. Thank you, Mr. Chairman and members of the committee, for this opportunity to testify before you on the critically important subject of pandemic influenza preparedness.

Pandemics are, indeed, a fact of life, a reality of living on this planet. They have occurred numerous times in the past, and they will likely, unfortunately, occur in the future.

Our ultimate goal must, therefore, be to achieve a constant, yet flexible state of national preparedness, an enduring national ethic of readiness for any and, indeed, for all hazards.

If the next pandemic is anything like the one that we experienced as a planet in 1918, I know currently of no nation that can credibly claim to be ready today. Therefore, much work remains to be done.

We hope and pray that the next pandemic is a mild one. But as my colleague Julie Gerberding often says at the CDC, hope is not a strategy, and prayer is not a plan. More, quite frankly, is expected of Government.

Fortunately, some recent modeling shows that with aggressive Nation-wide preparedness, exercised readiness—not just a paper plan, but an exercised plan—and an unhesitant leadership when the alarm bell rings, that we can actually manage our way through a pandemic, greatly reducing its negative impact on individuals and our community.

We learn more with each passing day. And as we learn, we will continue to strengthen our planning and our preparedness.

On November 1, 2005, the President announced the release of the National Strategy for Pandemic Influenza, including a request for $7.1 billion to fund that strategy. Already $3.8 billion has been appropriated, and our journey of preparedness is now well underway.

This month, the White House released a more detailed implementation plan that delineates 300 critical preparedness tasks for agencies of Government and the private sector. Of these, 199 are assigned to the department—the U.S. Department of Health and Human Services.

HHS is clearly identified as being in charge of all the public health and medical aspects of preparedness and our response in a pandemic, and we work very closely with our sister agency, the Department of Homeland Security.

We have international and domestic responsibilities. Our efforts abroad involve the strengthening of international public health and medical partnerships and cooperation, global surveillance, and
rapid response—the building of rapid response capabilities and enhanced capacity globally to respond.

Our efforts at home include improved intra- and interagency collaboration, coordination, at both the horizontal and vertical level across public health in medical communities, the continued strengthening of surge capacity across the Nation, enhanced domestic surveillance, and improved State and local planning and exercising of those plans, including a recent effort to reach out to every State in the form of pandemic summits in which the Secretary himself participated. We've now completed 49, and we continue to reach those that we haven't got to yet.

We focus and recognize the importance of preparedness of individuals and families in this movement to develop a nation prepared for a pandemic. The development of clear and open risk communication is an essential strategy and a part of our plan.

Our efforts include the stockpiling of pre-pandemic H5N1 vaccine and efforts to build our capacity to provide 300 million pandemic vaccine courses within 6 months of the declaration of a pandemic. Our strategy includes efforts to promote scientific research and to advance technology used in vaccine development and manufacturing. While we are working to stockpile antiviral drugs, we are also investing in the search for new and improved antiviral alternatives.

We are working to further the search for rapid, accurate, yet portable diagnostic tests for H5N1, and we continue to stockpile other drugs and resources, including ventilators and personal protective equipment.

In conclusion, Mr. Chairman, preparedness is a journey, not a destination. It's a journey that must be Nation wide, involve Federal, State, and local leaders in partnership, and include every sector of society. Every individual, every community must do their part.

In combination, our efforts to prepare for a pandemic can and will have a dramatic impact on even the worst type of pandemic. But it may also help us resolve the recurring problems that we have seen in recent years with seasonal flu vaccine distribution and perhaps even reduce the dramatic numbers of citizens lost each year to seasonal influenza. As you know, sir, on average about 36,000 lives are lost per year.

Preparedness for a pandemic makes us a nation better prepared for any and all hazards, man made or natural. We're better prepared today than we were yesterday, and Mr. Chairman, I have no doubt we will be better prepared as a nation tomorrow than we are today.

Thank you.

[The prepared statement of Dr. Agwunobi follows:]
Testimony
Before the Committee on Government Reform
U.S. House of Representatives

Working Through an Outbreak: Pandemic Flu Planning and Continuity of Operations

Statement of
John O. Agwunobi, M.D.
Assistant Secretary for Health
U.S. Department of Health and Human Services
Mr. Chairman and members of the Committee, I am honored to be here today to describe for you how the Department of Health and Human Services (HHS) is working to improve the nation’s preparedness for a potential human influenza pandemic. Thank you for the invitation to testify on this issue, which is one of our highest priorities at HHS.

**Strategy and Threat Assessment**

On November 1, 2005, President Bush released the *National Strategy for Pandemic Influenza*, which outlines the roles of the Federal government and sets expectations for State, local, and tribal governments, private and international partners, and individual citizens in preparing for and responding to an influenza pandemic. The following day, Secretary Leavitt announced the *HHS Pandemic Influenza Plan*—a blueprint for all HHS pandemic influenza preparedness and response planning. The HHS Plan provides guidance to national, State, and local policy makers and health departments with the goal of achieving national readiness and the ability to respond quickly and effectively to a pandemic. The HHS plan also includes an outline of key HHS roles and responsibilities during a pandemic. In the event of a pandemic, under the National Response Plan, HHS will lead the public health and medical response with the Department of Homeland Security carrying out its responsibility for overall domestic incident management and Federal coordination. However, ultimately, the center of gravity for such a response will be at the state and local level.
As you know, the President requested $7.1 billion in emergency funding for the National Strategy for Pandemic Influenza, of which $6.7 billion was requested for HHS. Congress appropriated $3.8 billion as the first installment of the President's request to begin these priority activities, and of this amount, $3.3 billion was provided to HHS. We appreciate the action of Congress on this appropriation as it takes us an essential step forward to becoming the first generation in history to be prepared for a possible pandemic.

We must also continue to prepare against a possible pandemic influenza outbreak. The President's Budget includes $2.3 billion in funding for the 2007 portion of the emergency funding request to fulfill the next phase of the Strategy. It is vital that this funding be allocated in the most effective manner possible to achieve our preparedness goals, including producing pandemic influenza vaccine for every American within six months of detection of sustained human-to-human transmission of bird flu virus; ensuring access to enough antiviral treatment courses sufficient for 25 percent of the U.S. population; and enhancing Federal, state and local as well as international public health infrastructure and preparedness.

The President’s FY 2007 budget also requests more than $350 million for important ongoing pandemic influenza activities at HHS such as safeguarding the Nation’s food supply (FDA), global disease surveillance (CDC), and accelerating the development of vaccines, drugs, and diagnostics (NIH).

Pandemics are not new. There were three in the 20th century, the worst of which was the Spanish flu epidemic in 1918-1919 that is estimated to have killed over one-half million people in the U.S. and 50 million worldwide. While we are focusing today on the impact
of the H5N1 avian flu virus from a strain currently circulating in birds in many parts of Asia and Europe, many of the policy issues and preparedness measures that arise for this strain of influenza apply as well to pandemics of other types of influenza, other emerging infectious disease outbreaks and public health emergencies. For example, pandemic preparedness offers tangible benefits in the fight against seasonal influenza which causes an average of 36,000 deaths each year.

