

**Statement by Dr. Thomas Kirsch, MD, MPH, FACEP
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**Before the Energy and Commerce Subcommittees on Health and Oversight and
Investigations
U.S. House of Representatives**

Chairman Deal, Chairman Whitfield, Congressman Brown and Congressman Stupak, I am Dr. Tom Kirsch, and I serve in a volunteer capacity as the American Red Cross Medical Director for Disaster Health Services. My professional position is Director of Operations, Department of Emergency Medicine at the Johns Hopkins School of Medicine. I appreciate the opportunity to appear before the Subcommittees on behalf of Red Cross and to share with you the public health efforts that have been undertaken following Hurricane Katrina.

As an independent, not for profit organization, the Red Cross is part of the first response community, working with police and fire personnel by helping move people out of harm's way and providing shelter, first aid and food. When the National Response Plan is activated following a federal disaster declaration, Red Cross is the only nongovernmental organization with Primary Agency responsibilities for Mass Care (feeding and sheltering), known as Emergency Support Function #6.

In addition to being a primary agency for Mass Care, we serve as support agency to the Department of Health and Human Services in the provision of Public Health and Medical Services, as outlined under Emergency Support Function #8 (ESF 8).

Our major responsibilities Under ESF #8 include:

- Provision of emergency first aid;
- Assistance for community health personnel;
- Mental health counseling for individuals affected by the disaster;
- Coordination with the American Association of Blood Banks Interorganizational Task Force on Domestic Disasters and Acts of Terrorism to provide blood products and services as needed through regional blood centers;

As we focused on the public health issues that could arise in the many congregate shelters needed as a result of the massive evacuation following Hurricane Katrina, we assembled a team of public health experts at Red Cross National Headquarters in Washington, D.C. on Wednesday, August 31, 2005. Within 48 hours, we had two assessment teams already deployed to Louisiana and Mississippi to assess our sheltering operations in order to conduct an emergency assessment of our shelters. As a Red Cross volunteer, I led the efforts with my colleague, Dr. Courtland Robinson from the Johns Hopkins Bloomberg School of Public Health. The purpose of the visit was to:

- Assess the health and public health needs of the shelters;
- Establish relationships with local hospitals and health care practitioners; and
- Begin liaising with other governmental and non-governmental agencies providing aid.

Our teams visited the regional Red Cross headquarters in Baton Rouge, Louisiana and Montgomery, Alabama as well as local chapter headquarters and individual shelters throughout the two states. We also coordinated activities and established relationships with local, state and governmental officials through each state's Emergency Operations Center (EOC) and by direct visits to these agencies. Based on these preliminary assessments, an emergency public health response was developed for each of the states.

We also developed a public health command center in the Red Cross Disaster Operations Center in Washington, D.C. Along with two of my colleagues, Dr. Gregg Greenough of Johns Hopkins and Harvard Universities, and Dr. Ed Hsu of Johns Hopkins, the command center is manned effectively. Not only have we been able to better coordinate our public health efforts, but we have also developed assessment tools and educational materials for use in the field.

To date, we have accomplished a great deal, including:

1. Emergency health and public health assessments in more than 35 shelters in Louisiana, Mississippi and Texas;

2. Medical and public health expert advice for the Red Cross at the national and regional levels.
3. Ongoing engagement with FEMA, the CDC, Public Health Service, state health departments, DMAT teams and local health facilities in three states.
4. Deployment of 27 public health trained physicians, including the Dean of the Johns Hopkins Bloomberg School of Public Health.
5. State-wide survey of all shelters in Louisiana in conjunction with the CDC and U.S. Public Health Service.
6. Completed a state-wide shelter assessment in Mississippi and implemented surveillance system using a toll-free number for all shelters.
7. Developing and adapting health education handouts and brochures for distribution to ARC shelters.

I am proud of the work that we are doing to ensure that shelters remain safe for evacuees and survivors. I am also proud of the medical community for their immediate support to these shelters. There was some concern that an organization like the Red Cross would have to assume responsibilities for coordinating local medical needs and medical personnel. I am happy to report to you that this is not the case. There was tremendous response from local physicians and nurses with providing direct medical care throughout the state including in shelters. However, there needs to be better coordination of these local doctors, nurses, and other medical professionals so that credentials and skills can be verified to ensure the highest possible care for those affected by disaster. This type of oversight could be conducted by academic medical schools, the Medical Reserve Corps, or other state agencies.

