



## **Commissioned Officers Association of the U.S. Public Health Service**

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The Honorable David R. Obey, Chair  
Subcommittee on Labor, Health and Human Services, Education and Related Agencies  
Committee on Appropriations  
Rayburn House Office Building, Room 2358-C  
Washington, D.C. 20515

### **Re: DHHS Health and Medical Response (HAMR) Teams**

Dear Chairman Obey:

I write to express once again this Association's strong support for full funding in FY 2010 of the Health and Medical Response (HAMR) Teams proposed by the Department of Health and Human Services.

The HAMR Team proposal could not be more timely. Our country is collectively tracking a rapidly spreading epidemic that seemed to come from nowhere just one week ago today. I can think of no better way to make the case for a highly trained and instantly deployable public health asset than to point to the swine flue scare we are in the middle of right now.

For each of the last three years, the U.S. Department of Health and Human Services has included in its budget request approximately \$30 million to create and train two Health and Medical Response (HAMR) Teams of 105 USPHS officers each. The Department has designated this initiative a top priority and a critically essential element in its overall emergency preparedness and disaster response program. Our Association strongly supports the Department's request.

The HAMR Team proposal was not funded for FY 2007 or 2008. It was not funded in the Omnibus spending bill for FY 2009 that Congress approved in March.

Last October, we met with senior House Appropriations staff. Our goal was to understand and hopefully overcome any concerns on the House side about fully funding the proposed HAMR Teams.

We addressed the view that the proposed HAMR teams would somehow diminish or compete with the all-volunteer National Medical Defense System (NDMS) and its Disaster Medical Assistance Teams (DMATs). The NDMS DMATs are volunteer teams that, when activated under ESF 8, are organized and paid as temporary federal employees at the GS-15 pay grade. Their mission is to provide clinical medical care, primarily trauma care. They are outfitted and equipped for two weeks of operations. At the end of two weeks, they disband; team members return to their regular private-sector or state or local public service jobs.

HAMR teams, by contrast, would be full-time federal employees. While their primary mission would be emergency preparedness and crisis response, they would also be tasked with a variety of other critically important public health missions including support to state and local health departments. Their pay grades would generally be below that of a GS-15 (more likely in the O-2 to O-4 range).

Their emergency preparedness and crisis response tasking are already defined in ESF 8 and reaffirmed by Katrina lessons learned. They are not short-duration clinical medicine response teams. Their overarching mission is public health. This means restoring and maintaining disrupted water supplies and sanitation systems. It means preventing the spread of disease, including infectious diseases and food-borne and water-borne diseases. It also includes emergency mental health services and support for patients with chronic diseases. These are missions for which the NDMS is neither staffed nor outfitted.

HAMR Teams would be deployed for the long haul. The USPHS Commissioned Corps had officers deployed to the Gulf Coast for several months after Hurricane Katrina, long after the DMAT volunteers had returned home.

HAMR teams are designed to relieve a significant problem that exists now with the deployment of Corps officers who work throughout the federal government at CDC, FDA, IHS, and other federal agencies. The HAMR teams would replace the USPHS Commissioned Corps Rapid Deployment Force (RDF) teams as full-time rather than part-time federal first responders. RDF teams are composed of officers pulled from all the federal operating divisions and agencies. In the aftermath of 9/11 and the hurricane and other natural disasters that have occurred since, the tasking for these teams has increased exponentially. RDF teams have responded to California wildfires; Midwest floods, and a rash of suicides on an Indian reservation, among other emergencies.

This rapid increase in crisis response has exacerbated problems in the federal health agencies where USPHS officers are assigned. The more these RDF team members are called away for ESF 8 missions, the less time they have to devote to their primary jobs – all of them in key public health assignments throughout the federal government.

We sought to allay concerns that HAMR team members would be needlessly and expensively transported from coast to coast for specialized training. While reasonable support for reasonable travel will in fact be necessary, there are certainly no plans (and no reasons) to, say, assign a team to the West Coast but provide the near-continuous training that is required only on the East Coast. (At present, there is little funding for emergency preparedness training of any kind, and we have heard anecdotal accounts of dedicated USPHS officers paying for their training themselves.)

Finally, we addressed the objection that the HAMR team concept is preliminary in nature and has not been adequately thought through. This may possibly reflect a lack of sufficient detail or clarity in DHHS budget documents, but the HAMR Team concept has indeed been carefully thought-through.

We hope to continue this dialogue with members and staff of the House Appropriations Committee's Subcommittee on Labor, Education, and Health and Human Services. We also want to suggest that Subcommittee staff request a face-to-face meeting with the senior USPHS Commissioned Corps leaders who developed the HAMR Team concept. COA would be pleased to help facilitate such a meeting. Thank you for your consideration.

Sincerely,



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