Scientists cannot accurately predict the severity and impact of an influenza pandemic, whether from the H5N1 virus or the emergence of another influenza virus of pandemic potential. However, it is still useful to model possible scenarios based on analysis of past pandemics. In a report released in December 2005, the Congressional Budget Office presented the results of modeling a severe pandemic scenario similar to the 1918 Spanish flu outbreak and a more moderate outbreak resembling the flu pandemics of 1957 and 1968. In the severe scenario, roughly 90 million people become ill and 2 million die in the United States and the impact on the real Gross Domestic Product [GDP] is about a 5 percent reduction in the year following the outbreak. While there is substantial uncertainty associated with these estimates, they illustrate the enormous public health threat of an influenza pandemic and the need for effective access to vaccines, treatments, and a robust public health infrastructure to meet the challenge.

There are several important points to note about an influenza pandemic:

- A pandemic could occur anytime during the year and is unlikely to behave like a typical seasonal influenza. Rather, past pandemics have occurred in multiple "waves" of infection and could persist in the world for over a year.
In the absence of effective vaccines and antivirals, the capacity to prevent or control transmission of the virus once it gains the ability to be efficiently transmitted from person to person will be limited.

Right now, the H5N1 avian influenza strain that is circulating in Asia and Europe among birds is a significant concern, but there is no way to know whether this virus will in fact lead to a human pandemic. Whether or not the H5N1 adapts itself to the human host, we know that influenza viruses are constantly evolving, and it is possible that this strain or another influenza virus, which could originate anywhere in the world, could cause the next pandemic. This uncertainty is one of the reasons why we need to maintain year-round surveillance of influenza viruses to be able to determine if there are genetic changes that may signal a potential pandemic, to develop reference viruses that can be used to develop pandemic vaccines, and to assess whether influenza viruses have developed resistance to antiviral drugs. As is the case with the H5N1 that is currently in birds around the world, pandemic influenza viruses often emerge in animals. Like other viruses, they tend to remain within a species. However, as we have seen already in the more than 200 documented cases of human infection of H5N1 confirmed by the World Health Organization, they do have the ability to infect humans who have been exposed to infected birds. Of greatest concern for human health is the question of whether the viruses will develop the ability to readily infect people and whether these viruses will be able to transmit efficiently from person to
person as is the case with seasonal flu. For all of these reasons, it is critical to maintain constant surveillance of viruses worldwide affecting animal populations and that can potentially be transmitted to humans.

- We often look to history in an effort to understand the impact that a new pandemic might have, and how to intervene most effectively. However, there have been many changes in society since the "great influenza" of 1918, including dramatic changes in population and social structures, medical and technological advances, and a significant increase in international travel. Some of these changes have increased our ability to plan for and respond to pandemics, but other changes may have made us more vulnerable.

**HHS Preparations for Pandemic Influenza**

As you know, the President announced the *Implementation Plan for the National Strategy for Pandemic Influenza* on May 3, 2006. The purpose of this plan is to ensure that the efforts and resources of the Federal government and State, local and tribal governments and the private sector will be brought to bear in a coordinated manner against the pandemic threat. The *Plan* describes more than 300 critical actions, many of which have already been initiated, to address the threat of pandemic influenza. The *Implementation Plan for the National Strategy for Pandemic Influenza* confirms HHS’ role as the lead federal agency for the public health and medical preparation and planning for and response to a pandemic. The Secretary of HHS will lead the Federal health and medical
response efforts, serve as the primary Federal spokesperson for pandemic health issues, and coordinate the actions of other departments and agencies in the overall public health and medical emergency response efforts. The Secretary of the Department of Homeland Security (DHS) will provide broader overall incident management for the Federal response, will ensure necessary support to HHS to coordinate the public health response, and coordinate with HHS and other Federal, State, and tribal agencies in providing non-medical support.

The timing of the release of this Plan does not signal that a pandemic is imminent. The Plan is the result of much work in many Federal Departments and agencies to further prepare the government for a pandemic, whenever it might occur. It is important to note that the H5N1 avian influenza is a disease of birds, the virus has not yet appeared in the U.S., and there is no influenza pandemic in the world at this time.

HHS has been working with many Federal agencies, including the U.S. Department of Agriculture, the Departments of Homeland Security, State and others, in drafting the public health and medical aspects of the Implementation Plan for the National Strategy. The Plan spells out over 199 specific tasks that HHS will take the lead in or play a supporting role in to accomplish the human health aspects of the strategy. It is important to note that HHS has already started to make progress on many of the tasks delineated in the plan.

The Department’s key tasks outlined in the plan include:
• Building stockpiles of pre-pandemic vaccine adequate to immunize 20 million persons against influenza strains that present a pandemic threat;

• Expanding domestic influenza vaccine manufacturing surge capacity for the production of pandemic vaccines for the entire U.S. population within 6 months of a pandemic declaration;

• Building stockpiles of antivirals adequate to treat 25% of the U.S. population, divided between Federal and State stockpiles;

• Building a Federal stockpile of 6 million treatment courses reserved for domestic containment efforts.

• Developing clear guidelines and decision criteria to assist State, local, and tribal governments and the private sector in defining groups that should receive priority access to existing limited supplies of vaccine and antiviral medications and other critical medical care.

• Working with State and tribal entities to develop and exercise influenza countermeasure distribution plans and to include the necessary logistical support of such plans, including security provisions.
• Establishing a strategy for deploying Federal medical providers from across the USG, including expanding and enhancing programs such as the Medical Reserve Corps and supporting the transformation of the Commissioned Corps of the Public Health Service.

• Creating plans to rapidly credential, organize, and incorporate volunteer health and medical providers as part of the medical response in areas that are facing workforce shortages.

• Supporting local and national efforts to:
  o establish "real-time" clinical surveillance in domestic acute care settings such as emergency departments, intensive care units, and laboratories;
  o link hospital and acute care health information systems with local public health departments; and
  o advance the development of the analytical tools necessary to interpret and act upon these data streams in real time.

• Establishing a single interagency hub for infectious disease modeling efforts, and ensuring that this effort integrates related modeling efforts for transportation decisions, border interventions, economic impact, etc. HHS will also work to ensure that this modeling can be used in real time as information about the characteristics of a pandemic virus and its impact become available.
• Providing guidance to all levels of government on a range of options for infection control and containment, including those circumstances where social distancing measures, limitations on gatherings, or quarantine authority may be an appropriate public health intervention.