Conclusion

As the hurricane season continues, and the need for shelters is still prevalent, it is imperative for the American Red Cross to continue having a public health presence for the next 2-4 weeks or until local, state and federal authorities can complete the infrastructure needed to ensure public health safety.

My hope is that as we continue to assess the sheltering operations that we will continue to work to mitigate any potential public health crises. This will require long term public health expertise and advice as the sheltering of these displaced peoples continues.

Thank you for the opportunity to appear before you today.

Appendix

Louisiana

In Louisiana, our team¹ initially met with the leadership of the regional Red Cross response and reported through the Disaster Health Services manager. Over the next four days we assessed 19 Red Cross shelters and three very large state shelters, established relationships with the local emergency health facilities such as the Pete Marovich Center in Baton Rouge, and met with multiple agencies through the state EOC. Reports of possible infections at two shelters were also directly investigated.

Major initial findings:

1. Initially there remained many logistic, communication and supply problems but these rapidly improved.
2. There were no infectious disease issues identified at any shelter.
3. Every shelter had good access to medical care either through local physicians providing care in the shelter, visiting medical teams, DMAT teams or relationships with local hospitals.
4. There were no outside resources rapidly available to access public health issues in Red Cross shelters or to begin surveillance for infectious diseases.

Based on the preliminary findings plans were made to:

- Create a full-time health liaison position to coordinate activities with other agencies providing aid; and
- Create four teams of public health experts to visit each ARC shelter and assess public health needs, begin a passive surveillance system and provide health education to shelter nurses.

Surveys and educational tools were drafted and more public health experts were sent to the field. However, soon thereafter the Red Cross health liaison found that the state, in association with the U.S. Public Health Service and the Centers for Disease Control, was interested in a similar survey and our efforts were combined. There are now 24 teams conducting surveys of every shelter in Louisiana. Urgent findings will be available immediately for operation purposes. Thus far there are no reports of problems with infectious disease outbreaks.

Mississippi

In Mississippi, the team² initially met with the leadership of the regional Red Cross response center in Montgomery, Alabama. We then conducted assessments along with a regional physician in 12 shelters in the Biloxi-Gulfport area. After these visits a health liaison was sent to the state EOC in Jackson, Mississippi to begin coordinating with other agencies.

Major initial findings:

1. There continued to be severe disruption in basic logistical support and communications.

¹ Thomas Kirsch, MD, MPH (Johns Hopkins), Hilarie Cranmer, MD, MPH (Harvard), Alex Vu, MD, MPH (Johns Hopkins), Joyce Sophle, MD (private).

² Courtland Robinson, PhD, Margurite Kearney RN, PhD and Kellogg Schwab, PhD (Johns Hopkins), and Jonathan Spector, MD, MPH (Harvard).

2. There were difficulties in staff availability.
3. There was reasonable availability of health care for the clients of Red Cross shelters.
4. There were no infectious disease problems identified, although some shelters were continuing to improve shelter services and sanitation.
5. There was a need to begin disease surveillance and health education.

During meetings in Jackson, the Mississippi Health Department requested that the Red Cross begin shelter assessments and disease surveillance. The means chosen for this was to develop four health intelligence teams, whose goals are similar to those in Louisiana but will focus more on establishing a 'passive-active' surveillance system with county public health authorities and health education of ARC staff and clients through the use of educational tools. These teams will begin work on September 12.

Texas

A team³ was sent to Houston on September 8 primarily to liaise with other health and public health agencies to ensure the safety of the shelters. Thus far they have been conducting planning with the CDC and state public health officials to finalize surveillance and education systems. They have also conducted assessments in more than 10 shelters in conjunction with a team of epidemiologists from the CDC.

³ Michael Klag, MD, MPH (Dean of the Johns Hopkins School of Public Health), Alex Vu, MD, MPH (Hopkins) and Sarah Tuneberg, BSW (Tulane).