Current HHS Progress

In December 2005, Congress appropriated $3.8 billion to help the Nation prepare for pandemic influenza preparedness activities. Of that total, Congress allocated $3.3 billion to HHS for the first year of funding of the HHS Pandemic Influenza Plan. HHS will use these emergency funds to help achieve five primary objectives:

1. Monitoring disease spread to support rapid response;
2. Developing vaccines and vaccine production capacity;
3. Stockpiling antivirals and other countermeasures;
4. Coordinating Federal, State and local preparation; and
5. Enhancing outreach and communications planning.

HHS is working both domestically and internationally to monitor the spread of H5N1 and other possible pandemic viruses. On the international front, HHS is spending $125 million of its FY 06 allowance to promote international pandemic preparedness and planning and augment existing capabilities in areas such as international surveillance,
epidemiological investigation, and diagnosis of illness. Through collaborations with the World Health Organization (WHO), the United Nations Food and Agriculture Organization, the World Organization for Animal Health, and numerous national governments, HHS is working to build capacity in other countries to detect outbreaks early and to contain the spread of the virus. HHS has signed Memoranda of Understanding (MOUs) on influenza and other emerging infectious diseases with Institute Pasteur (IP); the Gorgas Institute and the Ministry of Health of Panama; and most recently, the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B). HHS experts have participated in WHO-led investigations into human cases of avian influenza in Indonesia, China, and Turkey and are providing substantial technical assistance for influenza containment activities to many other countries on an as needed basis. Overall, HHS is supporting influenza activities in approximately 40 countries and has assigned influenza staff to the World Health Organization (WHO) Secretariat, Regional, and country offices in Europe and Southeast Asia.

On the domestic front, CDC is devoting $50 million to strengthen local laboratory capacity and capability and $35 million to accelerate the implementation of the national BioSense program to enhance our ability to detect an outbreak early. On January 1, 2006, BioSense RT (Real-Time) was launched in 10 select cities and 32 healthcare institutions across the country. Real-time transmission of existing clinical diagnostic and health information is being sent to CDC and analyzed. In April 2006, CDC launched a new data visualization and analysis tool for the use of all jurisdictional levels of public health (hospital, city, county, state, national). The BioSense implementation timeline is to link up to several hundred hospitals in over 30 cities by the end of 2006.
In the event of a pandemic, infection control practices and social distancing measures (such as school closures, cancellation of public gatherings, etc.), and antiviral drugs will be the first line of defense before a vaccine is available and could limit and delay the spread of the pandemic. Currently, the Strategic National Stockpile (SNS) has over 5 million treatment courses of antiviral drugs on hand. On March 22, Secretary Leavitt announced the purchase of additional antiviral drugs that could be used in the event of a potential influenza pandemic. With these purchases, the SNS will have 26 million treatment courses of antiviral drugs that will be available to the States when an influenza pandemic is imminent. HHS’ strategy is to federally procure an additional 24 million treatment courses of antiviral drugs through FY 07 and FY 08 funds and to offer a 25 percent federal subsidy for state purchase of another 31 million treatments courses. Thus, additional money will be needed to meet our goal to have enough antivirals for 25 percent of the population during a pandemic. Congressional support of $2.3 billion for the second year of the President’s Pandemic Influenza plan will be critical to meet this goal.

The cornerstone of the HHS Pandemic Influenza Plan is to create domestic manufacturing capacity sufficient to produce 300 million vaccine courses within 6 months of the onset of a pandemic outbreak, and to maintain a stockpile of pre-pandemic vaccine. We currently have approximately 4 million courses of pre-pandemic vaccine against a clade 1 H5N1 avian influenza strain. Plans and procedures are also underway to manufacture pre-pandemic vaccine against a clade 2 H5N1 avian influenza strain that is currently circulating the globe.
On May 4, 2006 Secretary Leavitt announced the award of $1 billion for five contracts to support the development of advanced techniques using a new cell-based, rather than an egg-based, approach to producing influenza vaccines. Using a cell culture approach to producing influenza vaccine is a promising technology and offers a number of benefits. Vaccine manufacturers can bypass the step needed to adapt the virus strains to grow in eggs. In addition, cell culture-based influenza vaccines will help meet surge capacity needs in the event of a shortage or pandemic, since cells may be frozen in advance and large volumes grown quickly. U.S. licensure and manufacture of influenza vaccines produced in cell culture also will provide security against risks associated with egg-based production, such as the potential for egg supplies to be contaminated by various poultry-based diseases, including pandemic influenza strains. Finally, the new cell-based influenza vaccines will provide an option for people who are allergic to eggs and therefore unable to receive the currently licensed vaccines.

A total of $1.7 billion in FY 2006 funding is allocated for vaccine development to increase vaccine production capacity by accelerating cell-based manufacturing technology, increasing egg-based vaccine production capacity, and supporting the advanced development for antigen sparing technologies that could extend the vaccine supply by decreasing the amount of antigen needed to protect each individual.

Progress has also been made in the SNS purchase of medical supplies and equipment essential to pandemic readiness. HHS has purchased over 150 million N95 respirators and surgical masks with approximately $50 million of FY06 funds. Other planned
procurements include personal protective equipment (PPE), ventilators, IV antibiotics, and other medical supplies. Advanced development for rapid diagnostic tests also continues through the use of FY06 funds. A request for information (RFI) was issued for a point-of-care diagnostic on March 30, 2006 and a request for proposal (RFP) will be issued soon.

**State and Local Preparedness**

Pandemic influenza preparedness requires the active planning and participation of States and local communities. If a pandemic were to occur in the U.S., it would likely affect thousands of communities at the same time over the course of many weeks. The Federal Government is working to provide guidance regarding how state, local, and tribal governments can develop pandemic preparedness plans and respond in the event of a pandemic. As part of the Administration's effort to enhance State and local pandemic preparedness, HHS has held pandemic influenza summits in 47 States and the District of Columbia so far. These summits have brought together State and local officials, public health, schools, businesses, and other stakeholders to discuss pandemic preparedness. With the FY 2006 emergency funding, HHS has awarded $100 million of the $350 million allocated for State preparedness for pandemic influenza preparedness planning activities. The remaining portion of these funds will be awarded based on benchmarks that will measure States' progress.
It is important to note that HHS funding to enhance State and local preparedness for public health emergencies, including pandemic influenza, has existed since 2001. Principally through CDC and HRSA funds have been provided to States and localities to upgrade infectious disease surveillance and investigation, enhance the readiness of hospitals and the health care system to deal with large numbers of casualties, expand public health laboratory and communications capacities and improve connectivity between hospitals, and city, local and state health departments to enhance disease reporting.

First, CDC provides preparedness funding annually to public health departments of all the States, certain major metropolitan areas, and other eligible entities through cooperative agreements. Second, HRSA employs complementary cooperative agreements to provide preparedness funding annually within States for investment primarily in hospitals and other healthcare entities. HHS collaborates with DHS toward ensuring that the guidance associated with the CDC and HRSA awards is coordinated with the guidance associated with those DHS awards that address other aspects of State and local preparedness, such as emergency management and law enforcement. Including the funding we have requested for FY07, CDC and HRSA’s total investments in State and local preparedness since 2001 will total almost $8 billion.

In addition, the ability to quickly increase the number of health care workers available is a critical component of State and local public health emergency response capacity. HRSA has supported efforts to improve personnel surge capacity. Funds are used to allow jurisdictions to develop or enhance Emergency Systems for Advance Registration of
Volunteer Health Professionals (ESAR-VHP), authorized under the Public Health Security and Bioterrorism Preparedness and Response Act. ESAR-VHP is designed to help States develop registries of volunteer health professionals whose credentials have been verified in advance of an emergency so that they can be quickly called on and utilized in an emergency. In addition to the FY07 budget request of $8 million to continue HRSA’s registration system, the budget also proposes development of a web-based portal that would create the means for integrating the state ESAR-VHP systems into a National system, thereby promoting a more coordinated national deployment of personnel. The portal is intended to not only integrate existing state ESAR-VHP systems, but to also provide a credentialing service that could assist states with the development of their ESAR-VHP databases. The budget also proposes to fund a Mass Casualty Initiative, including the Medical Reserve Corps and Healthcare Provider Credentialing and the Commissioned Corps Transformation initiatives.

Lastly, effective communications and outreach are essential to pandemic preparedness at the Federal, State and local levels. President Bush called for the development of a single, comprehensive web site to be the official Federal source of pandemic and avian influenza information. This web site, www.PandemicFlu.gov, includes a wide range of information on pandemic influenza and preparedness activities. In addition, HHS has developed a series of checklists intended to aid preparation for a pandemic in a coordinated and consistent manner across all segments of society. Thus far, ten checklists have been released and are aimed at State and local governments, the business community, the
education sector, the health sector, community organizations, and individuals and families.

Conclusion

Thank you for the opportunity to share this information with you. Although much has been accomplished, continued vigilance and preparation are needed for us to be ready for a pandemic. I am happy to answer any questions at this time.
Mr. SHAYS. Thank you.

Before you jump in, Mr. Runge, I have heard three kind of memorable statements. Hope is not a strategy. Prayer is not a plan. Preparedness is a journey, not a destination.

So I want to add mine. When one of the witnesses says, “We are taking steps in the right direction,” I want to remind you of what former senator Sam Nunn, his observation, said. It is often not enough to take steps in the right direction. A gazelle running from a hungry cougar is “taking steps in the right direction.” But survival in that case, and in ours, is more a matter of speed than direction.

So the question isn’t just are we doing the right things, but are we doing them in time? The sense of urgency is as critical against a pandemic flu as the plan to fight the outbreak.

So now I have added mine. And Mr. Runge, you can add one, too, if you care to. [Laughter.]

STATEMENT OF JEFFREY W. RUNGE

Dr. RUNGE. Thank you, Mr. Chairman.

I would like to add that my name is Jeff Runge, R-U-N-G-E. Yes, sir. Thank you very much for the chance to——

Mr. SHAYS. Mr. Runge, I apologize.

Dr. RUNGE. That’s no problem.

Mr. SHAYS. It is nice to have you here, Mr. Runge.

Dr. RUNGE. I serve as the Chief Medical Officer for the Department of Homeland Security, as well as the Acting Under Secretary for Science and Technology. I am very pleased to be here with my colleague, Dr. Agwunobi, to discuss the role of DHS as the overall incident manager and the coordinator of the Federal response in the event of a flu pandemic.

DHS is working very closely with its Federal partners—the HHS, Department of Defense, USDA, and the Veterans Administration, and the Homeland Security Council—to prepare for the worst and to ensure that we are coordinated. Together with our Federal partners, we understand our roles in managing the outbreak of disease, whether it’s an outbreak that’s confined to the bird population or whether it is a full-scale human pandemic.

The USDA, with support from its State agriculture counterparts, will manage an outbreak in the bird population without help from DHS. HHS will manage the public health and medical aspects of an outbreak in the human population in prevention, response, and treatment. DHS will support HHS in fulfilling their responsibilities in any way we can.

Now even though we recognize the need to be ready at the Federal level, Secretary Leavitt and Secretary Chertoff, as well as Dr. Agwunobi and I, have made the point on numerous occasions that preparedness for an incident such as this must be defined at the local level. We have stood shoulder to shoulder with our colleagues in HHS and USDA at nearly 50 State pandemic summits, discussing the need to work together with State and local governments, nongovernmental organizations, faith-based organizations, and the private sector to ensure a condition of readiness.

Now the mechanism for coordination of a broad Federal response like this is the National Response Plan. The NRP supports the con-
cept that incidents are handled at the lowest jurisdictional level, even as it provides the mechanism for a concerted national effort.

Let me digress a moment into the likely scenario if a pandemic were to present serious and socioeconomic problems for the United States. The Secretary of Homeland Security, in consultation with other Cabinet members and the President, would likely declare an incident of national significance and implement the appropriate coordinating mechanisms. DHS is already ensuring that the appropriate multi-agency coordinating structures are in place well before an outbreak.

As a threat becomes more imminent and as a situation warrants, the Secretary may consider activating various elements of the national response, including designating a principal Federal official [PFO] standing up the joint information center and joint field offices.

Secretary Chertoff has already identified a candidate to become the national PFO for pandemic influenza. This individual will be intimately involved in the planning and exercising of all the contingency plans as we work toward the condition of readiness.

In the event we are faced with a pandemic, the Secretary would activate a national planning element composed of senior officials of relevant Federal agencies, who have already been identified, to coordinate strategic level national planning and operations. He would also likely establish as many as five regional joint field offices that would be staffed and resourced with a deputy principal Federal official in charge of each of these regional joint field offices to work directly with their State and local counterparts.

Now this framework provides a coordinated response for all levels of Government, for non-Government agencies and volunteer organizations, and the private sector. This system also affords full coordination between joint regional field offices and the military joint task forces that might be established.

In the event of a pandemic, obviously, a close, synchronous working relationship with HHS is absolutely essential. Our national public health and medical resources will unquestionably be taxed, probably beyond capacity. And DHS will do everything in its power to assist HHS with its mission.

As our department’s Chief Medical Officer, I am and will be the primary point of interface with HHS, as well as being Secretary Chertoff’s advisor on all medical issues, including pandemic influenza.

Implementation of the national strategy announced last week contains over 300 action items with very aggressive timelines. Dr. Agwunobi’s department has 199 that they are responsible for primarily. We have 58, and we are supporting other departments in another 84 items. We are prioritizing them and figuring out how we can best carry them out.

As the committee understands, the department has many competing priorities right now. But we are fully engaged to make sure that we are as prepared as we can be. In addition to our job as overall incident manager, we have some areas of unique responsibility to maintain the function of our Nation’s critical infrastructures, border management, and DHS work force assurance.
We are also focused on identifying the economic consequences to our Nation during the pandemic. These issues are interrelated as we consider policies related to the transportation industry, the flow of trade across borders, and maintenance of the supply chain for food and other goods.

Mr. Chairman, as with any illness, prevention is by far the most effective method of dealing with this disease. We fully support the efforts of President Bush and the Department of HHS to improve our domestic vaccine production, to stimulate transformational change in vaccine technology, and to reinforce the capacity of State and local public health organizations, as well as educating the public on good health practices.

And one last point, Mr. Chairman. I want to make the point that the best way to prepare for a pandemic is to strengthen the institutions that we use every day, namely, the public health medical and emergency services, as well as the support of medical science for new vaccines and therapeutics.

The collateral benefits that we gain will improve our Nation's quality of life as well as our preparedness for any biological incident, whether it's man made or through a terrorist action.

Thank you, Mr. Chairman. I will be happy to answer any questions.

[The prepared statement of Dr. Runge follows:]
Statement for the Record

By

The Honorable Jeffrey W. Runge, MD
Acting Under Secretary for Science & Technology
and Chief Medical Officer

U.S Department of Homeland Security

Before the

Committee on Government Reform
United State House of Representatives

May 11, 2006
Good morning Chairman Davis, Congressman Waxman and Members of the Committee on Government Reform. I am pleased to have this opportunity to appear before you today to discuss the current threat from Avian Influenza and how the Department of Homeland Security (DHS) will coordinate the Federal response if an influenza pandemic were to occur in the United States.

Like members of this Committee, the Department of Homeland Security and our Federal partners recognize that an influenza pandemic in the United States could trigger severe public health and economic consequences, catastrophic loss of life, and disrupt our nation's critical infrastructures. DHS is working closely with its Federal partners, especially the Department of Health and Human Services (HHHS), the U.S. Department of Agriculture (USDA), the Veterans Administration (VA), the Department of Defense (DOD), and the Homeland Security Council to prepare and to ensure that we are coordinated in our response.

The Role of DHS

As we coordinate, we recognize that each Department has responsibilities that are unique as well as some responsibilities that overlap. The DHS responsibilities are clear, pursuant to the Homeland Security Act of 2002 and Homeland Security Presidential Directive-5 (HSPD-5). As the domestic incident manager, the Secretary of DHS will coordinate the overall Federal response to a pandemic in order to ensure the continuity of our government, maintain civil order, preserve the functioning of society and mitigate the consequences of a pandemic. The Secretary of DHS serves as the principal Federal official for overall domestic incident management. In this
role, during a pandemic outbreak, the Secretary of Homeland Security is responsible for the coordination of Federal operations and/or resources, establishment of reporting requirements, and conduct of ongoing communications with Federal, State, local, tribal, private sector, and nongovernmental organizations.

Our Federal partners are also quite capable of fulfilling their respective roles in managing outbreaks of avian influenza, from well confined outbreaks in birds to a full-scale pandemic, and we are fully coordinated with them. The USDA, working with its state agriculture counterparts, has ample experience in managing an outbreak in the bird population. HHS has the responsibility and expertise to plan public health and medical preparedness. We all recognize that there is still significant work to be done to ensure the Nation is adequately prepared to respond to an outbreak in humans. As the National Strategy for Pandemic Influenza says, “Preparing for a pandemic requires the leveraging of all instruments of national power, and coordinated action by all segments of government and society.” This need for coordination of our National instruments is part of the reason that DHS exists. A pandemic could threaten the ability of the health and medical sector to manage all the consequences, which could likewise threaten the functioning of society and the Nation’s economy. It is the responsibility of DHS to coordinate the Federal response to manage those risks.

The NRP is the primary mechanism for coordination of the U.S. Government response to terrorist attacks, major disasters and other emergencies, and will form the basis of the Federal pandemic response. If a pandemic influenza were to present grave social and economic problems for the United States, the Secretary would—in consultation with other cabinet members and the
President—likely declare an Incident of National Significance and ensure implementation of the appropriate NRP coordinating mechanisms to ensure a coordinated Federal response.

The NRP supports the concept that incidents are handled at the lowest jurisdictional level. However, a pandemic will ultimately require a concerted national effort. Under the National Strategy and the NRP, Federal departments and agencies have assigned roles and responsibilities to support all incidents to include a biological incident.

The Secretary will consider the following four criteria set forth in HSPD-5 when making the determination to declare an Incident of National Significance; however, he will not be limited to these thresholds and may base his decision on other applicable factors:

- A Federal department or agency acting under its own authority has requested the assistance of the Secretary of Homeland Security
- The resources of State and local authorities are overwhelmed and Federal assistance has been requested by the appropriate State and local authorities
- More than one Federal department or agency has become substantially involved in responding to an incident, and
- The Secretary of Homeland Security has been directed to assume responsibility for managing a domestic incident by the President.

DHS will work collectively with the interagency to establish the appropriate multi-agency coordinating structures when the situation warrants, even before a full scale outbreak. The Secretary may consider activating elements of the national response, including designating a
Principal Federal Official, standing up the Joint Information Center and Joint Field Offices. The Secretary has already identified a candidate to become the national PFO for pandemic influenza. This individual will be intimately involved in the planning and exercising of our contingency plans.

The Secretary would also set up a national planning element composed of senior officials of relevant Federal agencies to coordinate strategic-level national planning. The Secretary would also likely establish as many as five Regional Joint Field Offices that would be staffed and resourced with a Deputy PFO in charge of each Regional JFO to work directly with state & local entities. This framework provides a coordinated response for all level of government, non-government and volunteer organizations (NGOs), and the private sector. This system also affords full coordination between the regional joint field offices and military joint task forces that may be established. Last month, Secretary Chertoff asked his fellow Cabinet members to identify senior officials to coordinate planning and operations among the Federal departments before a pandemic would strike. The list has been compiled, and we look forward to working with these individuals as we plan and train together with our pre-designated PFO and Deputy PFOs.

In the event of a pandemic, a close, synchronous working relationship with HHS is essential. Our national Public Health and medical resources will unquestionably be taxed, probably beyond capacity, and DHS will do everything in its power to assist HHS with its mission to prevent illness and mitigate the consequences of the anticipated widespread morbidity and mortality. The DHS Chief Medical Officer is the primary point of interface with HHS and is responsible for advising the Secretary of DHS on all medical issues, including avian influenza. The DHS Chief
Medical Officer is also responsible for directing and overseeing the planning, policy, training, and operations to protect the health of the DHS workforce in the event of a pandemic in order to maintain critical DHS operations. We are taking advantage of assets across the Department to accomplish this goal, especially the expertise of the U.S. Coast Guard medical officers.

**Federal Preparedness for Pandemic Influenza**

The National Strategy for Pandemic Influenza, issued by President Bush on November 1, 2005, provides the framework for the Federal government’s response to the influenza pandemic threat. It presents a high-level overview of the Federal government’s approach to an influenza pandemic, emphasizes the importance of the full participation of State Local, and Tribal Governments, the private sector and critical infrastructure components, the public, and the international community to prepare for, prevent, and contain influenza.

The National Strategy makes it clear that while the Federal government will pursue all avenues available to it to thwart an influenza pandemic, it is essential for the States and communities be fully informed and engaged as well. The resources of the Federal government alone may not be sufficient to prevent the spread of an influenza pandemic across the nation. Preventing, minimizing and mitigating the consequences of an influenza pandemic requires a coordinated and integrated national effort that includes the full participation of all levels of government and all segments of society.
The Implementation Plan for the National Strategy announced last week contains over 300 action items with very aggressive implementation timelines. DHS has the lead in 58 of these actions and participates with other departments in 84 additional items. The Department is currently prioritizing these actions and is attempting to identify resources to carry them out. The department has many competing priorities, but is fully engaged in planning efforts for our own departmental plans as well as fulfilling our responsibilities enumerated in the Implementation Plan.

While the Plan directs that departments and agencies undertake a series of action in support of the Strategy, it does not describe the operational details of how the departments will accomplish these objectives. Each department will devise its own planning documents that will operationalize the Implementation Plan and will address additional planning considerations that may be unique to each department.

The DHS Pandemic Influenza Implementation Plan

The DHS Pandemic Influenza Plan is structured around the three pillars of the National Strategy: Preparedness and Communication, Surveillance and Detection, Response and Containment. In order to support these pillars, the DHS plan focuses on the overall Federal incident management of a pandemic, as well as our unique responsibilities to manage our borders, protect our Nation’s critical infrastructures, ensure the health and safety of the DHS workforce, and find ways to mitigate the overall economic impact to our Nation.
Since December, DHS work groups comprised of representatives from across all components of the Department have been working to accomplish these goals and have been developing contingency planning documents. The DHS Office of Infrastructure Protection has developed plans and exercises to maintain the function of the 17 critical infrastructures, working closely with the private sector and our Federal partners. In conjunction with its interagency partners, the Department will release a Critical Infrastructure and Key Resource Pandemic Influenza Preparedness, Response and Recovery Guide. This guide will assist the private sector in business continuity planning efforts to cope with business disruption and high rates of employee absenteeism that would accompany a pandemic. Our overall incident management workgroup is developing playbooks with the directorates and components of DHS, and has focused efforts on synchronizing operation centers from across Federal and State governments and developing a common operating picture methodology so that real-time communications are optimized. The workgroup on Entry and Exit Policy and Border Management has been working very closely with our Federal partners and the Homeland Security Council to determine the best policy to delay and limit the introduction of a pandemic into the U.S. through effective screening of passengers, travel restrictions and border controls, supporting the CDC’s quarantine stations at our major point of entries, and providing training to our front line workforce. The Workforce Assurance workgroup has been working closely with the CDC and the Occupational Safety & Health Administration to devise scientifically sound policies for personal protective equipment and training protocols to minimize disruption to our workforce. They have also been developing contingency planning for Continuity of Government and Continuity of Operations to deal with disruptions in our workforce due to absenteeism or caring for loved ones. The Economic Consequences workgroup has been working with Federal partners and the National Laboratories
to identify and inventory the economic modeling capacity in order to drive policy decisions that would minimize economic disruption to our nation during a pandemic. Examples are policies related to transportation industry, the flow of trade within and across borders, and maintenance of the supply chain for food and other goods.

**DHS Expenditures: Pandemic Preparedness**

As part of the President’s supplemental appropriations request to fund the National Strategy for Pandemic Influenza, DHS received $47.3 million to increase the readiness and response capabilities of the department in the event of an influenza pandemic. The Supplemental Funding Plan allocates funds in six key categories that include:

- **Preparedness Planning:** The Plan targets $12 million in funding for preparedness planning. This effort is aimed at preparing for the significant implications that a pandemic influenza would have on the economy, national security and the basic functioning of society. It includes developing the capability to anticipate the impact of the disease on absenteeism across multiple sectors and how this will affect the continuity of essential functions in support of the Federal response. Conducting modeling and simulation to predict the impact of pandemic flu on critical infrastructure; engaging in international negotiations for screening protocols, procedures and quarantine authorities; and participating exercises to test readiness are part of this effort.
• **Training Development and Deployment:** The Plan calls for $10.7 million to be allocated for the protection of border and domestic air and maritime travel. These funds will be used for readiness assessments of high risk airports and ports and training related to the use of quarantine stations and the isolation, handling, and transportation of potentially infected individuals. The experience of HHS and CDC training exercises will add value to DHS training activities, which will involve personnel of the U.S. Coast Guard, Immigration and Customs Enforcement, Transportation Security Administration, and Customs and Border Protection.

• **Personal Protective Equipment (PPE):** The Plan sets aside $16 million for the acquisition of PPE for approximately 145,000 high risk and mission critical personnel. DHS will develop the requirements to provide these personnel with appropriate PPE and establish respiratory protection programs, which include respiratory fit testing, medical clearance and PPE related training.

• **Rapid Influenza Assay Study:** The Plan provides $1.5 million to support system studies and define operational requirements for a rapid diagnostic tests, working in coordination with HHS. This test could provide more effective screening prior to departure and entry, especially in situations when infected persons may require isolation. This could have broader applications in the transportation sector, the workplace, or for continuity of government purposes.
• **Isolation Systems:** The Plan dedicates $4.4 million to support infrastructure changes and construction of isolation systems at ports of entry or other major transportation hubs. Currently the CDC has only 18 quarantine stations among over 320 ports of entry, few of which have adequate facilities for isolation and containment of infected travelers.

• **Program Support:** The Plan allocates $2.7 million for technical, management, financial, and integration functions relating to the implementation of the Plan. This includes the coordination of requirements from DHS components for workforce protection, environment, training, staffing restrictions and protocols as well as documentation and tracking of requirements and plans.

**Conclusion**

Since the reorganization of DHS under Secretary Chertoff's 2nd Stage Review and the formation of the Office of the Chief Medical Officer, a tremendous amount of our focus has been on pandemic influenza planning, supplemental budget development and coordination, coordinating with other Federal agencies on policy matters, and participating in the writing of the *Implementation Plan*. DHS senior officials have been present with HHS at nearly every one of the 50 State Pandemic Summits.

The Department of Homeland Security is in the process of making recommendations to further clarify the National Response Plan to better fulfill its incident management role. In collaboration
with our international partners, we are developing screening and containment procedures to
decrease the likelihood of disease spread should sustained human-to-human transmission occur.
We have been working with our federal government and private sector colleagues to provide
business continuity guidance and recommendations, especially for critical infrastructure and key
resources. Our own plan addresses workforce protection and continuity of operations.

The challenge to complete an effective contingency plan for DHS and realize an appropriate
response to such a catastrophic incident is formidable. Carrying out the hundreds of actions in
the Implementation Plan will require significant amounts of time, human resources, and
budgetary resources. Even with the challenges, this effort will be worth it for the sake of our
Nation’s biodefense. It has become apparent that the newly found coordination among State,
local and tribal governments, HHS, DHS, USDA, VA, and DoD, NGOs and the private sector
will put our Nation in much better shape to deal with biological threats, regardless of whether
they are natural or man made. The collateral benefits of pandemic planning are undeniable and
are worth our department’s best efforts and full engagement.

As with any illness, prevention is by far the most cost effective method for dealing with this
disease. We fully support the efforts of President Bush and the Department of Health and
Human Services to reinvigorate our domestic vaccine production, to stimulate transformational
change in vaccine technology, reinforce the capacity of State and Local public health
organizations and educate the public on good public health and ways to keep every individual
and family safe.
The best way to prepare for and prevent a pandemic or any major catastrophic event is to strengthen the institutions that we use every day, namely public health, medical, and emergency services, as well as the support of medical science for new vaccines and therapeutics. They are also avenues to enhancing the quality of health care and the quality of life in our communities on a daily basis. We look forward to working with Congress as well as our State and local counterparts to ensure that the response is as efficient and effective as it can be.
Chairman Tom Davis [presiding]. Thank you very much.

Dr. Agwunobi, let me start with you. What lessons did HHS learn from Katrina and the 2005 hurricane season that can be applied to pandemic planning and preparedness?

Dr. Agwunobi. I think there’s one broad lesson that I think is very clear. And that is that a pandemic is fundamentally different than what we saw in Katrina. In Katrina, I think we realized that an essential part of our response was the rallying to the needs of those communities by the professionals and the first responders of other communities from around the Nation.

In a pandemic, we envision that every community will be simultaneously facing the crisis of a pandemic and that there may be—in fact, it’s probably guaranteed that there will be very limited ability for other States and other communities to rally to the aid of a community living through a pandemic.

I think other lessons are obvious, and that is that we need to collaborate and strengthen our ability to work with health professionals within every community. Medical Reserve Corps was one that we used during Katrina and are building upon now. This notion that practitioners from across the Nation can be prepared to respond to the needs of their own communities if you organize them beforehand, credential them beforehand, and train them beforehand. And we’re doing just that with the Medical Reserve Corps.

I think, last, I’ll just add that a great lesson learned and one that we will build upon is this notion of a partnership between us and Homeland Security. The need to not only focus on the health and medical aspects of a pandemic, but also those other aspects of the community that might be affected, like critical infrastructure, electricity supplies, water supplies, and the like.

Chairman Tom Davis. But given the decentralized nature of the U.S. public health system, much of the pandemic preparedness really needs to occur at the State and the local level. One of the problems of Katrina, of course, is we never got a unified command.

How many State pandemic plans has CDC reviewed or approved?

Dr. Agwunobi. I believe the CDC has actually reviewed all of the State pandemic plans to date. Clearly, those plans change with time. They’re constantly being improved at the State level, and CDC is constantly reviewing the updated versions as they are submitted.

Chairman Tom Davis. Is every State in compliance and has a plan at this point as far as you know?

Dr. Agwunobi. Every State does have a plan, and those plans are being improved on a continual basis.

Chairman Tom Davis. Do you have performance measures over these plans?

Dr. Agwunobi. The CDC guidance that is being prepared to date and will be issued with—along with funds designated to enhance preparedness and exercising of those plans will contain detailed performance requirements and expectations.

Chairman Tom Davis. The States found these guidelines helpful, do you think?

Dr. Agwunobi. I think we’re hearing back from the States that planning and preparedness is well underway. They recognize that,
like every nation, that there’s more that needs to be done. We’re hoping and are beginning to see that these plans are going beyond the State, but they’re now being developed into communities by local leaders, and that’s very heartening.

Chairman Tom Davis. And let me ask you, to what extent are you and the Department of Health and Human Services planning to use telework during a continuity of operations?

Dr. Agwunobi. Our continuity of operations plan contemplates the need for telework and work at offsite settings. I fully expect that as we release our own implementation plan for the Department of Health and Human Services that it will contain in large part great plans for telecommuting.

Chairman Tom Davis. Dr. Runge, as you saw during Hurricane Katrina, the National Response Plan can be ambiguous. Individual authorities among agencies were not always clearly identified. How are DHS and HHS using the lessons learned from Katrina to fix deficiencies in the National Response Plan so that the country is more rapidly prepared for future disasters?

I will tell, in Katrina, not being there rapidly getting things together ended up costing lives and money. In this case, with a pandemic, time is critical and being able to move in. What have we learned here?

Dr. Runge. That’s obviously a great question, and it’s one that we spent quite a bit of time.

I had the—I would say it was a luxury, but it actually is not a luxury of joining the department after Katrina and working backward with my new colleagues who arrived on the scene after Katrina. And we were not happy either with the coordination that occurred with DHS and HHS, and we have taken tremendous steps in fixing that.

The deputy secretaries of both agencies, together with our counterparts, have spent many hours talking about how we’re going to improve the coordination and function of the Emergency Support Function 8, as well as my chief of staff has spent the last week in the Gulf States talking about how we are better coordinated with hurricane preparedness, playbooks. We are coming together with a pandemic—a playbook for pandemic.

We’ve also, and I think you’ll be interested in this, have been going department by department and talking about the importance of using the National Response Plan and that the plan is no good unless it’s used.

It may be no surprise that the tenets of the National Response Plan, perhaps because they are a bit ambiguous and unusual for the nonmilitary, such as myself, that we actually have to sit down and discuss how to operationalize that coordination. And I think that we are well on the way toward a completely bolted together HHS and DHS.

The Office of the Chief Medical Officer was just created as a result of the second stage review, and they have a constant point of contact for all of these issues. I’m much more confident that we are better equipped not only for this hurricane season, but in the event of a pandemic.

Chairman Tom Davis. OK. Thank you very much.

To what extent is DHS planning to use telework during——
Dr. Runge. One of our workgroups, Mr. Chairman, is continuity of Government, continuity of operations. We have quite a bit of expertise in the department. We've got an integrated team working on that issue, headed by Coast Guard Chief Medical Officer, Admiral Higgins.

But I will say, in all fairness, that the other side of our agency, the Infrastructure Protection Office, has responsibility for the maintenance of the 17 critical infrastructures of which telecommunications is one, is looking very carefully at this issue.

It's one thing to say that we'll all go home and use the Internet for work. It's another matter to make sure that the backbone is in place, that the last mile of copper going into neighborhoods will, in fact, withstand the increased traffic.

Our Critical Infrastructure Partnership Office has had a couple of tabletops with the telecommunications industry involving this issue, and it turns out to be quite a more complex problem than simply saying, "Guys, go home and log on."

Chairman Tom Davis. Absolutely.

Ms. Springer, what happens if a Federal agency doesn't adequately incorporate telework in its COOP planning for a pandemic? In other words, what are the risks to that agency and the public if the agency isn't prepared to carry out its essential functions?

Ms. Springer. Well, each agency, in my judgment, needs to have telework as a part of its COOP plan. And as the Comptroller mentioned, the GAO guidance is, in fact, exactly that, that is an important component. So it's hard for me to imagine that wouldn't be.

The telework statute, as it exists right now, does not authorize OPM to regulate the telework program. So we aren't in the position to actually direct agencies to include it. But working with FEMA, I think——

Chairman Tom Davis. Would you like to have that authority?

Ms. Springer. I think someone needs to have it.

Chairman Tom Davis. OK.

Ms. Springer. But I think certainly from an emergency standpoint, which is different than the routine type of telework, the day-to-day normal condition telework, but in an emergency situation, I think at a minimum, the FEMA direction needs to be that is a must component of COOP plans.

Chairman Tom Davis. OK. OPM and DHS issue guidelines and offer assistance in COOP and telework planning, but Federal agencies can take it or leave it. And according to GAO surveys, they often leave it. Frankly, the progress of Federal agencies in adopting COOP plans and implementing telework is not very impressive.

In fact, the White House pandemic implementation plan says nothing at all about requiring Federal agencies to develop COOP pandemic plans or incorporate telework in those plans. It also doesn't require DHS or OPM to review agency plans once they are developed.

So what steps can OPM take to ensure that other Federal agencies follow your guidance on COOP planning, especially in the face of pandemic? And what additional authority would OPM need to assure compliance, and do you think OPM is the right agency?

Ms. Springer. Well, OK. There are several questions you asked there. Let me answer those because they're all important.
At this point, we think roughly half the agencies—or actually, this is our most recent telework survey. We're about to go out with another one, which I think is pretty timely. But about half the reporting agencies had included telework in their COOP plans. About another half were working to achieve that goal.

As you noted, we're required under the implementation plan from the White House to issue guidance. But to the extent that we want to help to ensure that guidance is actually put into practice, there are several things we can do. I've already arranged to meet with the inspectors general community, the PCIE, at their June meeting. And to work with them and encourage them, even though we don't have the authority to commit them to do this, but to put into place a protocol for practicing not just telework, but to make sure that there is a practice of those plans at their agencies.

I've asked our own inspector general at OPM to—at the right time to evaluate a test that we will be doing of telework. We may take a Saturday or we may take a week day or two and actually commit those who are going to telework to actually do that. And then we'll have our inspector general—so I think inspector general commitment and involvement is going to be helpful here.

I think that we will develop best practices. That will be one of the sets of guidance that we put out. Not just here's how telework can work, whether you need an agreement, what needs to be in writing, that kind of thing. But actually some best practices as a result of those tests and what we find at OPM.

So those are the things where I see us actually going a little bit beyond the strict task that we've been given under the implementation plan. Beyond that, we don't have any particular statutory authority. I think that would—that implementation role resides at this point more likely with FEMA than OPM.

Chairman Tom Davis. OK. What role will OPM have in this June's interagency COOP exercise Forward Challenge? Are there plans for an interagency COOP exercise based on a pandemic flu scenario? And how essential is it for all the Federal agencies to engage in Government-wide exercises for COOP?

Ms. Springer. Well, the last question is the easiest to answer. It's essential for everyone to participate. We will be participating in that June exercise. OPM, as I noted in my opening statement, has to make sure that OPM is running as well. In addition to the Government-wide guidance that we provide, we are a guidance agency.

But our own planning has led to the key essential functions that we need to do, and about a third of those are internal functions or infrastructure, keeping things running, telecommunications, things like that. But then there are others that are more externally focused. So we'll be testing those in the June exercise.

Chairman Tom Davis. All right. Ms. Koontz, let me move to you. One of the criticisms from GAO was that FEMA didn't provide adequate guidance to agencies to prepare for telework in the case of emergencies. Now the White House pandemic implementation plan directs OPM to issue guidelines for agencies on COOP planning criteria for a pandemic and to update its telework guidelines. Do you think that is an adequate response?
Ms. KOONTZ. We're encouraged that there's now a timeframe for issuing this kind of guidance. But what I'm not sure about at this point is whether the guidance will actually include the specifics on what agencies need to do to make sure that they are able to use telework effectively when—during an emergency situation. And that includes everything from testing to communications to technological capacity.

Chairman TOM DAVIS. If an agency already regularly uses telework, why does it need to test its COOP telework capabilities?

Ms. KOONTZ. I think as other witnesses have indicated, that testing is just critical of every part of continuity planning. But under an emergency, particularly a pandemic, you may have a lot more people teleworking than normal. And it may be—it's probably important to make sure that you actually have the technological—you have the communications capacity to do this. You have the software licenses that you need to do this.

Frankly, you don't know what you don't know. And what an exercise does is that it shows you those kinds of things, and you can feed them back into your continuity planning.

Chairman TOM DAVIS. What do you think is the most important thing agencies can do to prepare to continue operations during a pandemic?

Ms. KOONTZ. There are many things, but I'll touch on a few from the continuity perspective. And that is, first of all, they need to have a robust telework program that includes all the necessary preparations.

And then also I think agencies need to strengthen their basic continuity planning, and that includes identifying essential functions, identifying the interdependencies, identifying what resources you need, and then testing to make sure that it all works.

Chairman TOM DAVIS. Yes, but for agencies that have already begun planning to use telework, what should they do to ensure that the capability will be there in emergencies?

Ms. KOONTZ. We outline a full list of the practices that we think need to be present, but I'll highlight several. One is, is that they need to make sure that agency personnel understand that they are expected to work during an emergency using telework and understand what they're supposed to do in that scenario.

They also need to make sure that we have the technological capacity, including telecommunications, and we also need to test to make sure that we're able to do that.

Chairman TOM DAVIS. OK. Well, we have a vote on the floor. Unfortunately, somebody didn't get their amendment made in order on the defense authorization bill. So they are getting up and moving to adjourn every few minutes.

I think they think that by doing that, they will get maybe their amendment next time. I am not sure if that works that way or not. So I think at this point, I am going to let this panel go.

I want to thank you for your testimony. You know, we will stay in touch with you on this. It is just very, very important. We will take about a 10-minute recess while we go vote, and then we will swear in our next panel.

Thank you all very much.

[Recess.]